SINTERPORT OF DEFICIENCES AND FLAND CONSTRUCTION A BULDING DEMINIFICATION NUMBER: D21 MULTIPLE CONSTRUCTION A BULDING CONSTRUCTION A BULDING B		-	ID HUMAN SERVICES				FORM APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING COMPLETED SAME OF PROVIDER OR BUPPLIER STREET ADDRESS. CITY, STATE, ZP GOOL INME OF PROVIDER OR BUPPLIER STREET ADDRESS. CITY, STATE, ZP GOOL UNIVERSAL HEALTH CAREINORTH RALEIGH STREET ADDRESS, CITY, STATE, ZP GOOL INMER OF DEFICIENCY ON EDITION NUMBER STREET ADDRESS, CITY, STATE, ZP GOOL OPENAL PRIMARY RESIDENT OF DEFICIENCIES THE SUMPORT OF DEF				1			MB NO. 0938-0391
IMAGE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. 2P CODE UNIVERSAL HEALTH CAREINORTH RALEIGH STREET ADDRESS. CITY. STATE. 2P CODE Stot CLARKS FORK ORIVE AW PARTOR SUMMARY STATEMENT OF DEPORTORS STREET ADDRESS. CITY. STATE. 2P CODE Street ADDRESS. CITY. STATE. 2P CODE PARTOR SUMMARY STATEMENT OF DEPORTORS PRETX REGULATORY OR USE TO FILE AND TO CORRECTION CONSTREET ADDRESS TO CORRECTION CONSTR						(2	COMPLETED
UNIVERSAL HEALTH CAREINORTH RALEIGH S281 CLARKS FORK DRIVE NW RALEIGH, NC 27816 PREDUX TO TO DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES TWO SUMMARY STATEMENT OF DEFICIENCIES The SURVEY team entered the facility on 2/16/25 to conduct a recertification and complaint investigation survey. The survey team was onsite 2/16/25, 2/17/25, and 2/18/25. The survey team was conducted remotely on 2/19/25 through 2/21/25. The survey team returned to the facility on 2/22/25. Completed the survey, and exiled on 2/22/25. Chardfore, the exit date was changed to 2/24/25. Therefore the survey was conducted remotely on 2/19/25 through 2/21/25. The survey team vas onsite 2/16/25, 2/17/25, and 2/18/25. The survey team was onsite 2/16/25, 2/17/25, and 2/18/25. The survey team returned to the facility on 2/22/25. Additional information was obtained remotely on 2/22/25. Therefore, the exit date was changed to 2/4/25. Therefore, the exit date			345529	B. WING			-
UNIVERSAL HEALTH CAREMORTH RALEGH RALEIGH, NC 27818 (04)10 PREFIX NG IMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCIES OF FULL REQUILIENCE MUST BE MERCED BY FULL REQUILIENCE DEFICIENC	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ε	
PRETRY Trac SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEDED BYTULL REQUATIONY OR LSCIDENTLYMON INFORMATION) D PRETRY Trac D PRETRY PRECENT TO THE APPROPRIATE DEFICIENCY D PRETRY Trac E 000 Initial Comments E 000 E 000 Initial Comments E 000 The survey team entered the facility on 2/16/25 to conduct a recertification and complaint investigation survey. The survey team was onsite 2/16/25, 2/17/25, and 2/18/25. The survey team was unable to return to the facility on 2/19/25 through 2/21/25 due to adverse weather of snow and unsafe travel conditions; therefore the survey was conducted remotely on 2/19/25 through 2/21/25. The survey team returned to the facility on 2/22/25, Additional information was obtained remotely on 2/22/25. Therefore, the survey team explained to 2/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # PM/TD11. F 000 F 000 The survey team entered the facility on 2/19/25 to conduct a recertification and complaint investigation survey. The survey team was unable to return to the facility on 2/19/25 to conduct a recertification and complaint investigation survey. The survey team was onsite 2/16/25, 2/17/25, and 2/18/25. The survey team was conducted remotely on 2/19/25 through 2/21/25 due to adverse weather of snow and unsafe to return to the facility on 2/19/25 through 2/21/25. Therefore, the exit date was changed to 2/24/25. Therefore the survey was conducted remotely on 2/19/25 through 2/21/25. The survey team returned to the facility on 2/22/25. Additional information was obtained remotely on 2/24/25. Therefore the survey was conducted remotely on 2/19/25 through 2/21/25. Therefore the survey was conducte					5201 CLARKS FORK DRIVE NW		
PHERIC LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CLEACH CORPERING A STORMATION) PREFIX TAG CLEACH CORPUSATION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE COMMETTION DEFICIENCY E 000 Initial Comments E 000 E 000 The survey team entered the facility on 2/16/25 to conduct a recertification and complaint investigation survey. The survey team was onsite 2/16/25, 2/17/25, and 2/18/25. The survey team was unable to return to the facility on 2/19/25 through 22/124 to a dverse weather of snow and unsafe travel conditions; therefore the survey was conducted travel conditions; therefore the survey was conducted travel conditions; therefore the facility on 2/2/25. The facility was found in compliance with the requirement CFR 483.73. Energiency Preparedness. Event ID # PM7D11. F 000 F 000 INITIAL COMMENTS F 000 F 000 INITIAL COMMENTS F 000 The survey team entered the facility on 2/22/25, and 2/18/25. The survey team was onsite 2/16/25, 2/17/26, and 2/18/25. The survey team was onsite 2/16/25. Therefore, the exit date was changed to 2/24/25. Therefore, the exit date was changed to 2/24/25. Therefore, the exit date was conducted remotely on 2/19/25 through 2/21/25. The survey team returned to the facility on 2/22/25. Completed the survey, and exited on 2/22/25. Additional information was obtained remotely on 2/24/25. Therefore, the exit date was changed to 2/24/25. Therefore, the exit date was changed to 2	UNIVERSA	AL HEALTH CARE/NORT	n KALEIGN		RALEIGH, NC 27616		
The survey team entered the facility on 2/16/25 to conduct a recertification and complaint investigation survey. The survey team was onsite 2/16/25, 2/17/25, and 2/16/25. The survey team was unable to return to the facility on 2/19/25 through 2/21/25 due to adverse weather of snow and unsafe travel conditions; therefore the survey was conducted remotely on 2/19/25 through 2/21/25. The survey team returned to the facility on 2/22/25. Additional information was obtained remotely on 2/24/25. Threefore, the exit date was changed to 2/24/25. The facility was found in compliance with the requirement CFR 483.73, mergrency Preparedness. Event ID # PM/TD11.F 000INITIAL COMMENTSF 000The survey team entered the facility on 2/16/25 to conduct a recertification and complaint investigation survey. The survey team was onsite 2/16/25, 2/17/26, and 2/18/25. The survey team was unable to return to the facility on 2/19/25 through 22/126. Interefore the survey and unsafe travel conditions; therefore the survey was conducted remotely on 2/19/25 through 22/126. Therefore, the exit date was changed to 2/24/25. Therefore, the survey team was unable to return to the facility on 2/19/25 through 22/126. and 2/18/26. The survey team was unable to return to the facility on 2/19/25 through 22/126. Unter survey team enducted remotely on 2/19/25 through 22/2125. completed the survey, and exited on 22/2255. Additional information was obtained remotely on 2/24/25. Therefore, the exit date was changed to 2/24/25. Therefore, the exit date was <b< td=""><td>PREFIX</td><td>(EACH DEFICIENC</td><td>Y MUST BE PRECEDED BY FULL</td><td>PREFIX</td><td>(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE</td><td>N SHOULD BE</td><td>COMPLETION</td></b<>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETION
to conduct a recertification and complaint investigation survey. The survey team was onsite 2/16/25, 2/17/25, and 2/18/25. The survey team was unable to return to the facility on 2/19/25 through 2/21/25. The survey team returned to the facility on 2/22/25. Completed the survey, and exited on 2/22/25. Completed the survey team returned to the facility on 2/22/25. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # PM7D11. F 000 INITIAL COMMENTS The survey team entered the facility on 2/16/25 to conduct a recertification and complaint investigation survey. The survey team was unable to return to the facility on 2/19/25 through 2/21/25. The survey team was conducted remotely on 2/19/25 through 2/21/25. The survey team returned to the facility on 2/22/25. Completed the survey, and exited on 2/22/25. Completed the survey, and exited on 2/22/25. Event ID # PM7D11. The following intakes were investigated: NC00222086, NC0022366, NC00223400, NC00222686, NC00223648, NC002224128, NC00222686, NC00223648, NC00227583.	E 000	Initial Comments		E 0	00		
	F 000	to conduct a recertific investigation survey. 2/16/25, 2/17/25, and was unable to return a through 2/21/25 due t and unsafe travel con- was conducted remot 2/21/25. The survey on 2/22/25, complete 2/22/25. Additional in remotely on 2/24/25. changed to 2/24/25. changed to 2/24/25. changed to 2/24/25. Changed to 2/24/25. The survey team ent to conduct a recertific investigation survey. 2/16/25, 2/17/25, and was unable to return a through 2/21/25 due t and unsafe travel con- was conducted remot 2/21/25. The survey on 2/22/25, complete 2/21/25. The survey on 2/22/25, complete 2/22/25. Additional in remotely on 2/24/25. changed to 2/24/25. E The following intakes NC00222083, NC002 NC00224822, NC002 NC00224822, NC002	ation and complaint The survey team was onsite 2/18/25. The survey team to the facility on 2/19/25 to adverse weather of snow ditions; therefore the survey tely on 2/19/25 through team returned to the facility d the survey, and exited on nformation was obtained Therefore, the exit date was The facility was found in equirement CFR 483.73, ness. Event ID # PM7D11. ered the facility on 2/16/25 ation and complaint The survey team was onsite 2/18/25. The survey team to the facility on 2/19/25 to adverse weather of snow ditions; therefore the survey tely on 2/19/25 through team returned to the facility d the survey, and exited on nformation was obtained Therefore, the exit date was Event ID # PM7D11. were investigated: 222936, NC00223430, 23864, NC00224128, 225148, NC00227302,	FO	00		
		-			TITLE		(X6) DATE

Electronically Signed

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

03/19/2025

TATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			D. 0938-039 SURVEY PLETED
		345529	B. WING _				C 1 24/2025
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			201 CLARKS FORK DRIVE NW ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	deficiency. Immediate Jeopardy	nt allegations resulted in was identified at:	F	000			
F 558 SS=D	CFR 483.80 at tag F8 Immediate Jeopardy removed on 2/19/25.	726 at a scope and severity J 380 at a scope and severity J began on 2/17/25 and was odations Needs/Preferences	F	558			3/25/25
55=D	services in the facility accommodation of re preferences except w endanger the health o other residents.	sident needs and					
	Based on observatio resident and staff inter ensure an independe was able to exit the s the building without a designated smoking a location that had a co interior of the facility t (Resident #37); and t	area was moved to a new oncrete slope from the			The facility sets forth the following plar correction to remain in compliance with federal and state regulations. The facil has taken or will take the actions set fo in the plan of correction. The following plan of correction constitutes the facility allegation of compliance. All deficiencie cited have been or will be corrected by date or dates indicated.	⊢all ity rth /⊡s es	
	assistance as needed residents reviewed fo Findings included:	admitted to the facility on			F 558 1. A doorbell was placed at the smok area to allow the residents to ring for assistance to get out and to ring if needing assistance 3/19/2025. Resider 37 demonstrated that he can ring the	•	
		ses including stroke and			doorbell for assistance and resident #3	7 is	

Event ID: PM7D11

Facility ID: 20040007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/31/2025 APPROVED). 0938-0391	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING			C 02/24/2025		
NAME OF PF	ROVIDER OR SUPPLIER	1		ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH			201 CLARKS FORK DRIVE NW ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 558	Continued From page	2	E f	558				
	absence of lower limb).			also able to navigate the entrance an to the smoking area with no issues.			
	assistance with activi 8/6/2024 that listed o	blan included a focus for ties of daily living dated ne person assist with ention. The care plan also			Resident # 12 call light was put within reach.2. Current smokers are at risk3. Administrator to provide education			
	included a focus for s	moking dated 8/14/2024 uded performing smoking			maintenance staff to make sure the doorbell is in working order. The administrator educated current staff			
	A physician progress recorded Resident #3 amputation.	note dated 9/1/2024 7 had a left below the knee			members on answering doorbell whe they hear it. Education was complete 3/20/2025. Any staff member not receiving educa	d by		
	-	nt dated 9/6/2024 recorded			will not be able to work until education completed.			
	Resident #37 had dea indicated Resident #3	kterity problems and 37 could smoke as Resident #37's most			The Director of Nursing or designee we educate current staff including agence staff on ensuring call lights are always reach. Education completed on 3/25/2025.	y		
		/18/2024 indicated Resident			Any staff not receiving education will be allowed to work until education received including agency staff.	not		
#37 was moderately cognitively impaired and had upper and lower extremity limited range of motion on one side of the body. The MDS further indicated he was dependent on staff to assist with		emity limited range of motion dy. The MDS further endent on staff to assist with			Any agency staff will receive education prior to the beginning of their shift. Any new staff member will be educated			
	a manual wheelchair	and was able to maneuver 150 feet.			during the orientation process by the administrator or designee. The maintenance department or desi	gnee		
	smokers was provide Resident #37 was list	f independent unsupervised d by the Administrator and ed on the facility's smoking			will audit the doorbell to ensure good working order. Audits will be complete weekly x 4 weeks, then 3 x weekly x 4	ed 5x		
		t unsupervised smoker.			weeks, then weekly x 4 weeks, then monthly x 2.			
	the activities recreation	5 pm, the previous area was observed outside on room. The entrance to the moking area was through a			The Director of Nursing or designee v audit 10 random call lights weekly x 1 weeks then monthly x 2.			
		activities recreation room.			4. Results will be reported by the			

Facility ID: 20040007

If continuation sheet Page 3 of 167

					OMB NO. 0938-0 (X3) DATE SURVEY	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			TE SURVEY MPLETED
			A. BUILDING	<u> </u>		
		345529	B. WING			С
		345529	B. WING			2/24/2025
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 558	Continued From page	e 3	F 55	8		
		tivities recreation room to	1 00	administrator to the quality a	esurance	
		s flat and the ground outside		meeting x3 months for furthe		
	was made of concret	5		as needed.		
	On 2/16/2025 at 3:14	pm, the new designated		5. Date of completion: 3/25/	2025	
		oserved adjacent to the right				
	side of the dining roo	m. The entrance to the new				
	uncovered designate	d smoking area was through				
	a hinged door that op	pened into the dining room.				
	There was no push b	outton to automatically open				
	the door. The new ur	•				
	-	oncrete and there was a				
	slope downward upo	n entering the designated				
	smoking area.					
	On 2/18/2025 at 2.50) pm, an observation and				
		cted with Resident #37 in the				
	new designated smo					
		#37 was sitting in a manual below the knee amputation				
		•				
		arm that was rested inward				
		in a fict position. Posident				
		in a fist position. Resident				
	#37 was observed us					
		e with no identified safety				
		437 stated he was able to				
		he door to enter and exit the				
		smoking area outside the				
		oom. He indicated with the				
	-	king area; he was unable to				
		e area to return to the interior				
		he slope leading to the				
	doorway. Resident					
	attempting to independent					
		area by using his right foot				
		f-propel the wheelchair 180				
	-	on of the door that led to the				
1		Resident #37 self-propelled				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345529	B. WING			02	C 2/24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>_</u>	
					5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		I	RALEIGH, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558	was doing so, his whe backwards requiring the harder and brace him himself as he reached interior of the facility. reaching across his be attempt to open the d the door handle in an motion and was unable and move the wheelch door because he had right foot to avoid rollin new designated smoot Resident #37 was ob- center of the new designated family members prese On 2/18/2025 at 4:32 Resident #70, who wa 1/19/2025 MDS, oper and was observed in smoking area with Re- during the previous of stated Resident #37 w members back inside stated previously, who Resident #37) were re- designated smoking a Resident #37) were re- designated smoking a Resident #37) had to foot to avoid rolling ba On 2/18/2025 at 10:3 attended a Resident (eelchair was observed to roll the resident to self-propel self with one foot to stabilize d the door to return to the Resident #37 was observed ody with his right hand in an oor. Resident #37 moved upward and downward le to push the door open hair forward through the to brace himself with his ng backwards to exit the king area independently. served returning to the signated smoking area with ent. pm in an interview with as cognitively intact per the ated an electric wheelchair the new designated esident #37 on 2/18/2025 beservation. Resident #70 was assisted by his family the building. Resident #70 en they (Resident #70 and eady to exit the new area, he had assisted hing the back of Resident ause Resident #37 was bor open and move the rough the door as he o brace himself with his right ackwards. 0 am, eleven residents	F	558			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				5	5201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		F	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 558	aware of the facility m smoking area until the smoking items to the area on 2/16/2025. On 2/18/2025 at 4:45 Nurse Aide (NA) #13, could self-propel his w hallway independently self-propelled the whe designated smoking a not observed Resider independently exit the area. On 2/18/2025 at 4:46 conducted with Resid stated Resident #70 ft through the door of th area to exit when they the same time. Resid new designated smok maneuver independe On 2/22/2025 at 12:22 with other residents w the previous designat cover overhead. Resi facility was allowing th unsupervised smoker designated smoking a clears since the new of did not have shelter fr	dent Council was not hts stated they were not hoving the designated e staff were moving the new designated smoking pm in an interview with she stated Resident #37 wheelchair up and down the y and independently eelchair out to the new area. NA #13 stated she had ht #37's ability to e new designated smoking pm an interview was ent #37. Resident #37 helped push his wheelchair is new designated smoking at ent #37 restated exiting the king area was difficult to ntly. 9 pm, Resident #37 along vere observed smoking in ted smoking area that had a dent #37 explained the he independent and is to use the former area until the winter weather designated smoking area rom the weather. n in an interview with the	F	558			
	clears since the new o did not have shelter fr On 2/16/2025 4:38 pr Administrator, she ex	designated smoking area rom the weather.					

Facility ID: 20040007

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			000			10.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING	G		
		245500	B WINC			С
		345529	B. WING			2/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
	AL HEALTH CARE/NOR			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)	I SHOULD BE	(X5) COMPLETION DATE
F 558	Continued From page			-0		
F 330			F 55	28		
		area outside the activities				
		she had spoken personally				
		to face last week and no				
	concerns were voice					
		area. She stated as of this is designated smoking area				
		iew designated smoking area				
		lid not have sheltering if				
	raining.	in not have shellening in				
		pm in an interview with the				
		ated all smokers in the				
		d as unsupervised smokers				
	and independently er					
		areas. The observation of				
		e resident's expressed				
		bility to independently exit				
	the new designated s					
		issed with the Administrator.				
		ated Resident #37 was able				
		acility independently and she				
		ent #37 was having trouble				
		nated smoking area. The				
	the concrete at the e	she had noticed a slope of				
		area. She stated there was				
		e independent smokers				
	conducted prior to m	•				
		6/25 to ensure the residents				
		dently enter and exit the				
		tor explained smokers were				
		ited smoking area with a				
		because there was a winter				
	snowstorm on 2/19/2	025 and 2/20/2025 so they				
		he resident's to use the				
	-	ea because it was covered.				
		ated the designated smoking				
		ck to the area outside the				
	dining room without a		1			

Facility ID: 20040007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345529	B. WING _			C 02/24/2025		
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH			201 CLARKS FORK DRIVE NW ALEIGH, 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 558	 concrete entrance an weather cleared. 2. Resident #12 was 6/21/24 with diagnose diabetes mellitus, ost hypertension. Review of Resident # revealed a focus area for assistance with trat to place common item resident. There was assistance with activi an intervention for a 2 person assist with be Review of Resident # Data Set (MDS) date #12 was cognitively in staff assistance with ta and dressing. Reside staff for bed mobility. During an interview a 2:15 pm, Resident #1 call bell was on the floside of the bed. Whe was she replied, "I do stated she needed he bathroom. Resident ask staff who passed when she could not resident as a staff on a sta	d exit when the winter admitted to the facility on es which included type 2 eoporosis, and 12's care plan dated 7/22/24 a for falls risk due to a need ansfers and an intervention ns within reach of the also a focus area for ties of daily living (ADL) and 2 person transfer and 1 d mobility. 12's quarterly Minimum d 12/3/24 revealed Resident ntact. Resident #12 required toileting, hygiene, bathing, nt #12 was dependent upon nd observation on 2/16/25 at 2 was lying in her bed. The bor under the bed on the left n asked where her call bell on't know". Resident #12 er wheelchair to go to the #12 further stated she would by her room for assistance each her call bell. with Nursing Assistant (NA) pm, she stated the call bells within reach of the	F 5	558				
TAG	Continued From page concrete entrance an weather cleared. 2. Resident #12 was 6/21/24 with diagnose diabetes mellitus, ost hypertension. Review of Resident # revealed a focus area for assistance with tra to place common item resident. There was assistance with activi an intervention for a 2 person assist with be Review of Resident # Data Set (MDS) date #12 was cognitively in staff assistance with ta and dressing. Reside staff for bed mobility. During an interview a 2:15 pm, Resident #1 call bell was on the file side of the bed. Whe was she replied, "I do stated she needed he bathroom. Resident ask staff who passed when she could not re During an interview w #3 on 2/16/25 at 2:39 were supposed to be residents. NA #3 furt	 SC IDENTIFYING INFORMATION) A 7 d exit when the winter admitted to the facility on es which included type 2 eoporosis, and A 12's care plan dated 7/22/24 a for falls risk due to a need ansfers and an intervention ns within reach of the also a focus area for ties of daily living (ADL) and 2 person transfer and 1 d mobility. A 12's quarterly Minimum d 12/3/24 revealed Resident thact. Resident #12 required colleting, hygiene, bathing, nt #12 was dependent upon And observation on 2/16/25 at 2 was lying in her bed. The bor under the bed on the left n asked where her call bell on't know". Resident #12 er wheelchair to go to the #12 further stated she would by her room for assistance each her call bell. with Nursing Assistant (NA) pm, she stated the call bells 	TAG		CROSS-REFERENCED TO THE APPROPR			

Facility ID: 20040007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		345529	B. WING				24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 558	sure the call bells were residents. NA #3 was #12 but assisted Resident and had used her call indicated the resident call bell on the floor und A second observation 11:00 am with Reside bed with her eyes cloor wrapped around the be the bed out of reach. In an interview with N she stated the call be the resident. NA #4 f call bell to the resider NA #4 had worked with she was capable of und indicated if the call be bed rail Resident #12 During an interview we Nursing (DON) on 2/2 the staff should be en- clipped within reach, she bed. The Interim Direc Resident #12 was abl however, she would re bell if on the floor und around the bed rail. Resident/Family Grout CFR(s): 483.10(f)(5)(f	blained she would make re within reach for her not assigned to Resident ident #12 immediately. NA t #12 could use her call bell bell in the past. She twas unable to reach the nder the bed. was made on 2/22/25 at that #12. She was lying in her sed. The call light was bed rail on the right side of A #4 on 2/22/25 at 3:06 pm, Ils should be within reach of urther stated she clipped the ht's blanket or pillow case. th Resident #12 and stated sing the call bell. NA #4 ell was wrapped around the would be unable to reach it. with the Interim Director of 22/25 at 5:00 pm, she stated usuring the call bells are so they do not fall off the ector of Nursing indicated le to activate her call bell; not be able to reach the call ler the bed or wrapped up and Response U-(iv)(6)(7)		558			3/25/25
		ident has a right to organize dent groups in the facility.					

Facility ID: 20040007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/31/2025 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING				C /24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE	1	
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH			201 CLARKS FORK DRIVE NW ALEIGH, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	 (i) The facility must pr group, if one exists, w reasonable steps, wit to make residents and upcoming meetings ir (ii) Staff, visitors, or o resident group or fam the respective group's (iii) The facility must p person who is approv group and the facility providing assistance a requests that result fr (iv) The facility must of resident or family grout the grievances and re- groups concerning iss in the facility. (A) The facility must b response and rationa (B) This should not be facility must implement request of the resider §483.10(f)(6) The response and rationa §483.10(f)(7) The response and rationa (B) This should not be facility must implement request of the resider §483.10(f)(7) The response and rationa (B) This should not be facility must implement request of the resider §483.10(f)(7) The response and rationa (B) This should not be families or resident response (B) The response (C) The response (D) The response (D	rovide a resident or family vith private space; and take h the approval of the group, d family members aware of h a timely manner. ther guests may attend ily group meetings only at s invitation. provide a designated staff ed by the resident or family and who is responsible for and responding to written om group meetings. consider the views of a up and act promptly upon ecommendations of such sues of resident care and life be able to demonstrate their le for such response. e construed to mean that the nt as recommended every at or family group. ident has a right to have a right to have other resident et in the facility with the spresentative(s) of other y. is not met as evidenced ms, interviews with Resident d staff, and review of the utes, the facility failed to lity's efforts to address	F	565	F565 1. Resident council minutes for the 3 months were audited by the administrator to ensure response and resolution has been implemented. The		

Facility ID: 20040007

DEPARTMENT OF HEA						FOR	D: 03/31/2025 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C / 24/2025
NAME OF PROVIDER OR SUPP	LIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE NW		
UNIVERSAL HEALTH CAI	KE/NORT	H RALEIGH		R	RALEIGH, NC 27616		
PREFIX (EACH D	EFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
 months revier 2024, and Ja evidence that response to g by the Reside through Octo The findings in On 2/18/25 a revealed the Council minut The Administ they were una Additionally, f demonstrate such respons recommenda prior to Novel Resident Cour residents void answered tim section, wher the concerns documented, of who record A Service Co documented Council relate concern form on answering Report noted concern was the Dispositio would docum 	I to resol wed (Nov nuary 20 demons rievance ent Coun- ber of 20 ncluded: 8:49 AN facility ha active from rator indi able to lo hey had their resp es for an tions ma mber 202 ncil minu- ced conce ely. The e the fac from the was blar led the m ncern Re- the conce d to call noted nu call bells on 11/6/ "complet n by Adr ent the fo	ve repeat concerns in 3 of 3 vember 2024, December 25) and to maintain trated the facility's es/recommendations made cil from December 2023 24. A, the Administrator ad no record of Resident prior to November 2024. cated due to staff turnover cate those minutes. no documented evidence to ponses and rationale for by grievances and de by the Resident Council	F	565	 was completed 3/20/2025. Regional activities lead held a resident council meeting on 03/19/2025 to discuss resolution of the items discussed in the previous 3 months. Resolutions of resident council concerns will be provite the resident council during the follow meeting. Current Residents have the potent obe affected. Administrator provided education the management team by 03/20/2025 noting response to concerns voiced in resident council meetings are mandad Activities director was educated on Activities Policies and Procedures Powhich states she is to provide the administrator with the original minutes the Council Meetings along with administrative response to the Reside Council form for review and signature Education completed by the administion 03/20/2025. Any leadership team not receiving education will not be able to work unter education received. Any new management team member receive education during the orientati process. Regional Activity lead or administrator meet weekly with the Current Resider Council President weekly x 4 weeks, the monthly x3 months with monthly review of originaminutes of meeting along with administrative response to resident council. Results will be reported by the administration council. 	ided wing ntial to fory. licy, s of ent rator il s will on r will hen	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/31/2025 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NORT			52	201 CLARKS FORK DRIVE NW		
				R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 565	Continued From page	e 11	F	565			
		on of the concerns was			meeting x3 months for further resoluti	on	
		cern was resolved. There			as needed.		
		who completed the Service					
	Concern Report.				5. Date of completion: 3/25/2025		
	Resident Council min	uites dated 12/19/24					
	• • • • • • • • • • • • • • • • • • • •	ot being answered was					
		t meeting, but an entry under					
	•	d the repeat concern with					
	-	ered timely. Nursing services					
	concerns also noted	e getting their medications.					
		ed dietary concerns of cold					
		ion resolution section was					
	blank. There was no	indication of who recorded					
	the meeting minutes.						
	A Service Concern R						
	documented the cond						
		l light response and cold rm noted nurse aides were					
		ng call bells in a timely					
		r service and that the dietary					
	department would "in	-					
	•	lesident Council's concerns					
	U	ations was not addressed					
		The Report noted on					
		us of the concern was as no entry in the Disposition					
	by Administration sec						
		erns was ongoing or if the					
		d. There was no indication					
	of who completed the	e Service Concern Report.					
	Resident Council Min	utes dated 1/28/25					
	-	ivity Director noted the					
		peat concerns related					
		Iministered late and call bells					
	not being answered i	n a timely manner.					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COMF	
		345529	B. WING				24/2025
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 565	Continued From page	9 12	F	565	5		
	AM with the facility's f were 11 residents pre- residents expressed of of grievances discuss Council meetings. The reported not all grieval promptly by the facility explanation as to why resolved. The resident they discussed the sa- stated the Activity Dire Resident Council meet their concerns to the and had never heard back measures attempted grievances and believe them. Residents static concerns about dietar nurse aide response for multiple times for the department heads to themselves and none stated the former Adm with residents to discu- and they had the sam before the summer of the new Administrator residents but their cor addressed. In an interview on 2/2 Director said when the concerns, a copy of the to the Social Worker. concerns would be co-	y and there was no y the grievances were not ints stated at each meeting ime concerns. Residents ector was present at the etings and communicated Administration but said they is from anyone about by the facility to resolve their yed no one was listening to ted they continued to have ry and food palatability, times, and had requested Administrator and other come to the meetings had come. The residents hinistrator would not meet uss any of their concerns the concerns repeatedly since 2024. The residents said was more attentive to the neerns were still not being 2/25 at 3:31 PM, the Activity the Resident Council had he minutes would be given					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	
		345529	B. WING _				
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERSA	L HEALTH CARE/NORT	H RALEIGH			201 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580 SS=D	the issue and she had the council because s measures being taker In an interview on 2/2 Worker and the Social when the Resident Co Activity Director would and the Social Worke concern form. The So each department know to follow up and resolv An interview was cond Administrator on 2/22 since she started in the any concerns or griev Council would be report to the Social Worker, morning in the mornin heads. Each departme hours to resolve and g the Social Worker. Th Director would then sl information/resolution Council meeting verba Notify of Changes (Inj CFR(s): 483.10(g)(14) Notified (i) A facility must imme consult with the reside consistent with his or representative(s) whe (A) An accident involve	what was being done about a not reported a resolution to the had not heard of the in to resolve their concerns. 2/25 at 3:03 PM, the Social I Services Assistant said buncil had concerns, the d let the Social Worker know r would write up a grievance to al Worker would then let w of the concerns for them ve. ducted with the /25 at 6:34 PM who stated he facility in December 2024, ances from the Resident orted by the Activity Director who would review the next og meeting of department ent head would have 72 give the resolution back to the Social Worker or Activity hare the at the next Resident ally. fury/Decline/Room, etc.))(i)-(iv)(15) cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident in there is- ring the resident which as the potential for requiring		565			3/25/25

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	 (B) A significant changemental, or psychosocid deterioration in health status in either life-thric clinical complications) (C) A need to alter trea a need to discontinue treatment due to advect commence a new form (D) A decision to transing resident from the facilities (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the resi	ge in the resident's physical, ial status (that is, a , mental, or psychosocial eatening conditions or); atment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the tent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ms as specified in paragraph ecord and periodically mailing and email) and	F	580			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/ FORM APPRC OMB NO. 0938-	OVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C 02/24/2025	5
NAME OF PF	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
				5201 CLARKS FORK DRIVE NW		I
UNIVERSA	AL HEALTH CARE/NORT	HRALEIGH		RALEIGH, NC 27616		ſ
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLE	TION
F 580	by: Based on observatio interview, and record notify the Physician o of pain after an unwith residents (Resident # of change. The findings included Resident #25 was ad 9/24/24. Review of Resident # Data Set (MDS) date cognitively intact. A progress note date Nurse #3 revealed Re the floor lying on her and her wheelchair at Resident #25 denied complained her left knee. Review of the neurolo 1/27/25 completed by following: At 2:00 pm indicated expressions of pain at	 ⁻ is not met as evidenced n, staff interviews, Physician review, the facility failed to of Resident #25's complaints nessed fall for 1 of 4 (25) reviewed for notification :: mitted to the facility on (25's quarterly Minimum d 12/31/24 revealed she was (25's quarterly Minimum d 12/31/24 revealed she was (27/25 completed by esident #25 was found on back between her nightstand ind her left knee was bent. hitting her head but nee hurt "pretty bad". The d. The physician ordered an (25) reviewed for notification (26) reviewed for notification (27) reviewed for notification (25) reviewed for notification (26) reviewed for notification (27) reviewed for notification (28) reviewed for notification (28) reviewed for notification (2	F 58		ider ident #25 ment on the the to g notes to sidents to sidents to sidents to sidents to sidents to sidents to sidents to sidents to to shift Director of to shift Director of tent agency ovider ident to ble to eive eir shift by team. e process. designee otes for ation of	
	-	Resident #25 had verbal nd rated the pain as 6.		weekly x 4 weeks, then weekly x then monthly x 2		

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. DOILDI	NO _			C
		345529	B. WING				24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE/NORT			5	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	∋ 16	F	580			
	At 2.20 pm indicated	Resident #25 had verbal			5. Results will be reported by the Director of Nursing to the quality		
		ind rated the pain as 6.			assurance meeting x3 months for furth	ner	
		·			resolution as needed.		
		#25 had verbal expressions			6. Date of completion: 3/25/2025		
	of pain and rated the	pain as o.					
	At 3:15 pm Resident a of pain and rated the	#25 had verbal expressions pain as 3.					
	At 3:45 pm Resident of pain and rated the	#25 had verbal expressions pain as 3.					
	At 4:15 pm Resident a of pain and rated the	#25 had verbal expressions pain as 3.					
	At 4:45 pm Resident a of pain and rated the	#25 had verbal expressions pain as 3.					
	At 5:45 pm Resident of pain and rated the	#25 had verbal expressions pain as 3.					
	At 6:45 pm Resident of pain and rated the	#25 had verbal expressions pain a 3.					
	1/28/25 at 5:45 pm ar revealed Resident #2	ocumentation note dated nd completed by Nurse #3 25 reported pain in her left ined an order for x-ray of left					
	2:01 pm, she stated s when Resident #25 w 1/27/25. Nurse #3 did aide who reported thi stated she did neurolo Resident #25 which c	with Nurse #3 on 2/20/25 at she was the nurse assigned /as found on the floor on d not remember the nurse s to her. Nurse #3 further ogical assessments on documented Resident #25 ns of pain from 3 to 6 using					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			LETED
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			5201 CLARKS FORK DRIVE NW		
04015					RALEIGH, NC 27616 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	9 17	F	580	o		
	a numerical pain scal	e. Nurse #3 explained the			-		
	facility had a standing The facility's standing	order for pain medication.					
		milligrams (mg) every 4					
		nild pain for 72 hours and to					
	Nurse #3 indicated sh	72 hours if pain persisted. ne did not notify the					
	physician of Resident	#25's pain and did not have					
	an explanation. She notified the physician	stated she should have of Resident #25's					
		1/27/25 and on 1/28/25.					
	A physician's order w	as obtained on 1/28/25 for					
	an x-ray for Resident	#25's left knee and lity's mobile x-ray unit.					
		iity s mobile x-ray unit.					
		results of her left knee dated					
	the left knee with mild	an acute hairline fracture of swelling noted.					
	A physician's note da	ted 1/29/25 revealed he saw					
		low-up visit after an x-ray					
	•	e fracture of the left knee. <i>v</i> ithin normal limits. Physical					
	exam noted Resident	#25 was awake and alert					
		ity and left shoulder painful 25 was sent to emergency					
	department (ED) for f						
	During a telephone in	terview on 2/20/25 with					
	Physician # 1, he stat	ed he was aware of					
	Resident #25's fall on informed by Nurse #3						
		e pain on 1/27/25 and					
	1/28/25. He further s	tated he ordered x-rays of					
	her left knee.						
	In an interview with th Nursing (DON) on 2/2	e Interim Director of 22/25 at 5:00 pm, she stated					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMF	
		345529	B. WING				24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			3201 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	During an interview o the Administrator, she	Id have notified the #25's complaints of pain. n 2/22/25 at 5:00 pm with e stated her expectations of to notify the Physician	F	580			
F 583 SS=D	Personal Privacy/Cor CFR(s): 483.10(h)(1)- §483.10(h) Privacy ar The resident has a rig	fidentiality of Records -(3)(i)(ii)	F	583			3/25/25
	telephone communica and meetings of famil	dical treatment, written and ations, personal care, visits, y and resident groups, but the facility to provide a					
	right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to	onal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened packages and other the facility for the resident, red through a means other					
	and confidential perso (i) The resident has th of personal and medi	sident has a right to secure onal and medical records. ne right to refuse the release cal records except as n)(2) or other applicable					

Facility ID: 20040007

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	۱G		COMP	LETED
		345529	B. WING				C
	ROVIDER OR SUPPLIER	545525			TREET ADDRESS, CITY, STATE, ZIP CODE	02/	24/2025
	COMPER OR SOLT EIER				201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		ALEIGH, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583	Continued From page	<u>s</u> 19	F 5	83			
		llow representatives of the ng-Term Care Ombudsman					
		's medical, social, and					
		s in accordance with State					
	law.						
		is not met as evidenced					
	by:						
		n and staff interviews, the			F583		
	information by leaving	t a resident's health care			 Nurse # 1 received education by the Director of Nursing on 3/25/2025 	ie	
		ed, visible and accessible to			regarding locking screen on computer		
	others on the compute				when not at the computer.		
	medication carts obse			2. Current residents have the potentia	al to		
	confidentiality (100-ha				be affected.		
					3. Education initiated by the Director	of	
	Findings included:				Nursing and/or designee to current licensed nurses including agency license	sed	
	During a continuous of	observation on 2/17/2025 at			nurses regarding privacy and the		
		as observed walking away			importance of keeping the computer		
		dication cart located in the			screen locked when not in use. Educat	ion	
	•	t # 43's medical information			was completed on 3/20/2025		
	•	code status and list of six) visible on the computer			Any licensed nurse not receiving education will not be allowed to work u	otil	
	screen from the 100-h	· · · · · · · · · · · · · · · · · · ·			education will not be allowed to work un education received.	iui	
		om Resident #43's doorway.			Agency licensed nurses will receive		
		ed entering Resident # 43's			education prior to the start f their shift.		
		Nurse #1 returned to the			Any new licensed nurse will receive		
	100-hall medication c	•			education during the orientation proces		
	-	display Resident #43's			4. The Director of Nursing or designe		
		Nurse aide #9 walked by the			will audit 5 random nurses on med cart	s	
		art. Nurse #1 was observed er screen to Resident #26's			weekly x 12 weeks then monthly x 2.		
		name, date of birth, code			5. Results will be reported by the administrator to the quality assurance		
		ications) and walking five			meeting x3 months for further resolutio	n	
		00-hall medication cart to			as needed.		
	enter Resident #26's	room to take Resident #26's					
		e #1 was called back to the			6. Date of completion: 3/25/2025		
	100-hall medication c		1				1

Event ID: PM7D11

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	
		345529	B. WING				24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			3201 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 583 F 584 SS=E	On 2/17/2025 at 6:02: #1 revealed she realiz computer screen off to and Resident #26's m leaving the 100-hall m she should have locked hide Resident #43's at information before wat medication cart. On 2/18/2025 at 3:38 Director of Nursing, si have provided privacy Resident #26's medic computer screen blact walking by the 100-ha Nurse #1 was not pre and read Resident #4 medical information. Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(0) §483.10(i) Safe Envire The resident has a rig comfortable and home but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, of homelike environmen use his or her persona possible. (i) This includes ensu receive care and serv physical layout of the independence and do	am an interview with Nurse zed she did not turn the o protect Resident #43's hedical information before hedication cart. She stated ed the computer screen to and Resident #26's medical alking away from the 100-hall pm in an interview with the he stated Nurse #1 should <i>t</i> to Resident #43's and al information by turning the k (locking) so anyone all medication cart when sent was unable to visualize 3's and Resident #26's ble/Homelike Environment (7) onment. ght to a safe, clean, elike environment, including iving treatment and ig safely.		583			3/25/25

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/20 FORM APPROVE OMB NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		C 02/24/2025		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	•		
UNIVERS	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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION APPROPRIATE DATE		
F 584	Continued From page	e 21	F 58	84			
		esident's property from loss					
		eeping and maintenance o maintain a sanitary, orderly, ior;					
	§483.10(i)(3) Clean b in good condition;	ed and bath linens that are					
	§483.10(i)(4) Private resident room, as spe	closet space in each ecified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequa levels in all areas;	te and comfortable lighting					
	levels. Facilities initia	table and safe temperature Ily certified after October 1, a temperature range of 71 to					
	sound levels.	maintenance of comfortable is not met as evidenced					
	interviews, the facility	ns and resident and staff failed to maintain shower dition on 1 of 3 shower		F584 1. Floor tiles in 100 hall sho were repaired on 3/19/2025.	ower room		
	rooms (100-hallway s			 2. All shower rooms in the caudited by maintenance on 3. 			
	Findings included:			3. Education was complete the maintenance department	d 3/19/2025 by the		
	2/16/25 at 3:48 PM, b	00-hallway shower room on proken floor tiles were nd 2nd shower stalls on the		administrator on ensuring the shower room are in good con not needing repair. Education	dition and		
	left side of the showe present. He reported once he was assiste	In 2nd shower states on the r room. Resident #70 was I he could bathe himself d to the shower room. He self up with the grab bar in		provided to current staff by th maintenance director on ente orders into the electronic wor portal. Education completed of	e vring work k order		

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) [NO. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C	OMPLETED
		345529	B. WING			C 02/24/2025
NAME OF P	ROVIDER OR SUPPLIER	0.0020		STREET ADDRESS, CITY, STATE, ZIP C		02/24/2025
				5201 CLARKS FORK DRIVE NW	002	
UNIVERS	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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 584			F 584			
	on the broken showe he had expressed co- results. He stated he time he reported it or An observation was r room 2/16/25 at 4:47 there was 11 inches t below the temperatur In shower stall #2 the of broken tile at the c- the handrail and show An interview was con Maintenance Consult who stated the shower replaced, and they we residents when show was in the process of Supervisor. During an interview w Housekeeping Consu- he stated he was una the 100-hall shower r had mentioned it. An interview was con #15 on 2/18/25 at 2:4 not noticed the broke reported that there we the shower room to ta #15 stated residents	nade of the 100-hall shower PM. In shower stall #1 by 14 inches of broken tile e control and the handrail. re was 2 inches by 2 inches enter of the shower under ver head. ducted with the Regional ant on 2/18/25 at 11:41 AM er tiles needed to be ere a potential hazard to ering. He stated the facility i hiring a Maintenance		 3/20/2025. Any maintenance departmediation will not be allowed to work in received Any employee not receiving not be allowed to work until received Any new maintenance department process by the administrator or designee. Any new employee will receive eduation process by the administrator or designee. Any new employee will receive eduating the orientation process by the administrator or designee. Any new employee will receive eduating the orientation process by the administrator or designee. Any new employee will receive eduating the orientation process of the administrator or designee. Any new employee will receive eduating the orientation process during the orientation process during the orientation process of the administrator or designee. Any new employee will receive eduating the orientation process during the orientation process during the orientation process during the orientation process of the administrator or designee. Maintenance Director will a electronic system for work of days x 12 weeks then month the reporter administrator to the quality meeting x3 months for furth as needed. Date of Completion 3/25. 	until education g education will l education artment cation during the eive education ess. oms will be nce veeks, then 3x ekly x 4 weeks, udit the orders daily x 5 thly x 2 d by the assurance her resolution	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 02/24/2025
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•
UNIVERS	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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 584 F 602 SS=E	 5:23 PM stated she w and had reported it to weeks ago. She stat to the maintenance s one. An interview was con Nursing (DON) on 2/ stated she was not av the shower room and advised her. Attempts to contact th Director were not succ The Administrator wa 6:26 PM. She stated broken tiles in 100-ha Administrator stated s maintenance staff of Free from Misapprop CFR(s): 483.12 §483.12 The resident has the neglect, misappropria and exploitation as do includes but is not lim corporal punishment, any physical or chem treat the resident's m This REQUIREMENT by: Based on record rev staff, Pharmacist and interviews, the facility 	vith NA #16 on 2/18/25 at vas aware of the broken tiles o maintenance staff a few ed she reported her concern upervisor prior to the last ducted with the Director of 18/25 at 4:52 PM. She ware of the broken tiles in none of the staff had the former Maintenance ccessful. s interviewed on 2/22/23 at she was not aware of the all shower room. The she expected staff to notify any maintenance concerns. riation/Exploitation right to be free from abuse, ation of resident property, efined in this subpart. This inted to freedom from involuntary seclusion and ical restraint not required to edical symptoms. T is not met as evidenced iews, observations, and Pharmacy Consultant	F 584		

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ND HUMAN SERVICES			PRINTED: 03/31/202 FORM APPROVEI OMB NO. 0938-039
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
345529	B. WING _		C 02/24/2025
		STREET ADDRESS, CITY, STATE, ZIP	P CODE
RTH RALEIGH		5201 CLARKS FORK DRIVE NW	
		RALEIGH, NC 27616	
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	C PROVIDER'S PLAN C C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
Ations. In October 2024, this ts reviewed for property (Resident #232, ident #87, Resident #81, tesident #14) and on t #14's discontinued controlled emoved from 300-hall not returned to the ed: was admitted to the facility on ted 7/16/2024 included in opioid) 5 milligrams(mg) eded for pain. medication report recorded dispensed two separate s of Oxycodone HCL 5mg Medication Administration esident #232's last dose of ng was administered on m by Nurse #10. red on 10/5/2024 in the led substance count sheet for -hall recorded 35 controlled in 10/5/2025 at 7:00am when e #10 counted at the change	F		et in use were his was r of Nursing and d nurses narcotics on the or Nursing obtains pharmacy. 19/2025. ot be allowed to ceived. will receive rt of their shift will receive ntation process g or designee. signee will h med cart to are not in use monthly x 2 ted by the e quality onths for further
	IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 345529 B. WING	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 345529 B. WING RTH RALEIGH STREET ADDRESS, CITY, STATE, ZIF S201 CLARKS FORK DRIVE NW RALEIGH, NC 27616 STATEMENT OF DEFICIENCIES (CACH CORRECTIVE A CROSS-REFERENCED T DEFICIENCIES) (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIENT A CROSS-REFERENCED T DEFICIENT A CROSS-REFERENCED T DEFICIENT A CROSS-REFERENCED T DEFICIENT A CROSS-REFERENCED T DEFICIENT A CROSS-REFERENCED T CROSS-REFERENCED T DEFICIENT A CROSS-REFERENCED T CORRECTIVE A CROSS-REFERENCED T CROSS-REFERENCED T CORRECTIVE A CROSS-REFERENCED T CORRECTIVE A CROSULATION CROSS-REFERENCED T CROSS-REFERENCED T

Facility ID: 20040007

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 03/31/2025 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C 02/24/2025	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	HRALEIGH			RALEIGH, 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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 602	name of the controlled Resident #232 with N The number of contro recorded as 31 for the on 10/5/2024 at 7:00p #10 and Nurse #11. b. Resident #109 was 7/1/2024. Physician orders date Oxycodone HCL 5 mi for pain as needed. Resident #109 was no control medication rep controlled substances The October 2024 Me Record indicated Ress of Oxycodone HCL 5r -10/1/2024 at 1:20 pr -10/2/2024 at 1:20 pr -10/3/2024 at 9:07 am -10/4/2025 at 12:34 p -10/6/2024 at 9:32 ar -10/8/2024 at 1:50 p -10/9/2024 at 1:50 p -10/9/2024 at 1:50 p -10/9/2024 at 1:50 p -10/9/2024 at 12:54 There was no docume controlled drug receip Oxycodone 5mg of th removed for administr Resident #109's contr record/disposition forr indicated 60 tablets w #8 and the form state	d medications) removed for urse #14 co-sign signature. lled substance sheets was a 300-hall medication cart om at shift change for Nurse a admitted to the facility on ad 8/31/2024 included lligrams(mg) every 4 hours of listed on the pharmacy's bort as having received any a in September 2024. edication Administration ident #109 received doses mg on the following dates: n n n n n n n n n n n n n n n n n n n	F	602			

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		ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3		PLETED
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	2-112020
UNIVERS	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 602	Continued From page	26	F	602	2		
	Oxycodone 5mg med 14, 2024 through Oct were only 4 tablets re Resident #109 on Re	ded removed from the ication card from October ober 27,2024 and there corded as administered to sident 109's October 204 4, 2024 through October					
	medication card dated displayed 50 tablets a empty on the medicat to the Oxycodone HC	109's Oxycodone HCL 5mg d dispensed 10/13/2024 and bubble slots 51-60 tion card. On the back side d 5mg medication card, slots are observed as opened and					
	c. Resident #87 was a 9/21/2023.	admitted to the facility on					
	included Oxycodone	cian orders dated 9/04/2024 HCL milligrams (mg) tablet s every four hours for pain.					
	Pharmacy's control m Resident #87 was dis Oxycodone HCL 5mg	-					
	medication card dated displayed 30 tablets a and reported bubble s on the medication car Oxycodone HCI 5mg number 30 was open recovered.	and bubble slots 30 empty slot number 5 empty/missing rd. On the back side to the medication card, slot ed and number 5 was					
	-	ol drug receipt m for Oxycodone HCL 5mg /ere accounted for and the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLI	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>•</u>	
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 602	form stated each dose charting on the medic tablet recorded remove 5mg medication card Resident #87's Septe Administration Record doses of Oxycodone administered to Resid 9/9/2024 and 9/10/20 documentation on the Resident #87 receive 5mg on 9/23/2024. d. Resident #81 was a 7/6/2023. Physician orders date Oxycodone HCL 5 mi as needed for pain. A photo of Resident # medication card date displayed 57 tablets a empty and reported b 18 as empty/missing the back side to the C medication card, slot recovered. Resident #81's control record/disposition form indicated 50 tablets w 9/26/2024 and the for for here requires char record. There were 40 removed from the Oxy card with a zero balar	e signed for here requires sation record. There was one ved from the Oxycodone on 9/23/2024. mber 2024 Medication d (MAR) recorded three HCL 10mg were lent #87 on 9/6/2024, 24. There was no e September 2024 MAR that d a dose of Oxycodone HCL admitted to the facility on ed 6/30/2024 included lligram (mg) every six hours e81's Oxycodone HCL 5mg d dispensed 10/13/2024 and bubble slots 58-60 ubble slot number 27 and on the medication card. On Dxycodone HCI 5mg number 18 and 37 were	F	602			

Facility ID: 20040007

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	ì í				LETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	02/	24/2023
					5201 CLARKS FORK DRIVE NW		
UNIVERS	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
TAG F 602	Continued From page on Resident #81's con record/disposition for Resident #81's Octob Administration Record of Oxycodone HCL 50 Resident #87 from 10 10/22/2024. There was the October 2024 MA from Resident #81's or record/disposition for There were three dos October 2024 MAR th a removal on Resider record/disposition for e. Resident # 16 was 6/17/2024. Physician orders date Oxycodone 5 mg eve pain. A photo of Resident # medication card dated displayed 18 tablets a empty and reported b as empty/missing on back side to the Oxyc card, slot number 4 a Resident #16's control	e 28 ntrol drug receipt m. per 2024 Medication d (MAR) recorded 22 doses mg were administered to 0/1/2024 through as 10 doses not recorded on R documented as removed control drug receipt m for Oxycodone HCL 5mg. These recorded as given on the nat were not documented as nt #81's control drug receipt m for Oxycodone HCL 5mg. admitted to the facility on ed 8/30/2024 included ry six hours as needed for 416's Oxycodone HCL 5mg d dispensed 10/13/2024 and bubble slots 19-30 pubble slot number 4 and 14 the medication card. On the codone HCl 5mg medication nd 14 were recovered. ol drug receipt m for Oxycodone HCL 5mg		602	DEFICIENCY)	ATE	
	for here requires char record. There were 12 removed from the Ox	orm stated each dose signed ting on the medication 2 tablets total recorded ycodone 5mg medication alance on 10/18/2024.					

Facility ID: 20040007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/31/2025 MAPPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		F	RALEIGH, NC 27616		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE APPROPRIATE			DATE	
					DEFICIENCY)		
F 602	Continued From page	29	F	602			
	1.0						
	Resident #16's Octob	er 2024 Medication					
		d (MAR) recorded a total of					
	2 doses of Oxycodon	()					
		lent #87 on 10/14/2024 (1					
		(1 dose). There was 10					
	, ,	n the October 2024 MAR					
	that were documented	d as removed from Resident					
	#16's control drug rec	eipt record/disposition form					
	for Oxycodone HCL 5	• •					
	- ,	5					
	f. Resident #14 was a 2/7/2023.	idmitted to the facility on					
	every six hours as ne A photo of Resident # medication card dated displayed 18 tablets a empty and reported b as empty/missing on t	lligram (mg) tablets one eded for pain. 414's Oxycodone HCL 5mg d dispensed 9/13/2024 and bubble slots 19-30 ubble slot number 4 and 14 the medication card. On the					
	back side to the Oxyc	odone HCI 5mg medication					
	card, slot number 4 a	nd 14 were recovered.					
		m for Oxycodone HCL 5mg					
	indicated 90 tablets w						
		m stated each dose signed					
		ting on the medication					
		8 tablets total recorded					
		ycodone 5mg medication					
	card with 32 as the ba	alance on 10/18/2024.					
	Administration Record 2 doses of Oxycodon	mber 2024 Medication d (MAR) recorded a total of e HCL 5mg were dent #14 on 10/25/2024 (1					
		4 (1 dose). There were 26					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 602	that were documented #14's control drug red for Oxycodone HCL 5 Resident #14's Octob Administration Record 7 doses of Oxycodon administered to Resid through 10/16/2024. recorded on the Octo documented as remo control drug receipt re Oxycodone HCL 5mg The facility submitted dated 10/22/2024 sig Administrator reportin drugs to the state age report stated the facili incident on 10/17/202 the incident occurred 9/17/2024. The initial during a shift change identified that Oxycod medication) medication residents were tampet tablets in the medicat replaced with a different resembled oxycodone correct. The total of 2 were missing. All three pain or discomfort. The facility reported to department was notified 10/22/24 at 2:40 pm.	n the September 2024 MAR d as removed from Resident ceipt record/disposition form img. Per 2024 Medication d (MAR) recorded a total of e HCL 5mg were dent #14 on 10/1/2024 There were 25 doses not ber 2024 MAR that were ved from Resident #14's ecord/disposition form for p. an initial allegation report ned by the former og a diversion of facility ency. The initial allegation ity became aware of the 24 at 2:40 pm and reported between 9/3/2024 and allegation report stated an in-coming licensed nurse done 5mg (an opioid/pain on cards for three different ered with. The Oxycodone ions cards had been ent medication that e to make the count deem 27 tablets of oxycodone 5mg we residents have no signs of	F	602			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/31/2025 MAPPROVED O. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING			02	C 2/24/2025	
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE			
				520	01 CLARKS FORK DRIVE NW			
UNIVERS	AL HEALTH CARE/NORT	HRALEIGH		RA	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 602	10/28/2024 by the for that on 10/22/2024, th Nursing (DON) and th inspected the controll the medication carts is other medications can Two other residents' of were identified as hav with three tablets of C another tablet that res The total of oxycodor identified as 30 tablet reviewed the controlle be returned to the pha- identified two oxycod for Resident #232 we contacted Nurse #8 told th medication and did no A review of the control indicated Nurse #8 si cards out of the medic DON, Nurse #8 told th medication and did no A review of the control indicated Nurse #8 si cards out of the medic co-signed by the wee The DON interviewed did not co-sign with N showed Nurse #12 th substance count sheets on both medication can medications cards an The tampered medica oxycodone 5 mg, the #8 lost the two medic 232 and forged a co-s contacted Nurse #8 a	mer Administrator reported ne facility's Director of ne Unit Coordinator ed medications cards in all in the facility to identify any rds that were tampered with. controlled medication cards ving been tampered with, Dxycodone replaced with sembled oxycodone 5 mg. ne 5mg tablets missing was is. On 10/22/2024, the DON ed medications that were to armacy for disposal and one 5mg medication cards re missing. When the DON who removed the missing ation cart to return to the he DON she misplaced the ot know where she put them. Olled substance count sheet gned the two medication cation cart and was kend supervisor Nurse #12. I Nurse #12, who stated she lurse #8. When the DON we signature on the controlled et and Nurse #12 disputed the form and indicated that eated by another person. indicated Nurse #8 worked arts with tampered d missing medication cards. ation cards were for same medication that Nurse ation cards for Resident # signature. The DON	F	602				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/31/2025 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE SURVEY COMPLETED	
		345529	B. WING			_		C 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			201 CLARKS FORK DRIV RALEIGH, NC 27616	ENW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 602	asked to report to the Nurse #8 was an age periodically worked in to 10/14/2024. Nurse to work at the facility. based on circumstant signature, missing oxy cards and tampered of cards) there was reas #8 diverted Oxycodor residents (Resident # Resident #87, Reside Resident #14). The fa the North Carolina Bo 10/28/2024. Licensed aides were re-educate inspecting the medica were not tampered wi The facility's investiga 10/28/2024 signed by was submitted to the investigation report re Social Services (DSS with no on-site visit fro charges filed against On 2/17/2025, the fac 2024 misappropriation was reviewed. There sixteen nurses on 10/ educational in-service DON on inspection of and destruction of cor	the #8 refused to be e not to respond when facility for a drug screening. Incy employee who the facility from 8/21/2024 #8 will no longer be allowed The facility concluded ial evidence (forged ycodone 5mg medication of the oxycodone medication to nable suspicion that Nurse the 5mg tablets for 6 232, Resident #109, nt #81, Resident #16 and icility reported Nurse #8 to the of Nursing on d nurses and medication ed on the importance of tition cards to ensure they th. the former Administrator state agency. The tecorded the Department of) was notified on 10/22/2024 om DSS and there were no the accused individual.	F	602				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 602	There was no docume assessments related confirmed tampering of There was no docume education on the char removing controlled n medication carts and controlled medication There was documenta control medication au resident one controlle the former DON on 12 12/19/2024, 12/28/20 tablets on the controll was missing entries on sheet on 12/28/2024 changed entries on 12 12/28/24 for 2 resider audits were marked a 12/18/2024. Unit Manager #1 con January 2025 (1/8/25 and 1/27/25) one resi missing entries on co crossed out or change on medication card. T were not signed as re On 2/17/2025 at 5:30 was a corrective action controlled medication On 2/24/2025 at 9:09	entation of resident to pain management with of controlled medications. entation of the nursing staff nges in adding and nedications from the the DON returning s to the pharmacy. ation of random weekly dits conducted on one d medication per week by 2/10/2024, 12/12/2024, 24. There were no missing ed medication cards. There in the controlled medication (CF) and crossed out and/or 2/12/204, 12/19/20 and tts. The December 2024 is reviewed in QAPI on ducted random audits in , 1/14/25, 1/19/25, 1/15/25 dent per day audited with no ntrolled medication sheet, ed entries or missing tablets the January 2025 audits viewed in QAPI. pm, when asked if there on plan, the facility provided for the misappropriation of s. am in an interview with d she could not recall the	F	602			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/2025 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 02/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE
	AL HEALTH CARE/NORT			5201 CLARKS FORK DRIVE N	N
				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 CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5) THE ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE DATE
F 602	controlled medication Nurse #8. She stated attention the tablets in oxycodone didn't look card was removed, th similar but not exactly medication and there back of the medication bubble slots of the med- the acting Administration when all residents' co- were checked for tarm correct medication, the medication cards obs- missing controlled med- unable to recall the na- controlled medication stated the facility chai and removing controll medications cart after 2024. She explained counting controlled me- of the medication cards of tampering, (2) addi controlled medication required another nursi- nurse and (3) discont were to remain on the the Director of Nursin medications to return count and sign with th On 2/22/2025 at 4:17 with Nurse #8, she sta 2024 the night nurses controlled medication completing return to p pharmacy tote, secure	s at the change of shift with Nurse #8 brought it to her in a medication card of a right. When the medication here were tablets that look y like the controlled was tape observed on the in card over some of the edication card. She stated tor was notified. She stated ontrolled medication cards here were more residents' herved with tampering and/or edications. Nurse #13 was ames of the residents who is cards were affected. She inge the process of counting led medications from the r the incident in October the changes as: (1) when here tablets for suspicion ing and/or removing is to a medication cart se to count and sign with the inued controlled medications is medication cart and when ig removed the controlled to pharmacy, a nurse would he DON.	F 6	02	

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM): 03/31/2025 APPROVED 0. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345529	B. WING		_	C 02/24/2025	
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	· · · ·	
			5201 CLARKS FORK DRIV	ENW		
UNIVERSAL HEALTH CARE/NORTH	RALEIGH		RALEIGH, NC 27616			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
to the pharmacy in Octa since October 2024, the return controlled medic explained two nurses h controlled medications medications cart and/or pharmacy. She stated n carts let the DON know discontinued medicatio and DON was responsi- medications to the phar On 2/24/2025 at 10:26 with Nurse #8, she reca counting controlled medi- (unable to recall name) medications card was of She described the tamp had been made in the fit the controlled medication in the bubble slot and a covering area where th stated the tablet inside controlled medication a medication because the tablet. She stated the a the facility and informed medications were coun assessed for tampering performed on nursing s October 2024, two nurs when adding controlled medications cart and the	she was not given obled medications to return ober 2024. She stated e process to receive and cations had changed. She have to count and sign when added to the r removed to return to nurses on the medications when there were ons on the medication carts ible for returning rmacy now. am in a phone interview alled in October 2024 while diations with another nurse by the back of a controlled observed tampered with. pering as a tiny slit that back of the bubble slot on on card, there was a tablet a piece of tape was the slit was made. She looked similar to the and questioned the ere was a number on the facting Administrator was at d. She stated all controlled thed for accuracy and g and drug test were staff. She explained after ses counted and signed d medications to the the DON was the only ove controlled medications rt to return controlled	F 60				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		3	· · ·	MPLETED
			A. BUILDING			С
		345529	B. WING		02/24/202	
	ROVIDER OR SUPPLIER	040020		STREET ADDRESS, CITY, STATE, ZIP COD		2/24/2025
NAME OF F	ROVIDER OR SUFFLIER			5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616		
				-		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIOI DATE
F 602	Continued From pag	e 36	F 60	12		
1 002	-		FOU			
		t pm in an interview with ained she was the weekend				
		vorked at the facility since				
	February 2018. She stated controlled medications were stored in a double locked drawer on the					
		d two nurses were to count				
		ed medications records when				
	-	dications to the medication				
		rolled medications were				
	counted by two nursi	ng staff at the change of the				
	-	olled medications counts				
	were not correct the	supervisor was notified to				
	determine the reasor	n the count was incorrect and				
	notified the DON if u	nable to determine why the				
	controlled medicatior	n was inaccurate. She stated				
		October 2024 reports of				
		medication counts. She				
		worked during the week and				
		n there was a concern with				
		ns on the medication carts.				
		ig a call from the former				
		he controlled medications for				
		located. She stated she				
		nt #232 dying on a weekend				
	,	and Nurse #10 having				
	cards that consisted	e controlled medications				
		r oxycodone and one				
		n card for Lorazepam asking				
		to do with Resident #232's				
		ns cards. She stated she				
		the controlled medications				
		olled medication cards with				
		controlled medication sheet				
		x symbol. She stated she				
	informed Nurse #10	-				
		ght nurse to return the				
		-	1	1		
	medications to the pl	harmacy. She explained				

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		ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					LETED
						(C
		345529	B. WING			02/	24/2025
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH			5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	· · ·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 602	• • • • • • • • • • • • • • • • • • •		F	602	2		
		nd were counted at the					
	change of each shift u	on 10/19/2025 the former					
		where Resident #232's					
		s were located because					
		d the controlled substance Resident #232 controlled					
		n given to her (Nurse #14).					
	She stated she told th	ne former DON Nurse #10					
		give the discontinued					
		s to the night nurse to return she (Nurse #14) had not					
		ubstance sheet or received					
	Resident #232's conti	rolled medications. She					
	stated she reviewed t						
		et and that was not her 24 when Resident #232's					
	controlled medication						
	removed from the 300	0-hall medication cart.					
	Attempts to interview	Nurse #10 were					
	unsuccessful.						
	On 2/17/2025 at 4:12	pm in a phone interview					
	•	, she stated she was unable					
		recalled reporting to work ursing station #2 controlled					
	-	served tampered with when					
		d medications and the					
		fied. She stated the acting					
	-	esent and the nurses who g station #2 were drug					
		e facility did not drug test					
	everyone. She stated						
	Administrator checke	d all the controlled					
		edications carts for accurate					
	She reported the cont	of controlled medications. trolled medication.					
		lent #232 was not located.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/31/2025 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345529	B. WING			_		C 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				5	201 CLARKS FORK DRIV	ENW		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		F	RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 602	She explained that the sending residents' controlled medication of the stated on 10/22/24 with DON conducted a fact controlled medication with Resident #87' controlled medication with Resident #87' controlled medication pharmacy. She stated tampering of the control assessed by the form stated the nursing state the nursing state the nursing state the nursing state daministered and non medications in the elect documenting controlled medication in the elect documenting controlled the controlled medication of the control added and/or remove and the DON would be controlled medication On 2/21/2025 at 5:25 with Pharmacist #1 ar #1, they stated the Ph Services worked with related to misapproprimedications and the pharmacist #1 ar #1, they stated the pharmacist #232 control was returned to the pharmacist #232 control was returned to the pharmacist #1 an #1000000000000000000000000000000000000	e nursing staff were not ntrolled medications back to ntrolled medications were dication carts long after controlled medications. She hen she and the former cility wide audit on the s, tampering was observed introlled medications and the s were replaced by the d the residents affected with rolled medications were her DON and nurses. She aff was educated on the olled medication sheet, rolled medications sheet, rolled medications removed on thon sheet. She stated the ther educated on the ses were required to count off mathematications were ed from the medication carts be responsible for returning is to the pharmacy. pm in a phone interview and Pharmacist Consultant harmacy Director of Clinical the facility in October 2024 iation of controlled person in that position no pharmacy. Pharmacist #1 ecord in the pharmacy that olled medication, Oxycodone,	F	602				

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		ND HUMAN SERVICES MEDICAID SERVICES					RM APPROVE NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUC			NTE SURVEY	
		345529	B. WING			C 02/24/2025		
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDF	RESS, CITY, STATE, ZIP CODI	E		
				5201 CLARK	S FORK DRIVE NW			
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, N	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 COI (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 602	Continued From pag	e 30	F 6	:02				
1 002	1.0			02				
		Consultant #1, she stated						
		n the Director of Nursing						
		cy consultants had been						
		to the DON on the process of nedications using the return						
		rm to list the controlled						
		ng the red pharmacy totes to						
		dications to the pharmacy.						
		25 a medication inspection						
		e facility and there were no						
		ns observed to return to the						
	pharmacy.							
	On 2/22/2025 at 1.56	o pm in a phone interview						
	with the former Direc							
		ng a call about tampered						
		a cards discovered by Nurse						
		1, who was at the facility,						
	-	on all controlled medications						
		rts and removed all the						
		medications cards off the						
		d were replaced by the						
		d the controlled medications						
	-	ere not located. She stated						
	nurses were drug tes	sted with negative results						
		rse did not return for a drug						
		reported to the N.C. Board						
	-	ed residents' assessments for						
		as completed and the						
	-	d education on accuracy						
	•	olled medications when						
	-	ng controlled medications for						
		She stated it was changed						
		responsible in returning						
		ns to the pharmacy and						
		dications were to be returned						
		nd not remain in the facility.						
		ng staff receiving educational						
	uraining on two nurse	es counting and signing for						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		345529	B. WING				C 24/2025		
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·			
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH			5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	7616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
F 602	controlled medication number of tablets in e card sheet at the char another audit of all co medication carts were and further tampering medications. She sta audits conducted on of the medication carts of information was discu and Performance Imp On 2/22/2025 at 1:33 with the former Admir concern with misappr medications was iden controlled medication were audited and furt of controlled medication were audited and furt of controlled medication were audited and furt of controlled medication the medication cart. F with no negative findii explained there was a should be in the QAP She stated the Assista 2024 would have mor correction. On 2/22/2025 at 2:32 with the former Assist stated she was left th after the incident with controlled medication	s when adding and nedications to the counting the number of s cards and the actual each controlled medication inge of the shift. She stated introlled medications on the e conducted a week later of resident controlled ted there were ongoing controlled medications on conducted and the assed in Quality Assurance provement (QAPI) meetings. pm in a phone interview histrator, she stated when a opriation of controlled ttified by Nurse #13, all s on the medication carts her discovering of tampering ons were identified. medications of the changing ing controlled medications to Residents were interviewed ings related to pain. She a plan of correction and I minutes for October 2024. ant Administrator in October re information on the plan of pm in a phone interview cant Administrator, she e facility in October 2024 misappropriation of	F	602					

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		MEDICAID SERVICES				D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
			A. BOILDING			С
		345529	B. WING			/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NOR			5201 CLARKS FORK DRIVE NW		
	RE HEALTH OARE/NOR			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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 602	Continued From pag	ie 41	F 60	12		
		ern. She stated she was not	100			
	sure there was a pla					
	On 2/24/2025 at 10:	50 pm in a phone interview				
	On 2/24/2025 at 10:50 pm in a phone interview with Regional Clinical Consultant, he explained					
	-	istory with diversion of				
		ns there had been a plan of				
	•	nd the facility continued with				
	-	n in October 2024 when				
		ns cards were found at the				
		ered with. He explained that counting the number of				
		n cards and were not actually				
		of pilling in the controlled				
	-	ew practices included				
		of controlled medication				
		count for each controlled				
	medication card on t	he medication cart at the				
	•	, inspecting the back of the				
		ns cards and controlled				
		each medication cart				
		to count and sign when				
		ns were added and removed				
		cart. He stated the DON only olled medications from the				
		eturn controlled medications				
		nday through Friday. He				
		dications that remained on				
		were counted at the change				
		eekends to be returned to the				
		N on Monday. He stated				
		controlled medications were				
		024, all medications carts				
		e staff were educated on				
		nedications and the process				
	-	ed medications from the stated Nurse #10 was				
	medication cart. He	SIGIEU INUISE # IV Was	1			1
	reported to the North	Caroline Board of Nursing				

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If continuation sheet Page 42 of 167

	-	ID HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT				E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		345529	B. WING				24/2025	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 602	medications and audi new process for contr reviewed in Quality A Improvement (QAPI) On 2/22/2025 at 1:10 second time, the facil corrective action plan property related to co 2. Resident #14 was a 2/7/2023. Resident #14 died on Physician orders date included oxycodone H milligrams(mg) tablets hours as needed for p order dated 1/21/2029 one tablet every six h was discontinued on a also included the con Morphine sulfate cond 100mg per 5 milliliters 0.25 milliliters every ti moderate to severe p on 11/8/2024 and Lor medication) 0.5mg ev anxiety. A review of the Febru Administration Record received Oxycodone 2/15/2025 and 2/16/2	ts were conducted on the rolled medications and ssurance and Performance meetings. pm, when asked for a ity was unable to provide a for misappropriation of ntrolled medications. admitted to the facility on 2/16/2025. ed 2/15/2025 at 5:48 pm HCL (an opioid) 10 s; take two tablets every six pain. There was a previous 5 for oxycodone HCL 10mg ours for pain as needed that 2/17/2025. Physician orders trolled medications: centrate solution (an opioid) s with instructions to give hree hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness of breath azepam (antianxiety very six hours as needed for ain or shortness	F	602				

Facility ID: 20040007

If continuation sheet Page 43 of 167

		ID HUMAN SERVICES				FORM	M APPROVED	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	PLE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			3		PLETED	
							С	
		345529	B. WING			02/	24/2025	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			5201 CLARKS FORK DRIVE NW			
					RALEIGH, NC 27616			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	IV.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO THE APPROPRI		DATE	
					DEFICIENCY)			
			1					
F 602	Continued From page	e 43	F	60	12			
		ducted. Medication aide #4						
		observed counting the s at the change of shift						
		300-hall medication cart.						
		ed medications were on the						
	300-hall medication for							
	, , , , , , , , , , , , , , , , , , , ,	ntrolled medication card with						
		h the controlled medication						
	with 20 tablets verifie	g controlled medication card						
		a with the controlled						
		3 tablets verified with the						
		sheet and a bottle of						
		ution with 13.5 milliliters						
		olled medication sheet.						
		tated controlled medications						
		oharmacy at night and the iver medications on Sunday						
	(2/16/2025). She stat	-						
	removed the controlle	0						
		completed the return to						
		urn controlled medications to						
	the pharmacy.							
	A review of the contro	olled substance count sheet						
	for 300-hall medicatio							
	recorded three contro	lled medication cards for						
	Resident #14 were re							
	Oxycodone 5mg, Oxy	-						
		d the initials of the Director						
	controlled medication	the person that removed the s.						
	0 0/00/0000 /							
	On 2/20/2025 at 4:30	•						
	conducted with the D 2/19/2025. During the	-						
	-	r there were controlled						
	-	cabinet behind the locked						
		ice. No further information						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED		
		345529	B. WING				C / 24/2025		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
				ŧ	5201 CLARKS FORK DRIVE NW				
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		I	RALEIGH, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE			
F 602	was obtained in the ir On 2/22/2025 at 4:10 with Interim Director of had not received Res medication card from from any nursing staff understood unit mana controlled medication and giving them to the responsible for ensuri were returned to the p stated Resident #14's should have been rem medication cart and re immediately after Res On 2/22/2025 at 4:14 observation was cond #4, who was assigned cart, stated Resident Lorazepam controlled on the medications car removed the controlled 300-hall cart to return to the pharmacy. With medications and cont the 300-hall medication There were no contro observed on the 300- was one controlled m Sulfate solution and a	pm in a phone interview of Nursing, she stated she ident #14's oxycodone the 300-hall medication cart f. She stated she agers were removing s off the medication carts e DON, who was ing controlled medications oharmacy. The Interim DON controlled medications noved from the 300-hall eturned to the pharmacy sident #14's death. pm and interview and fucted with Nurse #4. Nurse d the 300-hall medication #14's Oxycodone and medication cards were not art and the DON would have et medications from the the controlled medications on Nurse #4, the controlled rolled medications sheet on on cart were observed.	F	602					
	Resident #14's Morph was listed on the cont observed in the bottle On 2/22/2025 at 4:30	nine Sulfate of 13.5 milliliters trolled medication sheet and							

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	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 PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 602	surveyor to the DON's the filing cabinet in th office was observed le nursing station #1 bes room. The Administrat the door to the DON's cabinet that was local in the DON's office. T were found to be unloc stated the filing cabin Controlled medication by the Administrator f the top of the unlocked with Corporate Nurse Resident #14's Loraz the medication card. substance sheet for F verify the count was a oxycodone controlled controlled substance located in the DON's On 2/24/2025 at 7:39 the Administrator was misappropriation of R medication, Oxycodo On 2/24/2025 at 7:50 with the DON, she co Resident #14's contro controlled medication on 2/17/2025. She ret with the help of Unit M #2 and the Assistant I discontinued controlled medications carts why started and on 2/17/2 nursing staff random!	s office for an observation of e DON's office. The DON's ocated on a short hall from side the residents' shower tor was observed unlocking s office. There was one filing ted behind the DON's desk the filing cabinet drawers ocked and the Administrator et did not have a lock. Is were observed removed rom the third drawer from ed filing cabinet and verified Consultant #1 that included epam 0.5 mg three tablets in There was no controlled Resident #14's Lorazepam to accurate. There were no medication card or sheets for Resident #14 filing cabinet am in a phone interview, informed of the concern of esident #14's controlled ne. am in a phone interview uld not recall removing olled medications and s sheet off the 300-hall cart membered on 2/16/2025 Aanager #1, Unit Manager	F	602			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/31/2025 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í				(X3) DATE COMP	SURVEY LETED
		345529	B. WING					C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	AL HEALTH CARE/NORT			5	201 CLARKS FORK DRIVE NW			
ONIVERO		TRALLION .		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	x	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 602	did not know whose of had received. She stat handing her controlled walking in the hall to of did not sign the control She stated she placed in the filing cabinet (th the DON's office until controlled medication stated she had not be controlled medication stated due to being bu not returned the control pharmacy and there w would have stepped a Manager #1's office w open. On 2/24/2025 at 8:11 with Unit Manager #1 remove discontinued the medications carts directly to return to the knew the DON kept c office until she could a medication cart had n controlled medication Resident 14's controll 300-hall medication c nurses were to count	Iled medications were illed medications sheets and controlled medications she ated due to the nursing staff d medications while she was complete another task, she obled substance count sheet. d the controlled medications nat could not be locked) in she could return the s to the pharmacy. She een instructed how to return s to the pharmacy. She usy with the survey, she had colled medications to the would have been times she across the hall to Unit <i>v</i> ith the DON's office door am in a phone interview , she explained she would controlled medications off and give them to the DON e pharmacy. She stated she ontrolled medications in her send the controlled he pharmacy. She stated	F	602				
		am in a phone interview , she stated she had been						

If continuation sheet Page 47 of 167

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
F 602	out of work since 2/15 on 2/21/2025. She sta Resident #14's control to give to the DON to medications cards to On 2/24/2025 at 12:2 with Medication Aide #14's Oxycodone was medication cart on the when she left from the On 2/24/2025 at 12:2 with Nurse #4, she sta assigned the 300-hall 2/21/2025 and 2/22/2 Oxycodone medication substance sheets for 300-hall medication c where they were loca #14's controlled medi remained on the 300- On 2/24/2025 at 9:38 Nurse #15, she stated discontinued controlle medications carts to r medications to the ph Resident #14 controll 10mg and 5mg medic medication cart on 2/ signing that the count and 5mg substance s she did not sign the c sheet that the controll removed. On 2/24/2025 at 10:3	5/2025 and returned to work ated no one had given olled medication cards to her return the controlled the pharmacy. 28 pm in a phone interview #4, she stated Resident s still on the 300-hall e morning of 2/17/2025 e 7:00pm to 7:00am shift. 5 pm in a phone interview ated when she was medication cart on 025, Resident #14's on card and the controlled Oxycodone were not on the art and she did not know ted. She stated Resident cation, Morphine Sulfate, hall medication cart. am in a phone interview with d the DON removed ed medications from the returned the controlled armacy and DON removed ed medications, Oxycodone cation cards off the 300-hall	F	602	2		

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							IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ISTRUCTION	· · ·	E SURVEY IPLETED
							С
		345529	B. WING _	B. WING			2/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH			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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 602	Continued From page	e 48	F	602			
		count sheet at the front of					
	the controlled medica						
		explained when controlled					
		noved by the DON from the					
		OON and a nurse were to					
	was accurate and ren	controlled medication count noved.					
	On 2/24/2025 at 9:44	am in a phone interview					
		⁴ 1, he stated the DON was					
	informed of the proce						
	controlled medication	s that were to be returned to					
		t to be destroyed at the					
		the process as: list the					
		s on a return to pharmacy					
		copy of the triple form with tions in the red pharmacy					
		edication zip tie to secure					
		nber of the zip tie on the					
	return to pharmacy tri						
		he red pharmacy tote when					
	-	s Monday through Saturday					
		edications were verified with					
		tions listed on the return to He stated the DON was to					
	retain the other two c						
		He further stated Resident					
		I not been returned to the					
	pharmacy.						
		am in a phone interview with					
		e stated that when the DON					
	-	5, the DON reported there filing cabinet of her office					
		filing cabinet of her office. ad Administrator and herself					
	-	DN office and visually saw					
		tions were in the unlocked					
	filing cabinet drawer a						
	controlled medication	<u>o</u> , , , , , , , , , , , , , , , , , , ,		1			1

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
					5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		I	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 602	maintenance to chang office that was comple and the Administrator the locked DON office explained she was sti facility for returning co pharmacy and unders form that listed the co returned to the pharm signed by two nurses controlled medication locked pharmacy tote pharmacy when delive On 2/24/2025 at 12:4 Regional Maintenance Administrator request office to be changed of installed a new lock of around 12:00pm. He work by himself and r office and no one else office. On 2/24/2025 at 12:2 with Pharmacist #1, h medications returned 2/24/2025 included R medications, Lorazep He stated Resident # tablets had not been to On 2/24/2024 at 2:23 the Administrator, she controlled medication been returned to the p	ge the lock to the DON eted by noon on 2/19/2025 was given the only key to a. The Administrator II learning the process at the pontrolled medications to the stood there was a pharmacy introlled medications being hacy that was completed and and accompanied the s that were placed in a red that was picked up by ering medications. 1 pm in an interview with the e Director, he stated the ed the lock to the DON's on 2/19/2025. He stated he in the DON office door stated he conducted the no one entered the DON's ed the lock. He stated the by ided the key to the DON e had a key to the DON 4 pm in a phone interview e stated the controlled	F	602			

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 03/31/2025 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345529	B. WING		_		C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	<u> </u>	
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH	-	201 CLARKS FORK DRIV ALEIGH, NC 27616	ENW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 602	Continued From page an investigation.	50	F 602				
F 623 SS=D	Notice Requirements	Before Transfer/Discharge (6)(8)	F 623				3/25/25
	the reasons for the me language and manner facility must send a correpresentative of the of Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para- and (iii) Include in the noti- paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, to discharge required un- made by the facility at resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section;	There is a soon as practicable is soon as practicable is a soon as					
		te transfer or discharge,					

Facility ID: 20040007

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/31/2025 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345529	B. WING			_		C 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				5	201 CLARKS FORK DRIV	ENW		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		F	RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten- notice specified in par- must include the follow (i) The reason for tran- (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailin- telephone number of the protection and add developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dis email address and tel agency responsible for advocacy of individual	hisfer or discharge is ent's urgent medical needs, ()(i)(A) of this section; or a resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how yrm and assistance in and submitting the appeal s (mailing and email) and the Office of the State budsman; / residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the	F	623				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		F	RALEIGH, 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 623	Continued From page for Mentally III Individu §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification prior to the State Survey A State Long-Term Card the facility, and the re well as the plan for the relocation of the reside 483.70(k). This REQUIREMENT by: Based on record revid and/or discharge to the representative for 1 of hospitalization (Reside	e 52 uals Act. es to the notice. ne notice changes prior to or discharge, the facility bients of the notice as soon ne updated information in advance of facility closure closure, the individual who is ne facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at § is not met as evidenced iew and staff interviews, the le a written notice of transfer ne resident and the resident f 1 resident reviewed for		623	F623 1. Resident # 90 was provided with a copy of the transfer discharge notice 2. An audit was completed by the Director of Nursing of the last 7 days of unplanned discharges to ensure that the	ſ	
	Findings included:	mitted to the facility on			written transfer discharge notice was provided. This was completed on 3/20/2025.		
		oses included Alzheimer's			3. Education was initiated by the Dire	ector	
	disease.				of nursing or designee to the current		
					licensed nurses including agency licens	sed	
	The admission Minim	um Data Set (MDS)			nurses on the procedure to send transf		
		28/2025 indicated Resident			discharge agreement upon transfer to t		
	#90 was moderately of				hospital. This was initiated on 3/19/202		
	,				Any new licensed nurse will not be		
	The discharge MDS a indicated Resident #9	assessment dated 2/9/2025)0 had an unplanned			allowed to work until education has bee received. Agency licensed nurses will	en	

Event ID: PM7D11

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		MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 02/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
UNIVERS	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 (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 623	Continued From page	e 53	F 62	23	
	discharge to a hospita anticipated to return to Nursing documentation by Nurse #7 recorded discharged from the f request of Resident # Resident #90's face as medical orders for sc form was given to the services (EMS) person documentation that a and/or discharge was their representative. On 2/22/2025 at 1:02 Nurse #2, who acted stated the nursing stat transfer form that rep condition and notifica resident representative transferred out of the was not familiar with	al, and Resident #90's was to the facility. In on 2/9/2025 at 6:15 pm d Resident #90 was facility to the hospital at the 490's family member, and sheet, medication list and ope of treatment (MOST) e emergency medical onnel. There was no written notice of transfer is given to the resident and the resident and the pm in an interview with as a shift supervisor, she aff completed the electronic orted the resident's tion of the physician and we when a resident was facility. Nurse #2 stated she a written notice of transfer in to give to residents and		receive education prior t shift. Any new licensed nurse education on the orienta The Director of Nursing audit the hospital transfe morning clinical meeting weeks, then 3 x weekly weekly x 4 weeks, then 4. Results will be repo administrator to the qual meeting x3 months for fr as needed. 5. Date of completion: 3	will receive tion process. or designee will ers during the 15 x weekly x 4 x 4 weeks, then monthly x 2. rted by the lity assurance urther resolution
	Interim Director of Nu know who was respo written notice of trans facility and suggested have completed Resi transfer and/or discha On 2/22/2025 at 4:18 Social Worker, she st was responsible for c	pm in an interview with the irsing, she stated she did not nsible for completing the sfer and/or discharge at the d the Social Worker would dent #90's written notice of			

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-	LTH AND HUMAN SERVICES ARE & MEDICAID SERVICES			PRINTED: 03/31/202 FORM APPROVE OMB NO. 0938-039		
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345529	B. WING		C 02/24/2025		
NAME OF PROVIDER OR SUPP	LIER	s	STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSAL HEALTH CAP	E/NORTH RALEIGH		201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			
PREFIX (EACH D	IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL 'ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 623 Continued Fro	om page 54	F 623				
Corporate Nu nursing depar completing the discharge form representative that the nursing transfer and/on notice of trans resident. F 641 Accuracy of A SS=E CFR(s): 483.2 §483.20(g) Ac The assessom resident's stat This REQUIR by: Based on receinterviews, the the Minimum area of Pre-A Review (PAS) and Resident (Resident #14 anticoagulant residents who reviewed. Findings inclue 1. Resident # 7/4/23 with dia and dementia	20(g) couracy of Assessments. ent must accurately reflect the us. EMENT is not met as evidenced ford review, observations and staff e facility failed to accurately code Data Set (MDS) assessment in the dmission Screening and Resident ARR) (Resident #17, Resident 67, #4), use of opioid pain medication -), schizophrenia (Resident #41) and s (Resident #10) for 6 of 54 see MDS assessments were ded: 17 was admitted to the facility on agnoses that included depression	F 641	 F641 Modifications to the Minimum Data Set were made to residents #53, 17,67 14 and 10. Current residents at risk for inaccurate MDS coding. MDS coordina audited all level II PASARR patients to ensure the PASARR was accurately coded on the MDS on 3/18/2025. Any residents found to not be accurately coded were modified. No residents sustained negative outcomes. Education was provided to the Minimum Data Set (MDS)nursing staff the importance of accurate coding of assessments and timely transmission of assessments. This was provided on 3/19/2025 by the Regional Director of Clinical Reimbursement (RDCR). 	on		

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		ND HUMAN SERVICES MEDICAID SERVICES				F	TED: 03/31/2025 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		OMPLETED
		345529	B. WING				C 02/24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE NW		
UNIVERSI	AL HEALTH CARE/NOR			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	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 641	Continued From page	e 55	F	541			
	administering medica			511	Any MDS nurse not receiving educat	ion	
					will not be allowed to work until educ		
	Resident #17's medic	cal record revealed a level II			is received.		
	PASARR determinati	on date of 8/17/23.			New MDS nursing staff will receive		
					education during the orientation proc		
	The annual Minimum				by the Regional Director of Clini	cal	
		6/24 indicated Resident #17 sidered by the state level II			Reimbursement. The Director of Nursing or designee		
		have a serious mental			educate the practitioners on Centers		
	illness.	have a concae montai			for Medicare/Medicaid services		
					(CMS) validation requirements for		
	On 2/21/25 at 2:08 P	M in an interview with MDS			diagnosing Schizophrenia per the		
		ated the 7/6/24 MDS for			Diagnostic and Statistical Manual of		
		have been coded as having			Mental Disorders for diagnosing		
	a Level II PASARR d				schizophrenia. This will be complete 3/25/2025.		
		admitted to the facility on			New providers will receive education	-	
	disorder and depress	es that included anxiety sion.			the Director of Nursing when they are onboarded to the facility.		
	Desident #67's sere r	alon included a facula for the			The RDCR or designee will audit for	death	
	-	plan included a focus for the nedications and behaviors.			in the facility and verify the resident assessment is completed within the		
		d administering medications			required timeframes per the RAI Mar	nual	
	as ordered.	J			5x weekly x 4 weeks, then 3x weekly		
					weeks, then weekly x 4 weeks, then		
		cal record revealed a level II			monthly x2.		
	PASARR determinati	on date of 2/7/23.			The RDCR or designee will review	-	
	The annual Minimum	Data Set (MDS)			residents with a new Level II PASAR determination letter and verify accurate		
	The annual Minimum	5/24 indicated Resident #67			MDS coding and care planning 5x w		
		sidered by the state level II			x 4 weeks, then 3x weekly x 4 weeks		
		have a serious mental			then weekly x 4 weeks, then monthly		
	illness.				The RDCR or designee will review		
					schizophrenia diagnosis for accurate		
		M in an interview with MDS			coding 5x weekly x 4 weeks, then 3x		
		ated the 4/5/24 MDS for			weekly x 4 weeks, then weekly x 4 w	eeks,	
	a Level II PASARR de	have been coded as having			then monthly x2. The RDCR or designee will review 5	īv	
					weekly x 4 weeks, then 3x weekly x		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/31/2025 M APPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NORT			52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	H KALEIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	 3/1/17 with diagnoses disorder. Resident #4's care pl behaviors such as references and passes and passes and passes and passes are passed at the passes and passes are passed at the passes are passes and passes are passes at the passes and partial passes and passes and	dmitted to the facility on s that included bipolar an included a focus for fusal of care. al record revealed a level II on date of 4/23/19. Data Set (MDS) 2/10/24 indicated Resident considered by the state level o have a serious mental M in an interview with MDS ated the 12/10/24 MDS for ave been coded as having a ermination. admitted to the facility on ses including osteoarthritis to al intestinal obstruction. Delan included a focus for s and bowel (intestinal) ns included administering ed.	F	641	weeks, then weekly x 4 weeks, then monthly x2. The MDS nurse or designee will revie new psychiatric practitioner notes prio uploading them in the electronic healt record, review new antipsychotic medication orders and the diagnosis I for the presence of Schizophrenia diagnosis 5x weekly x 4 weeks, then is weekly x 4 weeks, then weekly x 4 we then monthly x2. 4. Results will be reported by the MD2 nurse to the quality assurance month meeting x 3 5. Date of completion : 3/25/2025	or to h ist 3x eeks, S	
	Administration Record #14 received Oxycod	as needed for pain. mber 2024 Medication d MAR recorded Resident one daily on the following 2/8/2024, 12/10/2024 to					

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ON	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
) MULTIPLE CONSTRUCTION (X3) BUILDING	
	C 02/24/2025
SS, CITY, STATE, ZIP CODE	
FORK DRIVE NW	
PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F	CORK DRIVE NW 27616 PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIA

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
					5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	HRALEIGH		1	RALEIGH, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	depression and staff r concerns suggesting effective in managing schizophrenia. Resident #41's Febru Administration Record received Risperidone 2/22/2025. The quarterly Minimu assessment dated 2/7 #41 was moderately of displayed no behavio period. Resident #41' receiving antipsychoti basis and was not cord On 2/22/2025 at 8:27 MDS Coordinator #2, MDS dated 2/11/2025 schizophrenia due to evidence to validate t schizophrenia. She st physician note was not support coding Resid schizophrenia. On 2/22/2025 at 8:41 Corporate Nurse Con coding Resident #41 audit and Resident #41 audit audit audi	reported no behavioral the current medication was Resident #41's ary Medication d recorded Resident #41 2mg daily from 2/1/2025 to m Data Set (MDS) 11/2025 indicated Resident cognitively impaired and had rs in the 7-day look back s MDS was coded for ic medication on a daily ded for schizophrenia. p.m. in an interview with she stated Resident #41's 5 was not coded for not finding supportive he diagnosis of tated the psychiatric ot enough evidence to ent #4's MDS for p.m. in an interview with sultant #1, she stated as Schizophrenia triggers an 41's medical record may than the psychiatric e the MDS for	F	641			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345529	B. WING				/24/2025
NAME OF PI	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641 F 660 SS=G	dated 1/14/25 for Play milligrams (mg) one to Chewable (an antiplay There were no orders Resident #10's admis (MDS) assessment da was severely cognitivi indicated he was takin or reduce blood clottin (prevents platelets froc forming blood clots). In an interview with the 2/22/25 at 4:13 PM, s miscoded and Reside anticoagulants. In an interview with the at 6:34 PM, she said expected to be accura Discharge Planning P CFR(s): 483.21(c)(1)(§483.21(c)(1) Dischar The facility must deve effective discharge pla on the resident's disc	se. tian orders noted orders vix (an antiplatelet) 75 ablet daily and Aspirin telet) 81mg one tablet daily. for an anticoagulant. sion Minimum Data Set ated 1/20/25 indicated he ely impaired. The MDS ng anticoagulants (prevent ng) and antiplatelets om clumping together and the MDS Coordinator on he said the MDS was ent #10 was not on any the Administrator on 2/22/25 the MDS assessments were ate. Processs i)-(ix) rge Planning Process elop and implement an anning process that focuses harge goals, the preparation		641 660			3/25/25
	on the resident's discl of residents to be acti- transition them to pos- reduction of factors le readmissions. The fac process must be cons- rights set forth at 483	harge goals, the preparation ve partners and effectively t-discharge care, and the					

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Facility ID: 20040007

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 660	identify changes that discharge plan. The d updated, as needed, i (iii) Involve the interdi by §483.21(b)(2)(ii), in developing the dischar (iv) Consider caregive and the resident's or of person(s) capacity an required care, as part discharge needs. (v) Involve the resider representative in the of discharge plan and in resident representative (vi) Address the resider treatment preferences (vii) Document that a about their interest in regarding returning to (A) If the resident indit to the community, the referrals to local conta appropriate entities m (B) Facilities must up comprehensive care p appropriate, in respon from referrals to local appropriate entities. (C) If discharge to the to not be feasible, the made the determinatii (viii) For residents wh	and result in the charge plan for each evaluation of residents to require modification of the lischarge 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 d capability to perform of the identification of the and resident development of the form the resident and re of the final plan. ent's goals of care and s. resident has been asked receiving information the community. cates an interest in returning facility must document any act agencies or other tade for this purpose. date a resident's blan and discharge plan, as the to information received contact agencies or other	F	660			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/2029 FORM APPROVED OMB NO. 0938-0397		
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		C 02/24/2025		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/2-1/2020		
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH		201 CLARKS FORK DRIVE NW ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE COMPLETION		
F 660	provider by using data limited to SNF, HHA, patient assessment d measures, and data of the data is available. the post-acute care s assessment data, data data on resource use the resident's goals of preferences. (ix) Document, compli- on the resident's need record, the evaluation needs and discharge evaluation must be di- resident's representa- information must be in discharge plan to faci- to avoid unnecessary discharge or transfer. This REQUIREMENT by: Based on record revi- member, and home h- interviews, the facility effective discharge pl ensure a resident had arranged prior to disc reviewed for discharge The findings included Resident #181 was a 8/19/24 with diagnose mellitus and malnutrit	is and their resident lecting a post-acute care a that includes, but is not IRF, or LTCH standardized lata, data on quality on resource use to the extent The facility must ensure that tandardized patient ta on quality measures, and is relevant and applicable to f care and treatment lete on a timely basis based ds, and include in the clinical n of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident ncorporated into the litate its implementation and d delays in the resident's is not met as evidenced iew, and staff, family health agency staff f failed to implement an anning process and to d home health services tharge for 1 of 3 resident le (Resident #181).	F 660	F660 1. Resident # 181 received hor services after being discharged to community by primary care provided community by primary care provided 2. An audit was conducted by services team of the last 30 days discharges to the community to ethat all home health services were arranged. This audit was completed 3/18/2025. 3. Education was provided to to services team by the administrator designee on the discharge plannometers process including ensuring hometers	to the ider. the social s of ensure re eted the social tor or ning e health is		
	Resident #181's adm	ission Minimum Data Set		set up for all services. This educ			

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Facility ID: 20040007

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					NSTRUCTION		NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			` '	ATE SURVEY
		245520	R MINC				С
		345529	B. WING			()2/24/2025
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW				
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			EIGH, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 660			F 66				
	assessment dated 8/2			completed on 3/19/2025.	vill not		
	cognitively intact, requiring limited assistance for most activities of daily living, required a feeding tube and having the expectation to be discharged				Any social services team member v be allowed to work until education is		
					eceived.	-	
	to the community.			Any new social services team mem			
				e educated by the administrator du	uring		
		181's record revealed he			he orientation process.	udit	
	was discharged home	e on 8/29/24.			he Administrator or designee will a anned discharges to ensure home		
	A discharge note date	ed 8/29/24 written by the			ealth services have been ordered		
	-	evealed Resident #181 had		v	veekly x 4 weeks, then 3x weekly x	4	
	tolerated meals with			veeks, then weekly x 4 weeks, ther	ו		
	was clamped off. The			nonthly x 2			
	his hospitalization pri facility.		a	 Results will be reported by the administrator to the quality assuran- neeting x3 months for further resolution 			
	Record review reveal			as needed.			
	discharge planning for Resident #181 from the time of admission (8/19/24) through the date of his discharge home (8/29/24).			5	5. Date of completion: 3/25/2025		
	Resident #181 was n discharge.	Resident #181 was not care-planned for discharge. Review of Resident #181's discharge summary dated 8/29/24 revealed home health services were arranged with a local home health agency					
	dated 8/29/24 reveale						
	-	es, physical and occupational					
	therapy. The discharg	ge summary provided the					
		ency name and contact					
	number for reference. The discharge summary had no instructions for use of or care of the						
		scharge instructions stated					
		nically altered diabetic diet					
	with nectar thickened	l liquids.					
	An interview was con	nducted with Resident #181's					
		17/25 at 12:25 PM who					
	reported Resident #1	81 was not referred to home					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
AND I LAN OF	CONTECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				5	201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		R	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 660	reported she coordinations insurance and primary home health arranged stated Resident #181 ended which led to his Resident #181's famil him was difficult becare feeding tube, howeve could to care for Resile health was involved. Shome health agency of he was transferred to kept overnight for obstreturned home after heamily was able to care the assistance of home after heamily was able to care the assistance of home 327 (normal blood supe between 70 millight 100 mg/dL), and he has that was inserted on 8 patient did not know home health did not shospital records stated Resident #181 had lo hospital discharge on records stated Resider was for supplemental while at the nursing head that was not profeeding. Resident #18	rge from the facility. She ated with Resident #181's y care provider to get his d. The family member 's insurance coverage had s discharge on 08/29/24. Iy member stated care for use he came home with a er they did the best they dent #181 before home She reported that when the came to assess him 9/12/24 the local hospital. He was servation. Resident #181 his hospitalization and the re for his feeding tube with he health. ecords indicated on 181 was dysphagic ig), his blood glucose was gar levels are considered to ams per deciliter [mg/dL] to ad not been using the g-tube 8/13/2024 because the how to use the g-tube and start until 9/12/2024. The ed Resident #181 reported hstructions on how to use the hospital records indicated st 19.2 pounds since the 8/19/2024. The hospital ent #181 reported the g-tube feedings and was not used ome. Resident #181 ig oral intake at the nursing ovided g-tube supplemental 81 reported attempting oral	F	660			
	while at the nursing h reported only receivin home and was not pro feeding. Resident #18	ome. Resident #181 ig oral intake at the nursing ovided g-tube supplemental					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
					5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		1	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 660	from the nursing hom Resident #181 on slid before meals and at r diagnosed with a urin kidney failure and hyp condition in which the is higher than normal hospital. During hosp Speech Language Pa recommended contine primary means of nut medication administra summary dated 9/18// diagnoses of severe p failure to thrive, chron mellitus. The outpatie bolus tube feed regim was discharged with H During an interview w same local home hea Resident #181's disch at 3:25 PM the staff m #181 was referred to care provider on 9/11, no referral from the sl On 2/22/25 at 3:36 PP conducted with the fa stated she was not er time of Resident #181's she had checked the find no mention of his facility Social Worker should have been foll home health services prior to discharge. Sh	e. The hospital record listed ling scale insulin and insulin hight. Resident #181 was ary tract infection, acute berglycemia (a medical body's blood glucose level) and admitted to the italization, he was seen by a thologist who ued use of the g-tube as rition, hydration, and ation. The discharge 2024 included the protein-calorie malnutrition, tic dysphagia, and diabetes ent follow up items included the nand insulin regimen. He nome health services. With a staff member from the thagency listed on harge summary on 2/22/25 hember stated Resident their office by his primary /24. She reported there was killed nursing facility. M an interview was cility Social Worker who inployed at the facility at the t's discharge. She stated social work office and could stay at the facility. The stated the process that owed was Resident #181's should have been arranged he stated she documented ation in progress notes and	F	660			

Facility ID: 20040007

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345529	B. WING				24/2025
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	AL HEALTH CARE/NORT			52	01 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	n Kaleion		R/	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 660	Continued From page	65	F6	60			
	Attempts to contact th Worker were unsucce	e former facility Social essful.					
	Calls to the former Ad returned.	ministrator were not					
F 677 SS=D	responsible for ensuri for residents at the tin reported neither she r Worker were employe of Resident #181's dis	ted the Social Worker was ng services were in place ne of discharge. She nor the current Social ed with the facility at the time	F6	677			3/25/25
55-0	§483.24(a)(2) A reside out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on record revi	is not met as evidenced ew and resident			F677		
	failed to provide incor	÷.,,			 Resident #33 received incontinent care. Current residents with a BIMS of 1 15 will be interviewed by the leadership team to ensure incontinence care is occurring. This will be completed by 	3-	
	4/20/2022 with diagno	mitted to the facility on oses including Alzheimer's			 3/19/2025. 3. Education to current nursing staff including current agency staff on timeliness of incontinence care. Educativilly the private of Nurse 100 and 100 an		
	disease and aphasia Resident #33's care p indicated Resident #3				will be provided by the Director of Nurs or designee. Education initiated on 3/19/2025. Any nursing staff not receiving educatio		

Event ID: PM7D11

Facility ID: 20040007

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C	OMPLETED
		345529	B. WING			C 02/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02/24/2025
				5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	'H 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 677	Continued From page	2 66	F 67	7		
	and stool. Intervention assistance with toileti hygiene when changi The significant chang assessment dated 1/2 #33 was severely cog of urine and stool and staff to provide all act On 2/17/2025 at 10:4 with Resident #33's F concern that Residen urine when NA # 9 re 2/14/2025. Resident when she visited after #9 informed her Resid were soaked with urin that day. On 2/21/2025 at 7:37 with Nurse Aide (NA) on-coming nurse aide were to check the resi and on 2/14/2025, sh residents with NA #12 work at 3:00 pm on 22 personal belongings a checking the dependen assignment. She state observed with the adu	ns included one person ng and providing toileting ng adult briefs. e Minimum Data Set (MDS) 22/2025 indicated Resident gnitively impaired, incontinent d was dependent on nursing ivities of daily living. 7 am in a phone interview Representative, she voiced a t #33 was found soaked with ported to work at 3:00pm on #33's representative stated r 5:00pm on 2/14/2025, NA dent #33 and the bed linens he when she came on shift pm in a phone interview #9, she explained the e and off-going nurse aide sidents at the end of a shift e did not check the 2. She stated she reported to /14/2025, put away her and promptly began ent residents on her		 will not be allowed to work until eris received. Agency staff will recereducation prior to the start of thein New nursing employees will recereducation during the orientation proby the Director of Nursing or designee with the Director of nursing or designee with the Director of nursing or designee with the start of thein 3 residents weekly x 4, then 5 residents weekly x 4, then 5 residents weekly x 4, then 7 residents monthly x 2. The Director of Nursing or design audit 10 random residents with B than 13 for timely incontinence care will be done weekly x 12 weeks, the monthly x 2 4. Results will be reported by the administrator to the quality assuration meeting x3 months for further residents. 5. Date of completion is 3/25/202 	ive the r shift. ive process gnee. ill 13-15 kly x 4, 5 ee will IMS less are. This then ne ance colution	
	urine. She stated NA changing Resident #3	33 and she did not ask NA 3's adult brief had not been				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/31/2025 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING			C /24/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVERS	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From page every two hours.	67	F 67	7		
F 689 SS=D	with NA #12, she state 3:00 pm shift and a 3: 2/14/2025. She stated of rooms 13 rooms fo shift that included four eating during that shift to complete personal the assigned resident included in her assign the 7:00am to 3:00pm changing Resident #33 bath before lunch and #33 with lunch at app stated she assisted N care after 3:00pm and bed linens were wet. Resident #33's adult B the urine had wet the #33's pajamas rather On 2/22/2025 at 3:48 Interim Director of Nu not aware NA #9 had clothing and bed liner reporting to work at 33 staff were to check re assistance with activith hours and/or as need Free of Accident Haza CFR(s): 483.25(d) Accidents	 a that morning, during her a fter assisting Resident roximately 12:30 pm. She A #9 providing incontinent a dmitted Resident #33's She explained due to borief positioned sideways bed linens and Resident than the adult brief. pm in an interview with rsing, she stated she was observed Resident #33's ns wet with urine upon a op pm. She stated nursing sidents dependent on ties of daily living every two ards/Supervision/Devices 2) 	F 68			3/25/25
	The facility must ensu §483.25(d)(1) The res					

Facility ID: 20040007

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		ID HUMAN SERVICES			PRINTED: FORM A OMB NO.	PPROVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C 02/24/2025	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 689	Continued From page	e 68	F 689			
	supervision and assis accidents. This REQUIREMENT by: Based on observation interviews, the facility designated resident as preventative equipme Smoking Area #2) an smoking assessment reviewed for smoking Findings included: 1. On 2/16/2025 at 12 observed smoking in designated shelter co the activities recreation was observed with a inch diameter ash tra- trash can. There was blanket or self-closing ashtrays observed in On 2/16/2025 at 3:14 designated smoking a observed with three v pedal trash cans, a fi hanging fire aprons a tray. There was no s containers with self-co ashtrays would be en On 2/16/2025 at 4:38 Administrator, she sta	g (Resident #37). 2:35 pm, one resident was Smoking Area #1, the overed smoking area outside on room. Smoking Area #1 fire extinguisher, two small 4 tys and a small beige plastic is no smoking aprons, fire g metal containers to empty Smoking Area #1. 4 pm, a new non-sheltered area, Smoking Area #2, was vinyl chairs, two plastic foot re extinguisher, three and one metal standing ash smoking blanket or metal closing covers into which inptied in Smoking Area #2. 8 pm in an interview with the ated the facility was in the		 F689 1. Fire retardant blanket was place the smoking area on 3/19/2025. As were added to the smoking area or 3/19/2025. 2. Current residents will have a sess smoking tool completed by the nurse leadership team completed by 3/25. 3. The Administrator provided ed to the maintenance department on equipment needs of the smoking and This was completed on 3/19/2025. Director of Nursing or designee will educate licensed nurses on the neet complete quarterly safe smoking to Maintenance department will not be to work until education is received. New maintenance employees will reducation during the orientation proby the administrator. Any licensed nurse will not be allow work until education is received. Ag staff will receive education prior to start of their shift by the Director of Nursing or designee. The director of nursing or designee. 	afe sing j/2025. ucation the rea. dding d to hol. e able eceive pocess wed to gency the e will ave a t ents / x 4,	
	Administrator, she sta process of moving th				/ x 4, new	

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		MEDICAID SERVICES	(X2) MULTUR	E CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	1 ° '		· · ·	DMPLETED
						С
		345529	B. WING			02/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From page	e 69	F 689			
	the activities recreation On 2/18/2025 at 2:59 Smoking Area #2, the observed in the plastic residents were observed Area #2. On 2/22/2025 at 12:5 Smoking Area #2, the with trash and several the plastic bag in the to the right of the doo Area #2. On 2/22/2025 at 1:42 Administrator, she exist the facility were unsu- stated either Smoking weather only) or Smo- by the smokers. She amount of equipment smoking areas, all eq Smoking Area #2 was Area #1 when it was She stated she needed	pm in an observation of ere was one cigarette butt c foot pedal trash can. Two ved smoking in the Smoking 9 pm in an observation of ere was a plastic bag filled I cigarette butts observed in plastic trash can positioned r when entering Smoking pm in an interview with the plained all of the smokers in pervised smokers and g Area #1 (used in inclement oke Area #2 were used daily stated that due to the limited observed in the designated		 during the orientation proces Director of Nursing or design The Maintenance director of audit the smoking area for exweekly x 4 weeks weekly x 4 monthly x 1 to ensure equipmelace. 4. Results will be reported by of Nursing to the quality assumeeting x3 months for further as needed. 5. Date of completion 3/25/20 	ee designee will quipment 3x weeks and nent is in the Director irance r resolution	
	stated the facility did Smoking Area #1 and stated the smoking and fire blanket. 2. Resident #37 was 3/1/2024 with diagnos	and Smoking Area #2. She not have fire blankets for I Smoking Area #2 and prons could be used as a admitted to the facility on ses including stroke.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345529	B. WING			02	C 2/24/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	included performing s needed. A smoking assessme Resident #37 had dep indicated Resident #3 unsupervised. This w recent smoking asses The quarterly Minimu assessment dated 11 #37 was moderately of upper and lower extre on one side of the box On 2/16/2025, a list of smokers was provide Resident #37 was list list as an independen On 2/18/2025 at 2:59 observed smoking in designated smoking a members. Resident # his cigar in the right h movements to and from Resident #37 was ob- approximately four fea ashtray in a wheelchat the concrete. There w observed in the smok On 2/22/2025 at 3:11 Interim DON, she exp	amoking assessments as Int dated 9/6/2024 recorded Aterity problems and 37 could smoke as Resident #37's most asment. Im Data Set (MDS) /18/2024 indicated Resident cognitively impaired and had emity limited range of motion dy. If independent unsupervised d by the Administrator and ed on the facility's smoking t unsupervised smoker. pm, Resident #37 was the new non-sheltered area accompanied by family 37 was observed holding and with controlled om the lips while smoking. served positioned et from the metal standup air and dropping ashes onto vere no staff members ing area. pm in an interview with the blained smoking	F	68			
	On 2/22/2025 at 3:11 Interim DON, she exp assessments were tri quarterly after the MD admission and re-adm stated nurses were re	pm in an interview with the plained smoking ggered to complete					

Facility ID: 20040007

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	S FOR MEDICARE &		() (o) · · · · · - · - ·		OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 02/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 689	have had a smoking since the last docume dated 9/6/2024 in De due to starting emplo January 2025, she di did not have a smoki	assessment conducted ented smoking assessment cember 2024. She stated syment with the facility in dn't know why Resident #37 ng assessment completed in added Resident #37 had	F 689		
F 697 SS=D	CFR(s): 483.25(k) §483.25(k) Pain Man The facility must ensign provided to residents consistent with profest the comprehensive p and the residents' go This REQUIREMENT by: Based on observation and Physician interviter ensure effective pain with an unwitnessed and failed to provide assessed by the floor assessments (an assess to evaluate for potent mental status, level of function, sensation, of and used a numerical uses numbers from 0 0 meaning no pain an pain) and having pain three (3) assessment	ure that pain management is who require such services, ssional standards of practice, erson-centered care plan, als and preferences. T is not met as evidenced on, record review, and staff ews, the facility failed to management for a resident documented fall on 1/27/25 pain management when r nurse during neurological sessment done by the nurse tial brain injuries by checking of consciousness, motor coordination, and reflexes) Il pain scale (a scale that to to to measure pain with nd 10 meaning the worst n verbalized a 3 out of 10 for ts and 6 out of 10 for four (4) 1 resident reviewed for pain	F 697	 F697 1. Resident # 25 is receiving adequipain control. 2. An audit was completed by the Director of Nursing and designee to review the last 7 days of nursing note ensure any noted changes in resider pain condition were noted and the physician had been notified. This wa completed by the Director of nursing 03/25/2025. The audit included a rev of nursing notes and 24-hour shift to reports. 3. Education initiated by the Director Nursing and designee to current licer nurses staff including agency staff regarding notification of provider whete 	es to nts□ s on ⁄iew shift or of nsed

Event ID: PM7D11

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/31/2025 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING _				C 24/2025
NAME OF F	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			201 CLARKS FORK DRIVE NW ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	The findings included Resident #25 was ad 9/24/24 with diagnose ischemic attack (TIA) deficits, and type 2 di Resident #25's care p a focus for fall risk rel assistance with trans offer to place residen common items within remind resident to us assistance with activi Review of Resident # Data Set (MDS) date cognitively intact. Re assistance with activi A progress note date #25 was found on the between her nightsta her left knee was ber hitting her head but c "pretty bad". The phy representative (RP) v was noted to have re- feet. The physician c knee. Review of the neurolo 1/27/25 at 2:00 pm a revealed the following - Q (every)15 minutes) at	i: mitted to the facility on es which included transient , cerebral infarction without abetes mellitus. olan dated 9/24/24 revealed lated to the need for fers. Interventions included: t in bed after lunch, place reach of the resident, and e their call light for ties of daily living (ADL). 25's quarterly Minimum d 12/31/24 revealed she was esident #25 required staff ties of daily living (ADL). d 1/27/25 revealed Resident e floor lying on her back and and her wheelchair and at. Resident #25 denied omplained her left knee hurt visician and resident vere notified. Resident #25 gular socks on both of her ordered an x-ray of the left pgical checklist dated and completed by Nurse #3 g: s (Nurse checks resident 2:00 pm b, respirations- 18, alert and	F	597	 observed. Education initiated on 3/19/2025. Any licensed nurse will not be able to work until education received. Agency licensed nurses will receive education prior to the start of their shift a member of nursing leadership team. Any new licensed nurses will receive the education in orientation. The Director of Nursing or designee with audit the nursing progress notes for an changes in pain and notification of provider 5 x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed. Date of completion: 3/25/2025 	his ill iy c eks,	

Facility ID: 20040007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	VERSAL HEALTH CARE/NORTH 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	 expressions of pain main scale: 6. Q15 at 2:15 pm Alert and Oriented x 3 verbal expressions of numerical pain scale: Q15 at 2:30 pm Alert and Oriented x 3 verbal expressions of numerical pain scale: Q15 at 2:45 pm Alert and Oriented x 3 verbal expressions of numerical pain scale: Q15 at 2:45 pm Alert and Oriented x 3 verbal expressions of numerical pain scale: Q30 minutes (Nurse minutes) at 3:15 pm Alert and Oriented x 3 verbal expressions of numerical pain scale: Q30 at 3:45 pm Alert and Oriented x 3 verbal expressions of numerical pain scale: Q30 at 4:15 pm Alert and Oriented x 3 verbal expressions of numerical pain scale: Q30 at 4:45 pm Alert and Oriented x 3 	 arked- yes, and numerical Person-Place-Time), pain marked- yes, and Person-Place-Time), pain marked- yes, and Person-Place-Time), pain marked- yes, and checks resident every 30 Person-Place-Time), pain marked- yes, and 	F	697			

Facility ID: 20040007

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/31/2025 RM APPROVED NO. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		345529	B. WING _			C 02/24/2025		
	ROVIDER OR SUPPLIER	TH RALEIGH		5201	EET ADDRESS, CITY, STATE, ZIP CODE CLARKS FORK DRIVE NW .EIGH, 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 697	5:45 pm Alert and Oriented x 3 verbal expressions of numerical pain scale: - Q 1 hour at 6:45 pm Alert and Oriented x 3 verbal expressions of numerical pain scale: - Q 1 hour at 7:45 pm Alert and Oriented x 3 verbal expressions of - Q 1 hour #4 at 8:45 Alert and Oriented x 3 verbal expressions of Review of a 72-hour dated 1/28/25 at 5:45 Nurse #3 revealed R4 her left knee. Nurse x-ray of left knee. The pain medication giver A physician's order w an x-ray for Resident completed by the fact Review of Resident # knee dated 1/29/25 d fracture of the left knee Review of a progress am and completed by Nursing (DON) revea	ecks resident every hour) at 3 (Person-Place-Time), f pain marked- yes, and 3. 3 (Person-Place-Time), f pain marked- yes, and 3 (Person-Place-Time) and f pain marked: No. pm 3 (Person-Place-Time) and f pain marked: No. pm 3 (Person-Place-Time) and f pain marked: No. post fall documentation note is pm and completed by esident #25 reported pain in #3 obtained an order for ere was no documentation of n to Resident #25 noted. ras obtained on 1/28/25 for #25's left knee and ility's mobile x-ray unit. 425's x-ray results of her left locumented an acute hairline ee with mild swelling noted. is note dated 1/29/25 at 9:09 y the Interim Director of led the Interdisciplinary discussed Resident #25's	F6	97				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/31/2025 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION			LETED
		345529	B. WING		_		C 24/2025
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH	-	201 CLARKS FORK DRIV RALEIGH, NC 27616	ENW		
0(0)15		ATEMENT OF DEFICIENCIES			PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	275	F 697				
		ussed and Resident #25 was					
		pain medication prior to pital for evaluation or after					
	1/29/25.						
		25's January Medication d (MAR) revealed no pain given.					
	after an x-ray report n the left knee. Her vita limits (WNL). Physica was awake and alert left shoulder painful to	a note dated 1/29/25 ident #25 for a follow-up visit noted a hairline fracture of al signs were within normal al exam noted Resident #25 with decreased mobility and to touch. Resident #25 was epartment (ED) for further					
	1/29/25 revealed Res emergency department fall on 1/27/95. A Cor scan of the head (whi a computer linked to a series of detailed pictor completed with no evit	scharge summary dated ident #25 presented to the nt (ED) for evaluation of a mputed Tomography (CT) ch is a procedure that uses an x-ray machine to make a ures of the brain) was idence of intracranial can of the cervical spine was					
	of the left femur (bone completed with no evi x-ray of the pelvis (the abdomen and upper t to the legs) was comp	idence of fracture. An x-ray e of the thigh) was idence of a fracture. An e bones between the lower highs that connect the spine oleted with no evidence of a the left tibia fibula (two long					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>			(X3) DA	TE SURVEY MPLETED
		345529	B. WING			0	2/24/2025
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	with no evidence of a swelling was noted. F from the hospital on 1 or medication orders. In a phone interview of 2:01 pm, she stated s Resident #25 was fou did not remember the this to her. Nurse #3 neurological assessm documented pain on a Resident #25. Nurse a standing order for p order for pain was Ac milligrams (mg) every pain for 72 hours and hours if pain persisted asked did she give Re Acetaminophen, she indicated she did not Resident #25's pain b physician of Resident During a telephone in Physician # 1, he stat Resident #25's fall on he ordered x-rays of H indicated he was not complaints of pain. T facility's standing order should have been adu During an interview o Resident #25, she sta January and hurt her further stated she was	ower leg) was completed fracture, but moderate Resident #25 was discharged /29/25 with no new referral with Nurse #3 on 2/20/25 at the was the nurse when and on the floor. Nurse #3 nurse aide who reported further stated she did tents on Resident #25 which a scale from 3 to 6 from #3 explained the facility has ain. The facility's standing etaminophen 650 4 hours as needed for mild to notify physician after 72 d. When Nurse #3 was esident #25 any replied no. Nurse #3 notify the physician of out should have notified the #25's pain. terview on 2/20/25 with ted he was aware of 1/27/25. He further stated her left knee. Physician #1 aware Resident #25 had any he Physician indicated the ers for Acetaminophen ministered. n 2/22/25 at 10:39 am with	F	697	7		

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345529	B. WING			02	C 2/24/2025
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			5201 CLARKS FORK DRIVE NW		
	1				RALEIGH, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	after returning from the recalled going to the H Resident #25 stated as medication for pain at sent to the hospital for returning to the facility 1/29/25. She explain- pain, and it hurts more her on her side to per When asked did she it her knee pain, she re- she asked for pain me Nurse Aide (NA) #4 w 3:06 pm. NA #4 state incident on 1/27/25 bo Resident #25 on that worked with Resident and she complained of care after the incident dates. NA #4 further complaints of pain to In an interview with the Nursing (DON) on 2/2 Resident #25 was ser evaluation on 1/29/25 expectations were that monitored the resider as needed (PRN) and pain management if it During an interview of the Administrator, she Resident #25's fall on she was unaware of F pain but expected the residents for pain during	the hospital. Resident #25 hospital for her knee pain. She did not receive any is the facility prior to being r evaluation or after y from the hospital on ed she still had mild knee e when the nursing staff roll form incontinent care. Inform the nursing staff of plied yes but did not state if edication. Was interviewed on 2/22/25 at ed she remembered the ut she was not assigned to day. NA #4 stated she #25 after her fall on 1/27/25 of leg pain with incontinent to but cannot recall the exact stated she reported the floor nurse. The Interim Director of 22/25 at 5:00 pm, she stated ht to the hospital for but to the hospital for to the hospital for to the hospital for to the hospital for to for pain every shift and thinform the Physician for holicated. The 2/22/25 at 5:00 pm with the stated she was aware 1/27/25. She further stated Resident #25's complaints of a nursing staff to monitor the	F	697	7		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			201 CLARKS FORK DRIVE NW ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page management if indica		F	697			
F 726 SS=J	Competent Nursing S	taff	F	726			3/25/25
	the appropriate comp provide nursing and re- resident safety and at practicable physical, re- well-being of each res- resident assessments and considering the n- diagnoses of the facili accordance with the fa- at §483.35(a)(3) The faci- licensed nurses have and skill sets necessa- needs, as identified th assessments, and de §483.35(a)(4) Providin limited to assessing, e- implementing residen to resident's needs. §483.35(c) Proficience The facility must ensu- to demonstrate comp- techniques necessary needs, as identified th assessments, and de This REQUIREMENT by: Based on record revi	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 a and individual plans of care umber, acuity and ity's resident population in acility assessment required cility must ensure that the specific competencies ary to care for residents' mough resident scribed in the plan of care. Ing care includes but is not evaluating, planning and t care plans and responding y of nurse aides. Irre that nurse aides are able etency in skills and y to care for residents'			F726 1. The facility failed to ensure Nurse	#1	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/31/202 MAPPROVE 0. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		345529	B. WING			02	C 2/ 24/2025
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		-	201 CLARKS FORK DRIVE NW		
				ĸ	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	Continued From page	e 79	F	726			
•	to ensure nursing sta			120	was trained and competent in followi	na	
		er's guidelines for cleaning			manufacturer and competent in following manufacturer		
		ared glucometer when Nurse			and disinfecting a shared glucometer		
	#1 was observed not				on knowing how to distinguish an		
		t #35). Also, Medication Aide			individually assigned resident glucon	neter	
	,	nember) failed to clean and			from a shared glucometer.		
		Ily assigned glucometer			2. Current residents who require fin	-	
	•	lisinfectant wipes according commendations for Resident			stick blood sugars received their owr individual glucometers and they were		
		ed having a blood glucose			labeled and placed in an individual	,	
		occurred for 2 of 7 nursing			container. The was completed by the	•	
		e #1 and Medication Aide #1)			Director of Nursing and the Assistant		
	reviewed for compete	ency.			Director of Nursing on 2/18/2025.		
					3. Education was started by the Di	rector	
		began on 2/17/25 when			of Nursing on 2/18/2025 to current		
		monstrate competency			licensed nursing staff, including ager	-	
	through her failure to	ifacturer's instructions.			staff, on proper procedure for cleanir glucometers and for proper storage of	-	
		was removed on 2/19/25			glucometers. Employees not receivir		
		emented an acceptable			education will not be allowed to work	•	
	credible allegation of				the education is received. The Direct	or of	
	removal. The facility	will remain out of			Nursing will track the education to er	sure	
	-	r scope and severity level of			that current staff have received.		
		th a potential for minimal			Education includes each resident wh		
		ediate jeopardy) for finding to complete agency and			receives a finger stick blood sugar w have an individual glucometer that is		
		ng with monitoring to ensure			labeled with their name and stored in		
		ions are put into place.			individual container inside the med c		
					Education also includes the proper		
	The findings included	1:			cleaning technique as recommended	l by	
					the manufacturer guidelines. The cle		
		n record for Nurse #1 dated			product will be kept on each medicat		
		e use of equipment that			cart. The Director of Nursing or charge		
	-	s. The former Assistant			nurse will check the med carts daily t	0	
	5/7/2024.	igned the validation form on			ensure that the cleaning product is present on each med cart. The Direct	tor of	
	0112027.				Nursing educated the charge nurses		
	An educational in-ser	rvice roster dated 9/11/2024			2/18/2025. The Director of Nursing w		
		aning glucometers between			educated on this process by the		

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					CONSTRUCTION		<u>0. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · ·	E SURVEY PLETED
			A. BUILDING	G			С
		345529	B. WING				2/24/2025
	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	02	./24/2025
			5201 CLARKS FORK DRIVE NW				
UNIVERS	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 726	Continued From page	e 80	F 72	26			
		or infection control practices			Administrator on 2/18/2025.		
		ucometer to air dry 2 minutes			Current Licensed Nurses will complete	ea	
	•	ble wipes and place on a			skills return demonstration on glucome		
		Nurse #1's signature was			cleaning and storage. This will be		
		oster to indicate she had			completed by the Director of Nursing.	Any	
	received the education	on.			licensed nurse will not be allowed to w	ork	
					until return demonstration has been		
	On 2/17/2025 at 5:50	am in preparation to check			completed. The Director of Nursing wil	I	
	Resident #35's blood	glucose, Nurse #1 was			track the education to ensure that curre	ent	
	observed searching f	or Resident #35's			staff have received.		
	glucometer. Nurse #1			The Director of Nursing or charge nurs			
	their individually assig			responsible for ensuring new admissio			
	-	Nurse #1 was observed			who require finger stick blood sugars a	are	
		er of the 100-hall medication			provided with their own individual		
		cometer pouches labeled			glucometer that is labeled with their na		
		Resident #33's and Resident			and stored in an individual container. T		
		m number upward toward			Director of Nursing was educated on th	nis	
		vas observed locking the cart and walking to the			process by the Administrator on 2/18/2025. The charge nurses are		
		cart before returning to the			educated on this process by the Direct	for	
		cart and reopening the top			of Nursing on 02/18/2025.		
		lipped Resident #66's,			New licensed nurses will receive this		
		Resident # 93's labeled			education and verify competencies du	rina	
		upward toward her and			the orientation process by the Director	•	
		33's glucometer pouch.			Nursing or charge nurse. Agency nurse		
		led glucometer not in a			will receive this education and		
		ouch observed underneath			competencies prior to the start of their		
		meter pouch. Nurse #1			shift. The charge nurses were educate		
	stated the unlabeled	glucometer was Resident			on this responsibility by the Director of		
	#35's glucometer and				Nursing on 02/18/2025. The Director o	of	
		meter before performing a			Nursing will assign the charge nurse to	0	
		n Resident #35 on 2/17/2025			complete this task when needed.		
		was observed returning the			Director of Nursing or designee will au		
	-	ometer to the top drawer of			10 resident glucometer checks weekly		
		on cart without disinfecting			weeks, then 5 x 4 weeks, then 3 week	ly x	
	the glucometer.				4 weeks. then 3 monthly x 2.	•••	
	0 0/17/0005 1005				The Director of Nursing or designee w		
) am in an interview with			audit the med carts for cleaning solution		
	Nurse #1, she stated	Resident #35 did not have a			3x weekly x 4 weeks, then 2 weekly x 4	4	

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		(X2) MULTIPI	ECONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
	IDENTIFICATION NUMBER:	. ,		COMPLETED		
				с		
	345529	B. WING		02/24/2025		
ROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
L HEALTH CARE/NORT	'H RALEIGH					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTIO		
Continued From page	81	F 726				
labeled glucometer per not disinfect the glucor the blood glucose was who used the glucom should have disinfect stated she did not thir glucometer after perfor test. Nurse #1 was ob pad from the top draw medication cart and w glucometer without ar glucometer pouch wit returning the unlabeled drawer of the 100-hal stated she always dis alcohol pads and Res blood glucose monito In an interview with N 10:08 am, she identifi unidentified glucomet a resident's name and glucometer. She state Resident #31 who res have individually assis shared the unlabeled She also stated a disi clean glucometers aft On 2/18/2025 at 10:4 interview with Nurse # the unlabeled glucom labeled with a resider on the 100-hall medic #35's glucometer on 2	buch and the reason she did ometer before performing is because the staff member eter before she used it ed the glucometer. Nurse #1 hk about disinfecting the orming the blood glucose oserved removing an alcohol wer of the 100-hall viping the unlabeled in resident identified h the alcohol pad and ed glucometer to the top I medication cart. She infected glucometers with sident #35 was the only ring she had to perform. urse #2 on 2/18/2025 at ed the unlabeled / er not stored in a pouch with d room number as a shared ed the Resident #35 and sided on the 100 hall did not gned glucometers and / unidentified glucometer. nfectant wipe was used to the er each use on a resident. A2 am in a follow up phone #1, she stated she thought eter that was not in a pouch it's name and room number ation cart was Resident 2/17/2025 when performing nitoring. She stated		weeks, then weekly x 4 weeks, th monthly x 2 The Director of Nursing will audit residents requiring glucometers to glucometers present 3x weekly x then 2x weekly x 4 weeks, then w weeks, then monthly x 2 4. Results will be reported by th Director of Nursing to the quality assurance meeting x3 months for resolution as needed. 5. Date of completion: 3/25/2025	the o ensure 4 weeks, reekly x 4 e		
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER AL HEALTH CARE/NORT SUMMARY STL (EACH DEFICIENCY REGULATORY OR I Continued From page labeled glucometer pro- not disinfect the glucor should have disinfect stated she did not thing glucometer after perfor- test. Nurse #1 was ob pad from the top draw medication cart and w glucometer without ar glucometer without ar glucometer pouch with returning the unlabeled drawer of the 100-hall stated she always dis alcohol pads and Ress blood glucose monito In an interview with N 10:08 am, she identified unidentified glucometer a resident's name and glucometer. She state Resident #31 who ress have individually assis shared the unlabeled She also stated a disis clean glucometer on 2 the unlabeled glucometer on 2 the unlabeled glucometer on 2 the blood glucose monito Resident #31 also ress the blood glucose monito Con 2/18/2025 at 10:4 interview with Nurse # the unlabeled glucometer on 2 the blood glucose monito Resident #31 also ress the blood glucose monito Con 2/18/2025 at 10:4 interview with Nurse # the unlabeled glucometer on 2 the blood glucose monito Resident #31 also ress the blood glucose monito Con 2/18/2025 at 10:4 interview with Nurse # the unlabeled glucometer on 2 the blood glucose monito Con 2/18/2025 at 10:4 interview with Nurse # the unlabeled glucometer on 2 the blood glucose monito Con 2/18/2025 at 10:4 interview with Nurse # Con 2/18/2025 at 10:4 interview with Nurse # Con 2/18/2025 at 10:4 Con 2/18/2025	CORRECTION IDENTIFICATION NUMBER:	S FOR MEDICARE & MEDICAID SERVICES IF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLI A BUILDING 345529 B. WING 345529 B. WING CORRECTION 345529 ROVIDER OR SUPPLIER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 81 F 726 Iabeled glucometer pouch and the reason she did not disinfect the glucometer before performing the blood glucose was because the staff member who used the glucometer before she used it should have disinfected the glucometer. Nurse #1 stated she did not think about disinfecting the glucometer after performing the blood glucose test. Nurse #1 was observed removing an alcohol pad from the top drawer of the 100-hall medication cart and wiping the unlabeled glucometer without an resident identified glucometer without an resident distified glucometers with alcohol pads and Resident #35 was the only blood glucose monitoring she had to perform. In an interview with Nurse #2 on 2/18/2025 at 10:08 am, she identified the unlabeled / unidentified glucometer not stored in a pouch with a resident*31 who resided on the 100 hall din ot have individually assigned glucometers and shared the unlabeled / unidentified glucometer. She also stated a disinfectant wipe was used to clean glucometers after each use on a resident. On 2/18/2025 at 10:42 am in a follow up phone interview with Nurse #1, she stated she thought the unlabeled glucometer that was not in a pouch labeled with a resident* name and	S FOR MEDICARE & MEDICAID SERVICES 0F DEFICIENCIES (11) PROVIDERBUPPLIENCLIA (22) MULTIPLE CONSTRUCTION 345529 8 WING CONDER OR SUPPLIER 345529 8 WING AL HEALTH CARE/NORTH RALEIGH STREET ADDRESS, CITY, STATE, 2IP CODE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX RECOLATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 81 F726 Labeled glucometer before performing the blood glucose was because the staff member who used the glucometer before show used it should have disinfected the glucometer. Nurse #1 F726 Very Continue for the 100-hall medication cart and wiping the unlabeled glucometer after performing the alcohol pad and returning the unlabeled glucometer without an resident identified glucometer with Nurse #2 on 2/18/2025 at 10.08 am, she identified the unlabeled glucometers. She stated the Resident #35 was the only blood glucose monitoring she had to perform. 5. Date of completion: 3/25/2025 the also state dise ad disinfectar wipe was used to clean glucometers after each use on a resident. ON2/18/2025 at 10.42 am in a follow up phone interview with Nurse #1, she stated she thought the unlabeled glucometers and shared the unlabeled glucometers and shared the unlabeled glucometers and shared the unlabeled show thing a resident. 5. Date of completion: 3/25/2025 the also state with was not in a pouch tabeled with a resident share and room number on the 100-hall medication ca		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH			5201 CLARKS FORK DRIVE NW		
	-	-		F	RALEIGH, NC 27616		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	1				52.10.2.001		
F 726	Continued From page	82	F	726			
	Resident #35 and Res			120			
		not in a labeled pouch.					
		was trained on how to use					
	and disinfect a glucor orientation and was u	neter with employment					
		o use the disinfectant wipes					
	at the facility. She rep	orted there were no					
	•	the 100-hall medication cart					
	to clean the glucomet 2/17/2025.	er on the morning of					
	_,,_0_01						
		am in an interview with the					
		OON), she stated the facility neter for every resident					
	-	se monitoring, and some of					
		ne medication carts were					
		lents. The DON stated					
	Nurse #1 was to clear shared between resid	n the glucometer that was					
		s and allow the glucometer					
	to dry for two minutes	before storing in the					
		cometer pouch. The DON					
	0	at the facility five weeks ago, entation that the nursing					
		educational in-services on					
	cleaning and disinfect	ting glucometers.					
	Thorowson as desires	ontation provided by the					
		entation provided by the educational in-services were					
	conducted on cleanin						
	glucometers since 9/1						
	The facility's Administ	rator was informed of the					
		IJ) on 2/18/2025 at 2:00 pm.					
	The facility provided t	he following plan for IJ					
	removal:						
	Identify those recipier	nts who have suffered, or					

Event ID: PM7D11

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
UNIVERS	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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	are likely to suffer, a s a result of the noncor The facility failed to e and competent in folk guidelines for cleanin glucometer and on kr individually assigned shared glucometer. Nurse #1 failed to ens unidentified glucometer Resident #35 and Re medication cart was of to and after use. (Res the glucometer was in Resident #35 and had unlabeled / unidentifie used on Resident #37 Nurse #1 indicated th Resident #35 was ind stated she did not thin disinfecting the unlab glucometer after perfor glucose and stated sh glucometer for every glucose monitoring ar on the medication car residents. The DON s be cleansed with an app	serious adverse outcome as npliance: nsure Nurse #1 was trained owing manufacturer's g and disinfecting a shared nowing how to distinguish an resident glucometer from a sure an unlabeled / er that was shared between sident #31 on the 100-hall cleaned and disinfected prior sident #35) Nurse #1 thought ndividually assigned to d forgotten that the ed glucometer was also 1. e glucometer used for lividually assigned. She nk about cleaning and eled / unidentified orming Resident #35's blood ne always cleaned residents' nol wipes. The Director of cility did not have a resident receiving blood nd some of the glucometers ts were shared between stated glucometers were to approved disinfectant. can be contaminated with eaned and disinfected after roved product and use an EPA-registered	F	726	3		

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	-					FOR	M APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		345529	B. WING			OULD BE COMPLETION	
NAME OF P	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345529 B. WING B. WING B. WING B. WING IDENTIFICATION NUMBER: A. BUILDING B. WING IDENTIFICATION NUMBER: A. BUILDING B. WING IDENTIFICATION NUMBER: A. BUILDING B. WING IDENTIFICATION STREET ADDRESS, CITY, STATE, ZIP CODE S201 CLARKS FORK DRIVE NW RALEIGH, NC 27616 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL IDENTIFICATION NUMBER: A. BUILDING B. WING B						
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH					
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION
F 726	manufacturer's instruct glucometer potentially spread of blood borned within the facility were diagnosis which inclu borne pathogens. Nurse # 1 was remov 2/17/2025 and will be competency prior to r completed by the Dire Current residents that sugar checks are at r FSBS and all forty hat individual glucometer Nursing completed ar Specify the action the process or system fait adverse outcome from when the action will b Current residents who sugars received their and they were labeled container. The was co Nursing and the Assis 2/18/2025. Education was started on 2/18/2025 to currer including agency staff cleaning glucometers glucometers. Employe education is received track the education to have received.	ctions to disinfect a shared y exposes residents to the e infections. Six residents e identified as having a ded one or more blood ed from the schedule on educated with a eturning to work. This will be ector of Nursing. t receive finger stick blood isk. Forty residents require ve been provided their . The Assistant Director of a audit on 2/18/2025. e entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete: o require finger stick blood own individual glucometers d and placed in an individual ompleted by the Director of stant Director of Nursing on d by the Director of Nursing ont licensed nursing staff, f, on proper procedure for and for proper storage of ees not receiving this allowed to work until the	F	720	δ		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345529	B. WING		COMPLETED C 02/24/2025 STREET ADDRESS, CITY, STATE, ZIP CODE S201 CLARKS FORK DRIVE NW RALEIGH, NC 27616 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	ЗE	COMPLETION
F 726	finger stick blood sug glucometer that is lab stored in an individua cart. Education also in technique as recomm guidelines. The clean each medication cart. charge nurse will che ensure that the clean each med cart. The D the charge nurses on Nursing was educate Administrator on 2/18 Current Licensed Nur return demonstration storage. This will be of Nursing. Any licensed work until return demo completed. The Direct education to ensure the received. The Director of Nursin responsible for ensurf require finger stick bloc their own individual gl with their name and s container. The Directo on this process by the Di 02/18/2025. New licensed nurses and verify competence process by the Direct nurse. Agency nurses	ar will have an individual eled with their name and I container inside the med holudes the proper cleaning bended by the manufacturer ing product will be kept on The Director of Nursing or ck the med carts daily to ing product is present on Director of Nursing educated 2/18/2025. The Director of d on this process by the /2025. reses will complete a skills on glucometer cleaning and completed by the Director of d nurse will not be allowed to onstration has been tor of Nursing will track the hat current staff have	F	726	6		

Facility ID: 20040007

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/31/2025 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				5201 CLARKS FORK DRIVE	NW		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH	1	RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 726	the charge nurse to caneeded. Immediate Jeopardy not the facility's credible jeopardy removal was A phone interview with 2/18/2025 validated the physician of the deficition was implementing new individual glucometer after use of the 43 residents' (42/18/2025) individually currently resided in the validated each reside monitoring had an indigucometer in a gluco their name and room reported during intervited during intervites with license hallway and on all shi training was conducted in the individually assigned blood glucose monitoring staff reported they had rect training on 2/18/2025	ere educated on this Director of Nursing on ctor of Nursing will assign omplete this task when removal date 2/19/2025. allegation of immediate a validated on 2/22/25. In the medical director on the facility had notified the ent practice and the facility w practices that included an per resident and educating bw to disinfect the on a resident. Observation 0 plus 3 admissions since y assigned glucometers who e facility on 2/22/2025 int receiving blood glucose ividually assigned meter pouch labeled with number. Medication aides iews that blood glucose med by licensed nursing medications aides did not e monitoring in the facility. ed nursing staff on each fts validated in-service id in regard to the use of glucometers for resident ring and the infection control fection of glucometers. All who were interviewed eived the required in-service or prior to beginning their	F 726		EFICIENCY)		
	hallway and on all shi training was conducted individually assigned blood glucose monito practices for the disim- licensed nursing staff reported they had rec training on 2/18/2025 next assigned shift aff	Its validated in-service ad in regard to the use of glucometers for resident ring and the infection control fection of glucometers. All who were interviewed eived the required in-service or prior to beginning their					

Facility ID: 20040007

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/31/2025 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				520	1 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		RA	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 726	blood glucose monito individual assigned gl labeled glucometer per and room number. The included a review of the instructions for the fact disinfectant wipes rela- glucometer and comp demonstration of the effective glucometer of observation in conduct and subsequent gluco completed the task we assigned resident gluco stored on the medicar pouches with residen Each medication cart canister of EPA disinf staff were recording we assigned glucometers on each medication cart canister of EPA disinf staff were recording we assigned glucometers on each medication cart canister of a new glucometers admissions, replacement individually assigned emergency as needed of a new glucometer of glucometer, the facility glucometer into the me each unit. There were identified during either observations.	s for each resident requiring ring and storing each lucometer in an individually puch with resident's name he in-service training also he manufacturer's cility's glucometers and ated to disinfection of the oletion of a returned proper procedure for disinfection. Nurse cting a blood glucose check ometer disinfection ithout difficulty. Individually cometers were observed tion carts in closed labeled t's name and room number. was observed with a tectant wipes. The nursing verification of individually s and EPA disinfectant wipes art at the change of shift. d unlabeled new glucometer edication cart that licensed d through interviews the new were available for new nent of a resident's glucometer or in an d. To prevent the likelihood used as a shared y removed the new, unused ch medication cart and of the new unused nedication storage rooms on a no further concerns	F	726			
	The immediate jeopa	rdy removal date of 2/19/25					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	5201 CLARKS FORK DRIVE NW		
UNIVERS	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 PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From page was validated. 2. The manufacturer's 10/2019 for Resident provided instructions the glucometer used a part: to minimize the p blood-borne pathoger disinfecting procedure each use. The manuf approved EPA registed disinfecting the glucoor registered wipes may glucometer used by the The cleaning and disi Resident #32's individe included in part: Step 5: using one EP, wipe the entire surface horizontally and vertice pathogens and Step 6: Treated surface recommended contace meter in a towelette. The instructions for the disinfectant wipes date wipe was an effective tuberculocide and fun surfaces. When using the wipe to a hard, no	e 88 s operator manual revised #32's assigned glucometer for cleaning and disinfecting at the facility. It stated, in risk of transmitting ns, the cleaning and e should be performed after acturer's instructions listed ared wipes for cleaning and meter and stated other EPA be used for disinfecting the ne facility. Infecting procedure for dually assigned glucometer A disinfectant towelette to e of the glucometer cally to remove bloodborne ce must remain wet for the at time. Do not wrap the the EPA approved ted 2023 stated the minute virucide, bactericide, glicide on hard non-porous the disinfectant wipe, apply on-porous surface (the it to remain wet for one		726	DEFICIENCY)		
	(agency) was observe monitoring using an ir	am, Medication Aide #1 ed performing blood glucose ndividually assigned ent #32. After obtaining a					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 726	observed cleaning Re assigned glucometer On 2/18/2025 at 7:57 Medication Aide #1, s glucometer needed to and she cleaned the g pad because she did wipes on the 300-hall On 2/18/2025 at 10:27 with Medication Aide # training less than a m using disinfectant wip after use. She stated wipes on the 300-hall did not know the disin 300-hall medication c checked the 300-hall On 2/18/2025 at 11:57 Medication Aide #1 re cleaning and disinfect resident use, she repo- informed on 2/18/202 allowed to perform blo the facility and stated perform blood glucose she was in nursing so training in performing and had attended an facility. On 2/18/2025 at 12:22 Administrator, she stated perform blood glucose	Medication Aide #1 was esident #32's individually with alcohol wipes. am in an interview with he explained Resident #32's be disinfected after use glucometer with an alcohol not have any disinfected medication cart. 5 am in a follow up interview #1, she stated she received onth ago at the facility on es to clean glucometers there were disinfectant medication cart, and she ifectant wipes were on the art because she had not medication cart. 0 am when interviewing egarding her training in ting glucometers after orted she had been 5 medication aides were not ood glucose monitoring at she would get a nurse to e monitoring. She explained shool and had received blood glucose monitoring educational in-service at the 2 pm in an interview with the ated medication aides could e monitoring if training and	F	726			
	competency were doo	cumented. She explained ad received training from the					

Facility ID: 20040007

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	-					FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		LETED
		345529	B. WING				C 24/2025
NAME OF PF	IND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BI 345529 B. W NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/NORTH RALEIGH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH			3201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	agency company and school where she rec On 2/18/2025 at 12:3 Director of Nursing, s weeks of employmen orientation/competen completed for the fact On 2/18/2025 at 5:10 with the Director of N #32's individually ass be disinfected after ea wipe and medications glucose monitoring at blood glucose monito licensed nurses in the aides. A skills competency ra the agency company #1 performed glucose and was proficient in An educational in-ser	was currently in nursing eived training. 0 pm in an interview with the he stated in the last five t she had not seen an cy form that agency staff lity. pm in follow up interview ursing, she stated Resident igned glucometer needed to ach use using a disinfectant a aides did not perform blood the facility. She stated ring was completed by e facility and not medication ating dated 9/30/2024 from indicated Medication Aide e monitoring daily to weekly the task.	F	726			
	patients every time for stated to allow the glu after wiping with purp clean surface to dry. signature was include she had received the RN 8 Hrs/7 days/Wk,	r infection control practices acometer to air dry 2 minutes le wipes and place on a Medication Aide #1 ed on the roster to indicate education. Full Time DON	F	727			3/25/25
	§483.35(b)(1) Except	when waived under					

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						FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345529 B. WING CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE L HEALTH CARE/NORTH RALEIGH STREET ADDRESS, CITY, STATE, ZIP CODE ILEACH ORE OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDENTIFYING INFORMATION) Continued From page 91 ID PREVIDENTIFYING INFORMATION) ID Continued From page 91 Tag CONSTREET ADDRESS, CITY, STATE, ZIP CODE S483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. F 727 S483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: F727 Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours for 3 of 92 days reviewed for staffing (12/30/24, 1/2/25 and 1/3/25). F727 The findings included: Current residents are at risk to be affected On 03/18/2025 the Director of Nursing and staffing schedules from 11/1/24 through 1/31/25 revealed the following: On 03/18/2025 the Director of Nursing and Administrator will continue to review ti monthy staffing schedule revealed there was no RN working on any shift that day. Admininistrator and Di		C 24/2025				
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 727	must use the services least 8 consecutive he §483.35(b)(2) Except paragraph (e) or (f) of must designate a regi director of nursing on §483.35(b)(3) The dir as a charge nurse on average daily occupa This REQUIREMENT by: Based on record revi facility failed to provid coverage for 8 consec reviewed for staffing (1/3/25). The findings included Review of the facility's staffing schedules fro revealed the following a. On 12/30/24 the da daily census of 113. Review of the staffing was no RN working o b. On 1/2/25 the daily daily census of 118. Review of the staffing was no RN working o c. On 1/3/25 the daily	s of a registered nurse for at ours a day, 7 days a week. when waived under f this section, the facility istered nurse to serve as the a full time basis. ector of nursing may serve ly when the facility has an ncy of 60 or fewer residents. is not met as evidenced ew and staff interviews, the le Registered Nurse (RN) cutive hours for 3 of 92 days (12/30/24, 1/2/25 and : s daily staff posting and m 11/1/24 through 1/31/25 g: aily staff posting indicated a schedule revealed there n any shift that day. r staff posting indicated a schedule revealed there	F	727	 No Residents were affected by this practice Current residents are at risk to be affected On 03/18/2025 the Director of Nurand administrator and scheduler was educated by the Regional Director of Clinical Services regarding the need to ensure a Registered Nurse is schedule for at least 8 hours per day 7 days per week. The Director of Nursing and Administrator will continue to review the monthly staffing schedule daily to ensure a Registered Nurse is scheduled for 8 hours a day. Any Registered Nurse we cannot work their assigned shift must of in directly to the Director of Nursing. Th Administrator and Director of Nursing have reviewed the facilities current recruitment plan for Registered Nurses Any new scheduler, Director of Nursing Administrator will be educated during orientation process. The DON/Administrator/designee will 	sing ed re no call ne	
	daily census of 119.	stan posting indicated a			monitor the nursing schedule daily to		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/31/2025 MAPPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345529	B. WING _				C 24/2025
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	· · · ·	0 _ 0
				52	01 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	HRALEIGH		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	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 727	Continued From page	92	F7	27	ensure there is 8 hours of consecutive	RN	
	Review of the staffing	schedule revealed there			coverage for the center. The Director o		
	was no RN working o				Nursing/administrator/designee will sha schedules with Regional Director of		
		e Scheduler on 2/22/25 at			Clinical Services and Regional Vice		
		he worked on the schedule			President of Operations weekly x 4, the	en	
	Scheduler indicated s	erifying RN coverage. The			3x week x 4, then weekly x 4.4. The results of the daily review will	ha	
		was no RN coverage. The			discussed at the monthly QAPI meeting		
		did not have RN coverage			Once the QAPI committee determines		
	for 12/30/24, 1/2/25, a	and 1/3/25.			problem no longer exists, the audits wil	I	
	.				be completed randomly.		
	5:00 pm revealed she	Administrator on 2/22/25 at			5. Date of completion: 3/25/2025		
		age for 12/30/24, 1/2/25					
		nistrator stated there should					
	be an RN for 8 conse	cutive hours in the building.					
	the Administrator.	nal information provided by					
F 755 SS=E	Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(edures/Pharmacist/Records (1)-(3)	F 7	'55			3/25/25
	§483.45 Pharmacy Se	ervices					
		ide routine and emergency					
		to its residents, or obtain					
	them under an agreer						
		ty may permit unlicensed					
	personnel to administ	-					
	a licensed nurse.	er the general supervision of					
		es. A facility must provide					
	-	es (including procedures					
		ate acquiring, receiving, nistering of all drugs and					
		ne needs of each resident.					
		onsultation. The facility					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/31/2025 / APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				52	01 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 755	Continued From page must employ or obtai pharmacist who-	e 93 n the services of a licensed	F 7	55			
	§483.45(b)(1) Provide aspects of the provisi the facility.	es consultation on all on of pharmacy services in					
		shes a system of records of n of all controlled drugs in able an accurate					
	order and that an acc is maintained and per	nines that drug records are in count of all controlled drugs riodically reconciled. is not met as evidenced					
	Based on record rev Pharmacist #1 intervi complete a return pha discontinued non-con	ews, the facility failed to armacy form and return trolled medications and			F7551. Narcotics not in use were returned the pharmacy on 2/24/20252. Med Carts were audited on 3/25/2	2025	
	whose controlled med located in the Directo #70, Resident #113, I #400, Resident #71,	s for 11 of 11 residents dications were observed r of Nursing office (Resident Resident #96, Resident Resident #85, Resident Resident #402, Resident			to ensure all narcotics not in use were returned to pharmacy. This was completed by the Director of Nursing 3. Education to licensed nurses including agency to keep narcotics on med carts until Director of Nursing obt them to send back to the pharmacy.	the	
		Disposal of Medications and			Education was initiated on 3/19/2025. Any licensed nurse will not be allowed work until education received, Agency licensed nurses will receive education		
	revised date stated w	nacy" with no reviewed or			prior to the start of their shift Any new licensed nurse will receive education during the orientation proce by the Director of Nursing or designee		
	medications were retriphermacy for credit w				4. Director of Nursing will complete a audit of each med carts to sent narcoti back that are not in use weekly x	an	

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
245520			С
345529	B. WING		02/24/2025
TH RALEIGH		RALEIGH, NC 27616	
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIC
e 94 he medication return form a, medication name and d prescription number. urned to the pharmacy ntil the time of pick up. am, an interview and ducted. Medication Aide #4 observed counting the us at the change of shift 300-hall medication cart. tated controlled medications pharmacy at night. She gers removed the controlled nedication carts and to pharmacy form to return as to the pharmacy. blled substance count sheet on cart on 2/24/2025 blled medication cards for emoved on 2/17/2025: igrams), Oxycodone 10mg ig and the initials of the DON moved the controlled e am in a phone interview stated the Director of ved discontinued controlled medications carts to return ations to the pharmacy and esident #14 controlled the 300-hall medication cart	F 75	 5 12weeks, then monthly x 2 The administrator or designee will a the DON office weekly to ensure the narcotics are stored appropriately a sent back to the pharmacy. This will completed weekly x 12, then month 5. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for furesolution as needed. 6. Date of completion 3/25/2025 	at ind I be Ily x 2.
	345529 TH RALEIGH ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) A 94 The medication return form a, medication name and d prescription number. The time of pick up. am, an interview and ducted. Medication Aide #4 observed counting the s at the change of shift 300-hall medication cart. tated controlled medications opharmacy at night. She gers removed the controlled to pharmacy form to return s to the pharmacy. Diled substance count sheet on cart on 2/24/2025 Diled medication cards for emoved on 2/17/2025: igrams), Oxycodone 10mg g and the initials of the DON moved the controlled am in a phone interview stated the Director of ved discontinued controlled medications carts to return tions to the pharmacy and esident #14 controlled one 10mg and 5mg	A BUILDING 345529 B. WING B. WING TH RALEIGH ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) DREFTX TAG P 94 F 75 The medication return form a, medication return form b, medication name and d prescription number. Urned to the pharmacy till the time of pick up. am, an interview and ducted. Medication Aide #4 observed counting the s at the change of shift 300-hall medication cart. tated controlled medications pharmacy at night. She gers removed the controlled ledication carts and to pharmacy form to return s to the pharmacy. DIeled substance count sheet on cart on 2/24/2025 DIeled medication cards for emoved on 2/17/2025: igrams), Oxycodone 10mg g and the initials of the DON moved the controlled am in a phone interview stated the Director of ved discontinued controlled medications carts to return tions to the pharmacy and asident #14 controlled one 10mg and 5mg the 300-hall medication cart pm an interview was	345529 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DR.VE NW RALEIGH, NC 27616 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY) a 94 F 755 a 100 medication Aide #4 Director of Nursing to the quality assurance meeting X3 months for fur resolution as needed. 300-hall medication cards for moreded 12/17/2025: igrams), Oxycod

		MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	E SURVEY
	CONTRECTION	DEIVINIOATION NOMBER.	A. BUILDING	3		
		0.45500	D WING			С
		345529	B. WING		02	2/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE NW		
				RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY 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	(X5) COMPLETIOI DATE
F 755	Continued From pag	e 95	F 75	5		
1700	-		F / 3			
	2/19/2025. During the					
		or there were controlled g cabinet behind the locked				
	door of the DON's of					
	-	nce. She stated the				
	pharmacy because s					
		g controlled medications to				
	-	was no further information				
	was obtained in the i					
	On 2/22/2025 at 4:30) pm, the Administrator and				
		nsultant #1 accompanied the				
	-	's office for an observation of				
	-	ne DON's office. The DON's				
	office was observed	located on a short hall from				
	nursing station #1 be	side the residents' shower				
	room. The Administra	ator was observed unlocking				
	the door to the DON	s office. Upon entrance to				
	the DON's office ther	e was a large gray pharmacy				
		nches) observed located				
	behind the DON's de	sk on the floor in front of the				
		nere was a large size paper				
	bag sitting on top of					
	Administrator and the					
		the medications observed in				
		er bag were residents'				
		ations. The big grey bin was				
		non-controlled medication				
		s of the gray bin could not paper bag sitting on top of				
	the gray bin was thre					
		ations observed inside.				
		cabinet that was located				
		sk in the DON's office. The				
		s were found to be unlocked				
	-	r stated the filing cabinet did				
		trolled medications were				
		y the Administrator from the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOI	RM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY MPLETED
		345529	B. WING			0	C 2/24/2025
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	 (an opioid/pain medici (mg): Fifty-two tablets medication card. Zolpidem Tartrate (a streat insomnia) 5mg: observed in one medicities and the second medicities of the second medicities of the second medicities and the second medicities were observed in the sulfate solution (an of (ml): Twenty eight milicablets were observed in the Sulfate solution (an of (ml): Twenty eight milicablets were observed) Resident #400: Prest to treat seizures and to treat seizures and the bottle. Morphine Stablets were observed Resident #71: Morphine Stablets were observed Resident #85: Meth opioid) 10mg: Five tal medication card. Ace Hydrocodone Bitartratablets were observed 	with Corporate Nurse cluded: bcodone- Acetaminophen cation) 7.5-325 milligrams a were observed in the sedative -hypnotic used to Twenty-five tablets were ication card. ng: Twenty-nine tablets were nedication card. azepam (a medication used asomnia) 1mg: Sixty-six d in the medication card. repam 1 mg: Thirty tablets medication card. Morphine pioid) 100mg per 5 milliliters were observed in the bottle. gabalin (a medication used anxiety) 75 mg: Twenty -four d in the medication card. hine Sulfate solution 100mg milliliter was observed in Sulfate solution 100mg per 5 was observed in a bottle. adone Hydrochloride (an blets were observed in the taminophen and te 325mg / 7.5mg: Five d in a medication card.	F	75	5		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED IO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		345529	B. WING_			IP CODE		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				5	5201 CLARKS FORK DRIVE NW			
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		F	RALEIGH, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 755	Continued From page	97	F	755	5			
	Two tablets were obs card. Naltrexone (use opioid use disorders to control physiological of tablets were observed - Resident #402: Lora were observed in the Lorazepam 1mg: Nine the medication card. - Resident #124: Oxy opioid) 5/325: Four ta- medication card. - Resident # 95: Bupr	nadol (an opioid) 50 mg: erved in the medication ed to treat alcohol and to reduce cravings and help dependence) 50mg: Sixteen d in the medication card. azepam 1mg: Sixty tablets medication card. ety tablets were observed in codone/Acetaminophen (an blets were observed in the enorphine (an opioid) patch nour: Two patches were						
	with the DON, she sta state survey began, re- controlled medication to the pharmacy were Manager #1, Unit Mai DON from the medication cabinet in the DON of controlled medication pharmacy. She stated nursing staff randomly controlled medication She stated she placed in the filing cabinet (the the DON's office until pharmacy. She stated	am in a phone interview ated on 2/16/2025 when the esidents' non-controlled and s that needed to be returned e collected by herself, Unit nager #2 and the Interim ation carts and residents' s were placed in the filing ffice for storage until the s could be returned to the d on 2/17/2025 and 2/18/25 y gave her discontinued s off the medications cart. d the controlled medications hat could not be locked) in she could return to the d she was busy with the not return the non-controlled						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/31/2025 MAPPROVED D. 0938-0391	
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING				C / 24/2025	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				520	01 CLARKS FORK DRIVE NW			
UNIVERS	AL HEALTH CARE/NORT	HRALEIGH		RA	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 755	before resigning from The DON stated the I have been left open a the hall to the Unit Ma stated since starting a she had not received return non-controlled to the pharmacy. She person with a key to t non-controlled medica medications that were medications carts unt pharmacy. On 2/24/2025 at 8:11 with Unit Manager #1 remove discontinued the medications carts directly to return to th knew the DON kept c office until she could a medications back to t nurses could complet form and place the no the gray pharmacy bin non-controlled medica the pharmacy. On 2/24/2025 at 9:44 with the Pharmacist # pharmacy bins were to medications to the ph non-controlled medica return to pharmacy fo pharmacy in the gray informed of the proce controlled medication	ations to the pharmacy the facility on 2/19/2025. DON's office door would and unlocked to go across anager #1 office. The DON at the facility 5 ½ weeks ago, an orientation on how to and controlled medications e stated she was the only he DON's office and the ations and the controlled e to be stored on the il they were returned to the I am in a phone interview , she explained she would controlled medications off and gave them to the DON e pharmacy. She stated she ontrolled medications in her send the controlled he pharmacy. She stated all e the return to pharmacy on-controlled medications in n for residents' ations that were to return to am in a phone interview £1, he explained grey used to return non-controlled armacy. He stated ations were to be listed on a arm and returned to the bin. He stated the DON was	F	755				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUR COMPLETE C NAME OF PROVIDER OR SUPPLIER 345529 B. WING 02/24/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616 VIND		MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED
345529 B. WING 02/24/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE UNIVERSAL HEALTH CARE/NORTH RALEIGH STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DAT	E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE UNIVERSAL HEALTH CARE/NORTH RALEIGH 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616 ID			345529	B. WING			0;	C 2/24/2025
UNIVERSAL HEALTH CARE/NORTH RALEIGH RALEIGH, NC 27616 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	_ _	
RALEIGH, NC 27616 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION						5201 CLARKS FORK DRIVE NW		
	UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH			RALEIGH, NC 27616		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF) BE	(X5) COMPLETION DATE
F 755 Continued From page 99 F 755 facility. He explained the process as: list the controlled medications on a return to pharmacy triple form, place one copy of the triple form with the controlled medication is the red pharmacy tote, use controlled medication is the red pharmacy tote, use controlled medications in the red pharmacy tote when delivering medications Monday through Saturday and the controlled medications were verified with the controlled medications listed on the return to pharmacy triple form. He stated pharmacy triple form. He stated the DON was to retain the other two copies of the return to pharmacy triple form. On 2/22/2025 at 4:10 pm in an interview with Interim Director of Nursing, she stated she understood unit managers were removing controlled medications stated medications and giving them to the DON, and the DON was responsible in ensuring controlled medications should have been removed from the 300-hall medication carts and giving them to the DON, and the DON was consulted with the Administrator and Corporate Nurse Consultant #1. The Administrator and Corporate Nurse Consultant #1. The Administrator and Corporate Nurse Consultant #1 both stated non-controlled medications and ontrolled medications and ontrolled medications and controlled medications and controlled medications and controlled medications and controlled medications carts and controlled medications and controlled medications and controlled medications carts and controlled medications carts and controlled medications carts and controlled medications and controlled medications carts and controlled medications and controled medications carts providing a double lock s	F 755	facility. He explained controlled medication triple form, place one the controlled medicat tote, use controlled me red tote and write nur return to pharmacy tri pharmacy picked up to delivering medication and the controlled medicat pharmacy triple form. retain the other two co pharmacy triple form. retain the other two co pharmacy triple form. On 2/22/2025 at 4:10 Interim Director of Nu understood unit mana controlled medication and giving them to the responsible in ensurir were returned to the p stated Resident #14's should have been ren medication cart and re immediately after Res On 2/22/2025 at 5:00 conducted with the Ac Nurse Consultant #1. Corporate Nurse Con non-controlled medicat the medication carts of returned to the pharm carts providing a dout controlled medication	the process as: list the s on a return to pharmacy copy of the triple form with tions in the red pharmacy redication zip tie to secure nber of the zip tie on the ple form. He stated the red pharmacy tote when s Monday through Saturday edications were verified with tions listed on the return to He stated the DON was to opies of the return to min an interview with rsing, she stated she agers were removing s off the medication carts the DON, and the DON was ng controlled medications obarmacy. The Interim DON a controlled medications noved from the 300-hall eturned to the pharmacy sident #14's death. pm an interview was dministrator and Corporate The Administrator and sultant #1 both stated ations and controlled e returned to the pharmacy ations should be stored in until collected by the DON to nacy due to the medications oble lock system for the s. They stated	F	75	5		

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	FED: 03/31/2025 RM APPROVED NO. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION	(X3) D/	ATE SURVEY DMPLETED	
		345529	B. WING _			C 02/24/2025		
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				5201	CLARKS FORK DRIVE NW			
UNIVER54	AL HEALTH CARE/NORT	H RALEIGH		RAL	EIGH, 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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 755	Continued From page	≥ 100	F7	55				
	not to be stored in the office.	e filing cabinet in the DON's						
F 756 SS=D	Drug Regimen Review CFR(s): 483.45(c)(1)	w, Report Irregular, Act On (2)(4)(5)	F 7	'56			3/25/25	
		imen Review. ug regimen of each resident east once a month by a						
	§483.45(c)(2) This re of the resident's medi	view must include a review cal chart.						
	irregularities to the at facility's medical direct and these reports mut (i) Irregularities included drug that meets the c (d) of this section for (ii) Any irregularities re- during this review mut separate, written report attending physician a director and director of minimum, the resident and the irregularity th (iii) The attending phy resident's medical reco- irregularity has been action has been taken be no change in the re-	de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a bort that is sent to the nd the facility's medical of nursing and lists, at a at's name, the relevant drug, e pharmacist identified. vsician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to nedication, the attending ument his or her rationale in						
	maintain policies and	cility must develop and procedures for the monthly that include, but are not						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/31/2025 RM APPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING			C 02/24/2025		
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				52	201 CLARKS FORK DRIVE NW			
UNIVERS	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 756	limited to, time frames the process and steps when he or she identi requires urgent action This REQUIREMENT by: Based on record revi Consultant Pharmacis failed to act on record consultant pharmacis documentation of the response to the pharm residents reviewed fo (Resident #17, Resid The findings included 1. Resident #17, Resid The findings included 1. Resident #17 was 7/4/23 with diagnoses and dementia. Resident #17's most (MDS) assessment d revealed Resident #1 impairment. Review of Resident # revealed she was tak bedtime (ordered 12/2 milligrams daily (ordered milligrams twice daily 12/3/24), and Senna milligrams once daily A medication regimer Pharmacist dated 9/1	s for the different steps in s the pharmacist must take ifies an irregularity that n to protect the resident. T is not met as evidenced iew, and staff and st interviews the facility mendations made by the at and maintain physician's review and macist's findings for 3 of 5 or drug regimen review ent #67 and Resident #11). admitted to the facility on s that included depression recent Minimum Data Set ated 1/1/25, a quarterly 7 had severe cognitive	F	756	 F756 1. Residents # 17, #67, # 11 pharm recommendations were completed. 2. The last 3 months of pharmacy recommendations were reviewed by t Director of Nursing and forwarded to the provider for review. This was complet on 3/25/2025 3. Education was provided to the nulleadership team by the Regional Director of Clinical Services to ensure the consultant pharmacy recommendation are reviewed and acted upon timely. education was completed on 3/18/202 Any nursing leadership team member will not be allowed to work until educareceived. New nursing leadership team member will receive education during the orientation process by the Director of Nursing or designee. Audit of pharmacy recommendations be completed by the Director of Nursi weekly x 12 weeks then monthly x 2. Results will be reported by the Director of Nursi go to the quality assurance meeting x3 months for furt resolution as needed. Date of completion : 3/25/2025 	he he ed ursing ctor ns This 25. s ttion rs will ng		

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	-	ID HUMAN SERVICES				FOI	RM APPROVED 10. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		345529	B. WING			C	C 2/24/2025
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 756	medications.	e 102 n review completed by the	F	756	3		
	Pharmacist dated 12/ discontinuing Miralax						
	Nursing on 2/18/25 a was not aware of the reviews and had been	ducted with the Director of t 4:52 PM who stated she process for drug regimen n unable to establish one nployed by the facility on					
	medication regimen r Director of Nursing, A	5 at 5:41 PM she stated her eviews were emailed to the Assistant Director of Nursing d she was unsure what the					
		admitted to the facility on es that included anxiety ion.					
		recent Minimum Data Set ated 12/25/24, a quarterly nitively intact.					
	revealed he was takin daily (ordered 11/9.24 daily(ordered 11/9/24 (ordered 11/9/24), Tra 24 hours as needed (67's medication orders ng Amlodipine 10 milligrams 4), Valsartan 160 milligrams .),, Lasix 20 milligrams daily azadone 50 milligrams every (ordered 1/10/25), Abilify 2 e (ordered 11/22/24), and at bedtime (ordered					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	/ APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		X3) DATE COMF	SURVEY PLETED
		345529	B. WING					C 24/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	I		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	E	(X5) COMPLETION DATE
F 756	Continued From page 11/27/24).	e 103	F	756	3			
	Pharmacist dated 8/8 discontinuing either the time of the second	n review completed by the /24 recommended ne Abilify, Klonopin, or sponse or documented						
	A medication regimer Pharmacist dated 11/ discontinuing Amlodi response or documer	pine or Lasix with no						
	Pharmacist dated 12/ clinical rationale for a milligrams every 24 h medication with no re rationale. The review	n review completed by the 6/24 recommended either a s needed Trazadone 50 ours or to discontinue the sponse or documented further recommended mlodipine or Lasix with no nted rationale.						
	Nursing on 2/18/25 a was not aware of the reviews and had bee	ducted with the Director of t 4:52 PM who stated she process for drug regimen n unable to establish one nployed by the facility on						
	medication regimen r Director of Nursing, A	5 at 5:41 PM she stated her eviews were emailed to the ssistant Director of Nursing d she was unsure what the						
		admitted to the facility on es including hypothyroidism						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3)		(X3) DAT	E SURVEY PLETED			
		345529	B. WING			02	C 2/24/2025
NAME OF PI	ROVIDER OR SUPPLIER	1	I	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	documented an order micrograms (mcg) on Resident #11's labora revealed her Thyroid test result was 0.23. (between 0.4 and 4.5) Resident 11's Physici the results of the test Resident #11's Physici 8/14/24 documented hypothyroidism and c replacement. Physicia monitor her TSH leve Review of Resident # 8/15/24 revealed ther TSH laboratory to tes Resident #11's pharm Review completed by documented she was mcg po daily; his/her revealed a level of 0.2 The pharmacist recor decreasing her Levet recheck her TSH leve have occurred around documentation on the Physician #2 or any c	levels). an orders dated 7/01/24 for levothyroxine 50 ce a day for hypothyroidism. atory results dated 8/09/24 Stimulating Hormone (TSH) The normal range was . The results indicated an, Physician #2, reviewed on 8/14/24. cian progress notes dated she had a history of ontinued on thyroid an #2 noted to continue to ls. f1's physician orders dated e was no order for a repeat t. hacy Medication Regimen the Pharmacist on 9/12/24 taking Levothyroxine 50 most recent TSH on 8/9/24 23 "which was quite low." nmended to consider hyroxine at that time and to el in 6 weeks (which would d 10/21/24). There was no e recommendation from	F	756			
	documented an order one time a day due to	cian orders dated 11/12/24 for levothyroxine 100 mcg a TSH result of 0.23 mIU/L. r results for a TSH test.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	ENTERS FOR MEDICARE & MEDICAID SERVICES rement of deficiencies (X1) PROVIDER/SUPPLIER/CLIA plan of correction identification number:				CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345529	B. WING _				C 24/2025	
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	AL HEALTH CARE/NORT		5201 CLARKS FORK DRIVE NW					
UNIVERSA	AL HEALTH CARE/NORT	n Kaleign		R/	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION Y MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		
F 756	Continued From page	e 105	F7	756				
	Physician #2 was una the survey.	able to be interviewed during						
	Director of Nursing (D recommendation shor on earlier than 11/12/ have been an order to but she didn't see an the clinical record. Sh	2/25 at 5:31 PM, the Interim OON) said the pharmacy uld have been followed up 24. She said there should o check Resident #11's TSH order for a repeat TSH in he was not sure why the dation was not acted on in						
F 759 SS=D	said Physician #2 rev after the results were but didn't make any c at that time. However recommendation sho and an order written t the TSH levels as not	rporate Nurse Consultant #1 iewed the TSH results soon available in August 2024, hanges to her levothyroxine , the pharmacy uld have been addressed o address how to monitor	F 7	759			3/25/25	
	§483.45(f) Medicatior The facility must ensu							
	percent or greater; This REQUIREMENT by: Based on observatio interviews, the facility error rate of less than medication errors out	tion error rates are not 5 is not met as evidenced ns, record review and staff failed to have a medication 5% as evidenced by 2 of 27 opportunities, ion error rate of 7.41% for 2			F759 1. Medication aide #4 and Nurse # 3 received education on the 6 rights of medication administration. The physicia was notified, and no adverse outcome	an		

Event ID: PM7D11

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION		TE SURVEY MPLETED	
		345529	B. WING			С
	ROVIDER OR SUPPLIER	040020		STREET ADDRESS, CITY, STATE, ZIP		2/24/2025
NAME OF PI	ROVIDER OR SUPPLIER				CODE	
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	COMPLETION DATE
F 759	Continued From page	e 106	F 7	59		
		ents #59 and #28) observed		was noted.		
		administration observation.		2. Current residents are	e at risk	
				3. Education began on		
	The findings included	I:		Director of Nursing or des		
	_			rights of medication admi		
		admitted to the facility on		current licensed nurses a		
	1/31/2025 with diagn	oses including depression.		medication aides staff inc	luding agency	
Desident #501s abusisiants and as date				staff.		
	Resident #59's physician's orders dated 1/31/2025 included Olanzapine 5 milligrams at bedtime for mood stabilizer.			Any licensed nurses and medication aides will not		
				work until education has l		
				Agency staff will be provid		
	An observation on 2/	18/25 at 8:47 am revealed		education prior to beginni		
	due to technical diffic	ulties, electronic medication		New licensed nurses and		
	administration record	s (MAR) were not available		medication aides will rece	eive education	
		rinted Medication Aide #4		during the orientation pro		
		dent #59's MAR. Before		4. The Director of Nursi		
		reparation, Medication Aide		will do medication pass o		
		ing Resident #59 about her Resident #59 refused.		nurses or medication aide weeks, then 2 nurses or r	•	
		as observed returning to the		weekly x 4 weeks, then 1		
		preparing four medications		medication aide weekly x		
	for administration to F			nurse or medication aide		
	medication (Levofloxa	acin, Divalproex Sodium,		5. Results will be report		
	· ·	zapine) was in a pharmacy		Director of Nursing to the		
		that Mediation Aide #4		assurance meeting x3 mo	onths for further	
		or to enter the medication		resolution as needed.		
		medication individually		6. Date of completion: 3/2	25/2025	
	before Medication Aid medication from the o					
	medication into a me					
		lets were verified with				
		n the medication cup. On				
		, Medication Aide #4 was				
		ng Resident #59 the four				
	medications with app	lesauce.				
	On 2/22/2025 at 7:05	pm in an interview with				
		opm in an interview with she recalled Resident #59				

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		ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		(X5) COMPLETION DATE		
F 759	refusing the calcium t Resident #59 a pink p a green pill (Proprand was reminded Reside Levofloxacin, an antib three tablets and only medication that was of scheduled for 9:00 an Olanzapine was sche did not give Olanzapin Medication #4 stated of the medications on MAR at a later time. A review of Resident # 2025 MAR on 02/22/2 #4 recorded the medi Divalproex Sodium ar administered on 2/18/ medication, Olanzapin pm on Resident #59's was recorded adminis 2/18/2025 by Nurse # On 2/22/2025 at 8:42 Corporate Nurse Con Resident #59 medicatia administered and doo MAR as ordered by th scheduled. 2. Resident #28 was a 9/22/2019 with diagno fracture of a bone. A review of Resident #	ablet and only giving bill (Divalproex Sodium) and blol). When Medication #4 ent #59 received biotic, she stated she gave a administered the on the printed MAR n. Medication #4 stated duled for 9:00pm, and she ne on 2/18/2025 at 9:00 am. she recorded administration Resident #59's electronic #59's electronic February 25 indicated Medication Aide cations Levofloxacin, nd Propranolol were (2025 as scheduled. The ne, was scheduled at 9:00 a February 2025 MAR and stered at 9:00pm on 66. pm in an interview with sultant #1, she stated tions were to be sumented on Resident #59's ne physician when admitted to the facility on bases including anemia and #28's current physician's nedication orders included a	F	75			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759	Vitamin D. On 2/18/2025 at 9:22 observed preparing s administration to Res included one chewab medication containing calcium carbonate wir from a bottle labeled Resident #28. On 2/2 #3 was observed adm calcium and vitamin D On 2/22/2025 at 11:3 #28's bottle of chewa vitamin D and minera pharmacy that read c D 800 units and mine Resident #28's Febru Administration Record administered calcium vitamin D 800 units w On 2/22/2025 at 10:2 with Nurse # 3, she e D3 mineral chewable of the bottle dispense with Resident #28's n the calcium vitamin D would be the dose the / 800 units tablets) an administering Resided the pharmacy labeled dose of Resident #28 mineral chewable tab the same as the physi	am, Nurse #3 was even medications for ident #28. The medications le tablet of a combination g 600 milligrams (mg) th 800 units Vitamin D taken by the pharmacy for 18/2025 at 9:31am, Nurse ninistering Resident #28 the D chewable tablet. 0 am, re-observed Resident ble calcium tablet with I dispensed by the alcium 600 mg and Vitamin rals. ary 2025 Medication d recorded Nurse #3 carbonate 300 mg and ith minerals on 2/18/2025. 8 am in a phone interview xplained the calcium vitamin tablet was administered out d by the pharmacy labeled ame. She stated the dose of 3 mineral chewable tablet e pharmacy dispensed (600 id she had been nt #28 the medication from I bottle. Nurse #3 stated the 's calcium vitamin D3 let administered should be	F	759	9		

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				SURVEY PLETED
			A. BUILDII	NG	C		
		345529	B. WING _				/24/2025
NAME OF PI	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NORT	TH 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 LSC 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 759	Continued From page	e 109	F	759			
		nsultant #1, she stated					
		alcium vitamin D3 mineral					
		to be administered as					
	ordered by the physic						
		f Significant Med Errors	F7	760			3/25/25
55=E	CFR(s): 483.45(f)(2)						
	The facility must ensu	ure that its-					
	§483.45(f)(2) Resider	nts are free of any significant					
	medication errors.						
		⊺ is not met as evidenced					
	by:	iow and staff Dharmasist			F760		
		iew, and staff , Pharmacist sician interviews, the facility			1. Resident #90 and #59 received		
		ntibiotic medications as			antibiotics as ordered		
	ordered by the physic	cian which resulted in a delay			2. Current residents on antibiotics		
	l i	nerapy for 2 of 4 residents			audited to ensure full treatment received	d.	
	reviewed for administ				This will be completed by 3/25/2025.		
	medications (Resider	nt #90 and Resident # 59).			3. Education to licensed nurses		
	Eindings included:				including agency staff by the Director of Nursing or designee timely delivery of		
	Findings included:				medications, where to get new		
	1. Resident # 90 was	admitted to the facility on			medications and notification to provider	if	
		oses including diabetes			unable to obtain new medication began		
	mellitus and heart fail	lure.			3/19/2025.		
					Any licensed nurse will not be allowed to		
	The admission Minim	um Data Set (MDS) 28/2025 indicated Resident			work until education completed. Agency		
		cognitively impaired. The			staff will receive education by the Direct of Nursing or designee prior to the start		
		Resident #90 as receiving			their shift.	51	
	antibiotics as a medic	•			Any new licensed nurse will receive		
					education during the orientation process	S	
		ed 2/4/2025 at 3:32 pm and			by the Director of Nursing or designee.		
		Treatment Nurse included			4. Audit will be completed by the Direct	ctor	
		antibiotic) 300 milligrams			of Nursing or designee to ensure new	E.,	
	three times a day for	TO days for cellulitis.			medications initiated. This will be done the week x 4 weeks, 3xweekly x 4 weeks,	XC	
			1		WEER A 4 WEERS, JAWEERIY X 4 WEERS,		1

Facility ID: 20040007

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · /	G	· · · ·	IPLETED
						С
		345529	B. WING		0	2/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NOR			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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 760	Continued From page	e 110	F 76	30		
1 / 00	Record (MAR) for Re			5. Results will be report	ad by the	
		Omg milligrams was not		Director of Nursing to the		
	-	n 2/4/2025 as scheduled.		assurance meeting x3 mo	· ·	
		recorded administration of		resolution as needed.		
	the first dose of Clind	lamycin 300mg on 2/5/2025		6. Date of completion : 3/	25/2025	
	at 9:00 am.					
	There was no nursing	g documentation related to				
	-	amycin administration for				
	2/4/2025.	,				
		pm in a phone interview				
	with Nurse #9, she w					
		amycin was delivered to the administer at 9:00pm as				
	-	d she didn't have access to				
		nated dispensing system at				
		ot aware Clindamycin				
		n the medication automated				
		lurse #9 stated she called				
		rm them the facility had not				
	received Resident #9 2/4/2025.	O's Clindamycin on				
	On 2/21/2025 at 4:53	pm in a phone interview				
		sultant #1, she stated				
		for Clindamycin 300mg was				
		macy system on 2/4/2025 at				
		signed delivery slip, the				
	medication was deliv	Pharmacist Consultant #1				
		ility's medication automated				
		as filled in January 2025 and				
	contained Clindamyc	•				
	On 2/21/2025 at 5:40) pm in a phone interview				
	with Pharmacist #1, h	ne stated that when the				
		eceiving a medication, the				
	pharmacy would rese	end or when in the facility's				

Facility ID: 20040007

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	the nursing staff remo automated dispensing resident. Pharmacist to document why a m facility and there was Resident #90's Clinda resent to the facility. F Resident #90's order and sent to the facility On 2/22/2025 at 3:59 Interim Director of Nu Resident #90's medic delivered to the facility administration, Nurse administered the dose 9:00 pm. She stated t automated dispensing back-up resource for former DON had not p herself with access to dispensing system. On 2/21/2025 at 4:35 with Physician #1, he Clindamycin 300mg w should have been sta because the earlier at better it was for Resic Physician #1 stated th Resident #90 with the 300mg tablets admini 2/5/2025. 2. Resident #59 was a	d dispensing system, have ove from the medication g system to administer to the #1 stated the pharmacy had edication was resent to the no documentation that anycin medication was Pharmacist #1 stated for Clindamycin was filled or 0.2/4/25. pm in an interview with the rsing, she stated that since ation, Clindamycin, was y at the time scheduled for #9 should have e scheduled for 2/4/2025 at here was a medication g system that served as a medications. She stated the provided the nursing staff or the medication automated pm in a phone interview stated when Resident #90's vas ordered, the medication rted as soon as possible ntibiotics were started, the lent #90 skin infection. mere was no harm to e medication, Clindamycin	F	760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345529 B. WING 02/24/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 02/24/2025 UNIVERSAL HEALTH CARE/NORTH RALEIGH STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET DATE (X5) COMPLET DATE		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
345529 B. WING 02/24/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE UNIVERSAL HEALTH CARE/NORTH RALEIGH STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	`, ´			(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE UNIVERSAL HEALTH CARE/NORTH RALEIGH STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			345529	B. WING				-
UNIVERSAL HEALTH CARE/NORTH RALEIGH RALEIGH, NC 27616 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET Date TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH					
DEFICIENCY)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	3E	COMPLETION
F 760 Continued From page 112 The admission Minimum Data Set (MDS) assessment dated 2/6/2025 indicated Resident #59 was cognitively intact and was incontinent of urine and stool. Resident #59 was not coded for the use of antibiotics on the MDS dated 2/6/2025. F 760 Resident #59's urine specimen collected on 2/1/2/2025 reported the urine contained bacteria, squamous epithelial cells (flat, scale-like ells that line the organs that may appear in the urine due to an infection) mucus and leukocyte esterase (enzyme produced by white blood cells) in the urine. F 760 Physician orders dated 2/14/2025 at 9.41 am for Resident #59 included Levofloxacin (antibiotic use to treat bacterial infection) mucus and leukocyte esterase (enzyme produced by white blood cells) in the urine. F From France France Physician orders dated 2/14/2025 at 9.41 am for Resident #59 included Levofloxacin (antibiotic use to treat bacterial infection) s00 milligrams tableto en time a day for urinary tract infection for seven days and the ordered indicated a start time of the medication on 2/15/2025 at 9:0 0am. The February 2025 Medication Administration Record (MAR) for Resident #59 indicated Levofloxacin 500mg that was scheduled for 9:00 am on 2/16/2025 was not given and the space on the MAR on 2/16/2025 was marked with the number 9 that was referenced as other/see progress note. Resident #59 inceived the first dose of Levofloxacin on 2/16/2025 during the scheduled time at 9:00 am. There was no nursing documentation that referenced administration of Resident #59's Levofloxacin on 2/15/2025. On 2/22/2025 at 12:30 pm in an interview with Medication Aide #6, she stated on 2/15/2025 at 9:00am, Levofloxacin was not available to administer to Resident #59 mina on there with Medication Aide #6, she	F 760	The admission Minim assessment dated 2/6 #59 was cognitively in urine and stool. Resid the use of antibiotics Resident #59's urine 2/12/2025 reported th squamous epithelial of line the organs that m to an infection) mucus (enzyme produced by urine. Physician orders date Resident #59 included use to treat bacterial tablet one time a day seven days and the o of the medication on 2 The February 2025 M Record (MAR) for Re Levofloxacin 500mg t am on 2/15/2025 was the MAR on 2/15/202 number 9 that was re progress note. Resid dose of Levofloxacin scheduled time at 9:0 There was no nursing referenced administra Levofloxacin on 2/15/ On 2/22/2025 at 12:3 Medication Aide #6, s 9:00am, Levofloxacin	um Data Set (MDS) 5/2025 indicated Resident nact and was incontinent of dent #59 was not coded for on the MDS dated 2/6/2025. specimen collected on ne urine contained bacteria, cells (flat, scale-like ells that hay appear in the urine due is and leukocyte esterase or white blood cells) in the ed 2/14/2025 at 9:41 am for d Levofloxacin (antibiotic infections) 500 milligrams for urinary tract infection for ordered indicated a start time 2/15/2025 at 9:0 0am. Medication Administration sident #59 indicated hat was scheduled for 9:00 is not given and the space on 5 was marked with the ferenced as other/see lent #59 received the first on 2/16/2025 during the 0 am. g documentation that ation of Resident #59's 2025. 0 pm in an interview with the stated on 2/15/2025 at was not available to	F	760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345529 B. WING 02/24/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 02/24/2025 NUNVERSAL HEALTH CARE/NORTH RALEIGH STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
MAKE OF PROVIDER OR SUPPLIER D2/24/2025 UNIVERSAL HEALTH CARE/NORTH RALEIGH STREET ADDRESS, CITY, STRE, ZIP CODE 5231 CLARS FORK DRIVE NW RALEIGH, NC 27618 5201 CLARS FORK DRIVE NW RALEIGH, NC 27618 0 (%) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BERECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREOVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BERECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREOVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BERECEDED BY FULL (EACH DEFICIENCY) PREFIX (EACH DEFICIENCY) 000000000000000000000000000000000000	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
UNIVERSAL HEALTH CARE/NORTH RALEIGH 5201 CLARKS FORK DRIVE NW RALEIGH. NC 27616 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIENC) WIST BE PRECIENCE 9F ULL REGULATORY OR USC DENTIFYING INFORMATION) IP PROVIDER'S PLAN OF CORRECTION (EACH CORRECT ACTION SHOLD BE CROSS-REFERENCE ACTION SHOLD BE DEFICIENCY) OOM LTDD DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECT ACTION SHOLD BE CROSS-REFERENCE ACTION TO CORRECTION USC DENTIFYING INFORMATION) OW LTDD DEFICIENCY F 760 Continued From page 113 note stating the medication aide, she could not get medications out of the medication automated dispensing system. Medication Aide #6 stated she informed Nurse #2 she didn't have Resident #59's antibiotic on 2/15/2025 so the medication actuated from the medication. She explained due to Resident #59 not receiving the first dose of antibiotic as scheduled on 2/15/2025, Nurse #2 should have recounted the number of days Levofloxacin was to be given with 2/16/2025, as the start day to ensure the medication was given for seven days as ordered. On 2/22/2025 at 1:01 pm in an interview with Nurse #2, she stated she did not recall Medication Aide #6 telling her Resident #59's Levofloxacin was not available to administer as scheduled on 2/15/2025. She stated she was an agency nurse and agency nurses did not have access to the medication automated dispensing system to obtain medications on treceived from pharmacy. She explained she would have informed the unit manager because they have access to the medication automated dispensing			345529	B. WING				-
UNIVERSAL HEALTH CARENORTH RALEIGH RALEIGH, NC 27618 MAID PREENX TAG SUMMARY STREMENT OF DEFICIENCIES (EACH ORRET/WE ATION OF CORRECTION) (EACH ORRET/WE ATION PROMATION) D PREINX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRET/WE ATION PROULD BE CARCORRET/WE ATION PROMATE DEFICIENCY) COMMENTION DEFICIENCY F 760 Continued From page 113 note stating the medication was on order. She stated the medication and not arrived from the pharmacy and as a medication aide, she could not get medication sut of the medication automated dispensing system. Medication Aide #6 stated she informed Nurse #2 she didn't have Resident #59's antibiotic on 2/15/2025 so the medication automated dispensing system or to call the pharmacy to send the medication. She explained due to Resident #59 not receiving the first dose of antibiotic as scheduled on 2/15/2025, Nurse #2 should have recounded the number of days Levofloxacin was to be given with Nurse #2, should have recould don to recail Medication Aide #6 telling her Resident #59's Levofloxacin was not be stated she was an agency nurse and agency nurses did not have access to the medication automated dispensing system to obtain medication automated from pharmacy. She explained use they have access to the medication automated dispensing system to obtain medication automated dispensing	NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
RALEICH, NC 27816 (X4) ID PRETX TX6 SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRETX TA6 PROVIDER'S PLAN OF CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OD OWNET FID EACH OERIECT TO THE APPROPRIATE DEFICIENCY) OD OWNET FID EACH OERIECT TO THE APPROPRIATE DEFICIENCY) OD OWNET FID EACH OERIECT TO THE APPROPRIATE DEFICIENCY) OD DATE F 760 Continued From page 113 note stating the medication had not arrived from the pharmacy and as a medication aide, she could not get medications out of the medication automated dispensing system. Medication Aide #6 stated she informed Nurse #2 she didn't have Resident #59's antibiotic on 2/15/2025 so the medication could be removed from the medication automated dispensing system or to call the pharmacy to send the medication was given for seven days as ordered. On 2/22/2025 at 1:01 pm in an interview with Nurse #2, she stated she did not recall Medication Aide #6 telling her Resident #59's Levofloxacin was to be stated she was an agency nurse and agency nurses did not have access to the medication automated dispensing system to obtain medication automated dispensing system to obtain medication automated dispensing ascent the unit manager because they have access to the medication automated from pharmacy. She explained she would have informed the unit manager because they have access to the medi					5	5201 CLARKS FORK DRIVE NW		
Image: Txg (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Txg (EACH DERRENCED TO THE APPROPRIATE DEFICIENCY) COMMETING IDENTIFYING INFORMATION) PREFIX Txg (EACH DERRENCED TO THE APPROPRIATE DEFICIENCY) COMMETING IDENTIFYING INFORMATION) COMMETING IDENTIFYING INFORMATION) COMMETING IDENTIFYING INFORMATION) COMMETING Txg Continued From page 113 note stating the medication was on order. She stated the medication and not arrived from the pharmacy and as a medication aide, she could not get medications out of the medication automated dispensing system. Medication Aide #6 stated she informed Nurse #2 she didn't have Resident #59's antibiotic our 2/15/2025 so the medication automated dispensing system or to call the pharmacy to send the medication. She explained due to Resident #59 not receiving the first dose of antibiotic as scheduled on 2/15/2025, Nurse #2 should have recounted the mumber of days Levofloxacin was to be given with 2/16/2025 as the start day to ensure the medication was given for seven days as ordered. On 2/22/2025 at 1:01 pm in an interview with Nurse #2, she stated she did not recall Medication Aide #6 telling her Resident #59's Levofloxacin was not available to administer as scheduled on 2/15/2025. She stated she was an agency nurse and agency nurses did not have access to the medication automated dispensing system to obtain medication sub received from pharmacy. She explained she would have informed the unit manager because they have access to the medication automated dispensing	UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH		F	RALEIGH, NC 27616		
note stating the medication was on order. She stated the medication had not arrived from the pharmacy and as a medication aide, she could not get medications out of the medication automated dispensing system. Medication Aide #6 stated she informed Nurse #2 she didn't have Resident #59's antibiotic on 2/15/2025 so the medication could be removed from the medication automated dispensing system or to call the pharmacy to send the medication. She explained due to Resident #59 not receiving the first dose of antibiotic as scheduled on 2/15/2025, Nurse #2 should have recounted the number of days Levofloxacin was to be given with 2/16/2025 as the start day to ensure the medication was given for seven days as ordered. On 2/22/2025 at 1:01 pm in an interview with Nurse #2, she stated she did not recall Medication Aide #6 telling her Resident #59's Levofloxacin was not available to administer as scheduled on 2/15/2025. She stated she was an agency nurse and agency nurses did not have access to the medication automated dispensing system to obtain medications not received from pharmacy. She explained she would have informed the unit manager because they have<	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	3E	COMPLETION
medication for Resident #59. She stated there was none of Resident #59's Levofloxacin medication left in the medication cart and thought she had completed receiving the seven days of administration. After looking at Resident #59's MAR, she stated the MAR did not record Resident #59 receiving a dose of the antibiotic on 2/15/2025 and received the antibiotic for only six days. She explained she would need to call the physician for further orders.	F 760	note stating the medication pharmacy and as a m not get medications of automated dispensing #6 stated she informer Resident #59's antibio medication could be m medication automated call the pharmacy to se explained due to Resi first dose of antibiotic Nurse #2 should have days Levofloxacin wa as the start day to en- given for seven days On 2/22/2025 at 1:01 Nurse #2, she stated Medication Aide #6 te Levofloxacin was not scheduled on 2/15/20 agency nurse and age access to the medicat system to obtain med pharmacy. She explai informed the unit mar access to the medicat system or called the p medication left in the she had completed re administration. After I MAR, she stated the I Resident #59 receivin 2/15/2025 and receive days. She explained s	cation was on order. She had not arrived from the nedication aide, she could ut of the medication g system. Medication Aide ad Nurse #2 she didn't have botic on 2/15/2025 so the removed from the d dispensing system or to send the medication. She ident #59 not receiving the as scheduled on 2/15/2025, e recounted the number of s to be given with 2/16/2025 sure the medication was as ordered. pm in an interview with she did not recall elling her Resident #59's available to administer as 125. She stated she was an ency nurses did not have tion automated dispensing ications not received from ined she would have hager because they have tion automated dispensing oharmacy to receive the ent #59. She stated there t #59's Levofloxacin medication cart and thought exciving the seven days of ooking at Resident #59's MAR did not record og a dose of the antibiotic on ed the antibiotic for only six she would need to call the	F	760			

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	דוסו ו	E CONSTRUCTION	(X3) DATE	0.0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
			-	-		(c I
		345529	B. WING			02/	24/2025
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH			5201 CLARKS FORK DRIVE NW		
				F	RALEIGH, NC 27616		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG	(SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
F 700			_				
F 760	Continued From page	e 114	F	760			
	On 2/21/2025 at 4:53	pm in a phone interview					
		sultant #1, she stated the					
	facility's medication a						
	system was filled in J	-					
		acin, would have been cation automated dispensing					
	system if it had not be						
	pharmacy at the time	scheduled					
	On 2/22/2025 o rovia	wy of the Echryony 2025					
		ew of the February 2025 ent #59 only received 6 days					
		ad of 7 days as ordered by					
		Resident #59 not receiving					
	Levofloxacin 500mg o	on 2/15/2025.					
	On 2/22/2025 at 4:06	pm in an interview with the					
	Interim Director of Nu	rsing, she stated					
		edication stored in the					
		d dispensing system and nurse, would not have had					
		tion. She stated that when					
		receive Levofloxacin on					
		should have called the					
	#59 to receive the an	seven days for Resident					
		5 pm in a phone interview					
	with Physician #1, he	explained the earlier ed, the better it was for the					
		have been better if Resident					
		had been started earlier as					
		. He stated there was no					
	-	59's condition and did not Resident #59 due to the					
	antibiotic starting on 2						
F 761	Label/Store Drugs an		F	761			3/25/25
SS=E	CFR(s): 483.45(g)(h)						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		F	RALEIGH, 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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	9 115	F	761			
	Drugs and biologicals	y and cautionary					
	§483.45(h) Storage o	f Drugs and Biologicals					
	Federal laws, the faci biologicals in locked of	rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.					
	locked, permanently a storage of controlled the Comprehensive D Control Act of 1976 at abuse, except when t package drug distribu quantity stored is min be readily detected.	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can					
	Based on observation interviews, the facility medications on the m a separately locked a compartment for stora medications were retu of 1 filing cabinet observations	n, and staff and Pharmacist failed to maintain controlled edication carts that provided nd permanently affixed age until the controlled urned to the pharmacy for 1 erved storing control of Nursing's filing cabinet).			 F761 1. Narcotics not in use were returned the pharmacy on 2/24/2025 2. Med Carts were audited on 3/25/2 to ensure all narcotics not in use were returned to pharmacy. This was completed by the Director of Nursing 3. Education to licensed nurses including agency to keep narcotics on the med carts until Director or Nursing obtat them to send back to the pharmacy. 	025 the	

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CONNECTION	BENTI TOATION NOMBER.	A. BUILDING		C
		345529	B. WING		02/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMPLETIO
F 761	Continued From page	9 116	F 76		
	was observed open w in Unit Manager #1's Unit Manager #1's do On 2/20/2025 at 4:30 conducted with the D who resigned on 2/19 the DON informed the controlled medication the locked door of the information was obtain On 2/22/2025 at 4:10 interim Director of Nu DON was responsible medications to the ph controlled substances medications carts and needed to return to the since beginning the ro 2/19/2025, she had n medications from the the pharmacy. On 2/22/2025 at 4:25 Administrator, she sta Nursing resigned on 2 facility of the controlled filing cabinet in the D Administrator in the a controlled medication the lock to the door of	pm an interview was rector of Nursing (DON), /2025. During the interview e surveyor there were s in a filing cabinet behind e DON's office. No further ned in the interview. pm in an interview with the rsing (DON), she stated the e for sending back controlled armacy. She stated a were stored on the d removed by the DON as e pharmacy. She stated ole as interim DON on ot received any controlled medication carts to return to pm in an interview with the ated when the Director of 2/19/2025, she informed the ed medications stored in the DN's office. The she and the Lead rea confirmed there were s in the filing cabinet and f the DON's office was as the Administrator, she		Education completed on 3/18/2025 Any licensed nurse will not be allow work until education received, Age licensed nurses will receive educat prior to the start of their shift Any new licensed nurse will receive education during the orientation pri- by the Director of Nursing or desig 4. Director of Nursing will comple audit of each med carts to sent nar- back that are not in use weekly x 12weeks, then monthly x 2 The administrator or designee will the DON office weekly to ensure the narcotics are stored appropriately a sent back to the pharmacy. This will completed weekly x 12, then month 5. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for the resolution as needed. 6. Date of completion: 3/25/2025	ved to ncy cion e ocess nee. ete an rootics audit iat and ill be nly x 2.

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		345529	B. WING			0;	C 2/24/2025
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			5201 CLARKS FORK DRIVE NW		
	1				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 OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 761	Corporate Nurse Consurveyor to the DON' the filing cabinet in the office was observed in nursing station #1 bear room. The Administrat the door to the DON's cabinet that was locar in the DON's office. The were found to be unlow stated the filing cabin following controlled me be removed by the Add drawer from the top of and verified with Corp - Resident #70: Hydro (an opioid/pain medic (mg): Fifty-two tablets medication card and the controlled substant Zolpidem Tartrate (and treat insomnia) 5mg: observed in one med were recorded on the Zolpidem Tartrate 5 medication the zolpidem Tartrate 5 medication the controlled substant to treat anxiety and in tablets were recorded substance sheet. - Resident #113: Lorat to treat anxiety and in tablets were recorded substance sheet. - Resident #96: Lorazt were observed in the no controlled substant	asultant #1 accompanied the s office for an observation of e DON's office. The DON's ocated on a short hall from side the residents' shower ator was observed unlocking s office. There was one filing ted behind the DON's desk the filing cabinet drawers bocked and the Administrator et did not have a lock. The nedications were observed to dministrator from the third of the unlocked filing cabinet borate Nurse Consultant #1: bocdone- Acetaminophen eation) 7.5-325 milligrams as were observed in the 52 tablets were recorded on nice sheet. sedative -hypnotic used to Twenty-five tablets were ication card and 25 tablets o controlled substance sheet. ing: Twenty-nine tablets were medication card and 29 d on the controlled	F	76			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE		
		345529	B. WING				C / 24/2025	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					5201 CLARKS FORK DRIVE NW			
UNIVERS	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 761	5 milliliters (ml): Twen the bottle. There was sheet for Resident #9 solution to verify that - Resident #400: Pre to treat seizures and a tablets were observed There was no controll #400's Pregabalin to accurate. Clonazepam (used to disorder) 1mg: Five ta medication card. The substance sheet for F to verify that the count - Resident #71: Morp per 5 ml: Less than a the bottle. The contro recorded 0.5 ml as the Morphine Sulfate solu Fifteen milliliters was was no controlled sub #71's Morphine Sulfate amount was accurate Lorazepam 1mg: Five the medication card. substance sheet for F verify that the count w - Resident #85: Mett opioid) 10mg: Five tal medication card. The substance sheet for F Hydrochloride to verif accurate.	ution (an opioid) 100mg per ny eight mI were observed in no controlled substance 6's Morphine Sulfate the amount was accurate. gabalin (a medication used anxiety) 75 mg: Twenty -four d in the medication card. led substance for Resident verify that the count was treat seizures and panic ablets were observed in the e was no controlled Resident #400's Clonazepam it was accurate. whine Sulfate solution 100mg milliliter was observed in lled substance sheet e amount in the bottle. ution 100mg per 5 ml. observed in a bottle. There ostance sheet for Resident te solution to verify that the set the solution to verify that the set ablets were observed in There was no controlled Resident #71's Lorazepam to was accurate. hadone Hydrochloride (an blets were observed in the re was no controlled Resident #85's Methadone	F	76	51			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE COMF	
		345529	B. WING				/24/2025
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	medication card. Thei substance sheet for F Acetaminophen and F verify the count was a - Resident #14: Lora: tablets were observed There was no controll Resident #14's Lorazi accurate. - Resident #401: Trar Two tablets were observed for Resident #14's Tra was accurate. Naltrexone (used to the disorders to reduce con physiological dependent were observed in the no controlled substant #401's Naltrexone to accurate. - Resident #402: Lora were observed in the no controlled substant #401's Naltrexone to accurate. - Resident #402: Lora were observed in the tablets were recorded substance sheet. Lorazepam 1mg: Nine the medication card a on the controlled substant - Resident #124: Oxy opioid) 5/325: Four ta medication card. The substance sheet for F	tablets were observed in a re was no controlled Resident #85's Hydrocodone Bitartrate to accurate. zepam 0.5 mg: Three d in the medication card. led substance sheet for epam to verify the count was madol (an opioid) 50 mg: erved in the medication controlled substance sheet amadol to verify the count reat alcohol and opioid use ravings and help control ence) 50mg: Sixteen tablets medication card. There was ce sheet for Resident verify the count was azepam 1mg: Sixty tablets medication card and 60 d on the controlled ety tablets were observed in and 90 tablets were recorded stance sheet. rcodone/Acetaminophen (an blets were observed in the re was no controlled	F	761			

Facility ID: 20040007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345529	B. WING			02	C 2/24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		F	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 761	Continued From page	9 120	F	761			
	100 micrograms per h observed and two pat controlled substance - Resident #403: Amp dextroamphetamine (stimulant) 15mg: The in the filing cabinet ar sheet recorded there of Amphetamine and Tramadol 50 mg: The in the filing cabinet ar sheet recorded there of Tramadol. Pregabalin 200mg: The observed in the filing substance sheet reco been 19 tablets of Pre On 2/22/2025 at 5:00 conducted with the Ac Nurse Consultant #1. Corporate Nurse Con controlled medication	ohetamine and a central nervous system re were no tablets observed ad the control substance should have been 43 tablets dextroamphetamine. ere were no tablets observed ad the control substance should have been 43 tablets here were no tablets cabinet and the control orded there should have egabalin.					
	carts providing a doul controlled medication medications were not cabinet in the DON's DON's office was able On 2/24/2025 at 7:50 with the DON, she sta state survey began, m controlled medication	acy due to the medications ble lock system for the s. They stated controlled to be stored in the filing office and only door to the e to be locked. am in a phone interview ated on 2/16/2025 when the esidents' non-controlled and s that needed to be returned e collected by the DON, Unit					

Facility ID: 20040007

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/31/2025 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345529	B. WING			c	C 02/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NORT			520	01 CLARKS FORK DRIVE NW		
		III NALLIOIT		RA	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 761	DON from the medical controlled medication cabinet in the DON of controlled medication pharmacy. She stated state survey and did in and controlled medication pharmacy. She stated state survey and did in and controlled medication former DON state facility 5 ½ weeks age orientation on how to controlled medication stated she was the or DON office and the medication stated she was the or DON office and the medication carts on 2 history with diversion October 2024. On 2/21/2025 at 5:40 conducted with Pharm report of a diversion of October 2024, the face medications back to the possible and not keep carts in the facility. Pharmacy form to list returned to the pharm tote and secure the to zip tie. Pharmacist #1 zip tie was to be writter return to pharmacy for were picked up at nig	e 121 nager #2 and the interim ation carts and residents' is were placed in the filing ffice for storage until the is could be returned to the d she was busy with the not return the non-controlled ations to the pharmacy the facility on 2/19/2025. ed since starting at the o, she had not received an return non-controlled and is to the pharmacy. She nly person with a key to the on-controlled medications edications that were to be tions carts until they were hacy were removed from the 2/16/2025 due to the facility's of controlled medications in pm, a phone interview was nacist #1 and Pharmacy hacist #1 stated due to a of controlled medications in cility was to return controlled he pharmacy as soon as o stored in the medication harmacist #1 reported the riple carbonate return to controlled medications hacy, placed in a pharmacy be closed with a numbered to stated the number of the en on the triple carbonate orm and pharmacy delivered cility. Pharmacist Consultant	F	761			

Facility ID: 20040007

If continuation sheet Page 122 of 167

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345529	B. WING			0	2/24/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 761	#1 stated the pharma when the facility retur controlled medication Pharmacist Consultar issues with the facility medications timely. S 2/18/2025 when audit were no issues with th medications on the m controlled medication Con 2/24/2025 at 8:11 Unit Manager #1, she controlled medication the medication carts a of each shift for accur present in the facility the nursing staff and a controlled medication to return to the pharm new practice from retur medications stored in pharmacy since Octoo further stated on 2/16 controlled medication to give to the DON to Manager #1 explained waiting to be returned stored on the 500-hal there were no resider She stated since the a storing resident medic storing the controlled office that had not be pharmacy. On 2/24/2025 at 8:49	cy was not able to control ned non-controlled and s back to the pharmacy. nt #1 stated there had been not returning controlled he stated on 1/5/2025 and s were conducted, there ne storage of controlled edication carts and the s accurately correlated with s sheets. am in a phone interview with s stated discontinued s were to remain stored on and counted at the change racy until the DON was to collect when notified by sign a sheet reporting when s were removed by the DON hacy. She stated this was the urning controlled the medication cart to the ber 2024. Unit Manager #1 /2024 she collected no s from the medication carts return to the pharmacy. Unit d controlled medications to the pharmacy used to be I medication cart due to at admitted to the 500 hall. 500-hall medication cart was cations, the DON was medications in the DON's	F	761			

Facility ID: 20040007

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		ID HUMAN SERVICES			FOF	ED: 03/31/202 RM APPROVEI
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	IO. 0938-039 [.] E SURVEY IPLETED
		345529	B. WING		0:	C 2/24/2025
NAME OF PR	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NORT			5201 CLARKS FORK DRIVE NW		
		TALEIGH .		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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761 F 801 SS=F	facility on 2/16/2025 medications from the stated controlled medi- controlled medication She stated she return On 2/24/2025 at 9:56 with the Administrator #2 had been out of w 2/20/2025. She expla- her through an email morning of 2/19/2025 were controlled medic the locked DON's offi a key to the DON offi a backup key to the D that when the Lead A facility on 2/19/2025 the and observed the cor- filing cabinet that did controlled medication nurse or returned to t in the unlocked filing requested maintenan DON's office. The Ad on the DON door was 12:00pm, she had the The Administrator sta 12/30/2024 and was in storing and returnin the pharmacy. Qualified Dietary Stat CFR(s): 483.60(a)(1)	5/2025 and was not at the to remove controlled medication carts. She dications were stored on the till the DON collected the as to return to the pharmacy. ned to work on 2/21/2025. The am in a phone interview r, she stated Unit Manager ork from 2/16/2025 to the dthat the DON informed of her resignation on the and also informed her there cations in the filing cabinet in ce. She stated the DON had ce and the Administrator had DON office. She reported diministrator came to the they went to the DON office htrolled medications in the not lock. She stated the swere not counted with a he pharmacy and remained cabinet. She explained she ce to change the lock to the ministrator stated the lock is changed on 2/19/2025 by e only key to the DON office. ted she started on still learning the processes ing controlled medications to	F 76			3/25/25
	§483.60(a) Staffing The facility must emp	loy sufficient staff with the				

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	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM): 03/31/2025 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345529	B. WING			_	(02/)	24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			201 CLARKS FORK DRIV ALEIGH, NC 27616	ENW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 801	out the functions of the taking into considerat individual plans of car and diagnoses of the in accordance with the required at §483.71. This includes: §483.60(a)(1) A qualit clinically qualified nut full-time, part-time, or qualified dietitian or o nutrition professional (i) Holds a bachelor's a regionally accredite United States (or an e with completion of the a program in nutrition an appropriate nation recognized for this put (ii) Has completed at supervised dietetics p supervision of a regis professional. (iii) Is licensed or cert nutrition professional services are performe provide for licensure of will be deemed to hav or she is recognized at the Commission on D successor organizatio requirements of parage this section. (iv) For dietitians hire November 28, 2016, the	ncies and skills sets to carry e food and nutrition service, ion resident assessments, re and the number, acuity facility's resident population e facility assessment fied dietitian or other rition professional either on a consultant basis. A ther clinically qualified is one who- or higher degree granted by d college or university in the equivalent foreign degree) e academic requirements of or dietetics accredited by al accreditation organization rpose. least 900 hours of oractice under the tered dietitian or nutrition ified as a dietitian or by the State in which the ed. In a State that does not or certification, the individual we met this requirement if he as a "registered dietitian" by ietetic Registration or its	F	801				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/31/2028 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C / 24/2025
NAME OF PF	OVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERSA	L HEALTH CARE/NORT	'H RALEIGH			201 CLARKS FORK DRIVE NW		
				R	ALEIGH, NC 27616		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 801	Continued From page	125		801			
1 001	as required by state la		F	801			
	as required by state is	aw.					
	clinically qualified nut employed full-time, th person to serve as the nutrition services. (i) The director of foo must at a minimum m qualifications- (A) A certified dietary (B) A certified dietary (B) A certified food set (C) Has similar nation service management certifying body; or D) Has an associate's service management course study includes management, from an higher learning; or (E) Has 2 or more ye position of director of in a nursing facility set	ed and nutrition services leet one of the following manager; or ervice manager; or hal certification for food and safety from a national s or higher degree in food					
	topics integral to man including, but not limit sanitation procedures purchasing/receiving; (ii) In States that have food service manager meets State requirem managers or dietary r	and e established standards for rs or dietary managers, ents for food service managers, and					
	from a qualified dietiti qualified nutrition prot This REQUIREMENT by:	-			F801		

Facility ID: 20040007

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		ID HUMAN SERVICES MEDICAID SERVICES				1 APPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		LETED
		345529	B. WING			C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NORT			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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 801	Continued From page		F 80			
		cility failed to designate a ector of food and nutrition lanager (DM).		 At the time of the survey the ce did not employ a certified dietary ma A new certified dietary manage 	anager	
	The findings included	2		 hired and began working on 3/10/20 3. The administrator was educate the Vice President of Operations on 	d by	
	provided by the facilit	ete staffing list of employees ty on 2/17/25 revealed that		3/18/2025 to ensure a qualified diet individual is hired to meet the regula	ary atory	
	the facility.	ed Dietary Manager (DM) at		compliance and nutrition standards facility. The administrator or designee will c		
	2/17/25 through 2/22 noted to be schedule full-time and was obs	throughout the survey from /25, the facility DM was d to work at the facility served as the staff member		weekly meetings x 12 with the dieta manager to ensure the nutritional ne of the residents and regulatory stan of the kitchen are maintained.	eeds	
	kitchen.	o-day operations in the		4. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolutions and the second seco		
	Regional Dietary Mar	on 2/18/25 at 12:04 PM, the nager said he came to the a week to support and ietary Manager.		as needed. 5. Date of completion: 3/25/2025		
	facility DM said he wa	n 2/22/25 at 12:56 PM, the as in school to become a not certified yet, but the				
		rtified and managed the was in school and would a week.				
	Administrator confirm certification as a dieta	on 2/22/25 at 6:34 PM, the ned that the DM did not have ary manager and that he was				
	She said the Regiona	complete his studies in June. al Dietary Manager managed ne being, coming to the a week.				
F 804 SS=E	-	ar, Palatable/Prefer Temp	F 80	4		3/25/25

Facility ID: 20040007

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		CONSTRUCTION	(X3) DATE	. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				COMP	
		345529	B. WING			02/2	24/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	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		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	E	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
					DEFICIENCY		
F 804	Continued From page	× 107					
F 004	- 15			304			
	CFR(s): 483.60(d)(1)((2)					
	§483.60(d) Food and	drink					
	Each resident receive	es and the facility provides-					
		repared by methods that ue, flavor, and appearance;					
		nd drink that is palatable,					
	attractive, and at a sa	fe and appetizing					
	temperature.	is not met as evidenced					
	by:	is not met as evidenced					
		ew, observations, and staff,			F804		
		resident interviews, and test			1. The facility failed to ensure that for	bd	
		to provide food that was			served to residents is palatable.		
	palatable and served	at an appetizing 13 residents (Residents			 A new certified dietary manager was hired and began on 3/10/2025. 	as	
	· ·	61, #5, #87, #62, #109, and			3. The dietary supervisor or designed	,	
	#106) reviewed for for				will provide education to all dietary staf		
					food preparation techniques, flavor		
	The findings included	:			enhancements and presentation skills I 3/21/2025. Any dietary staff member w		
	a. The Resident Cour	ncil minutes from December			does not receive this education will be		
		25 noted resident concerns			removed from the schedule until		
	with food palatability.				completed.		
	In a Posidant Council	interview on 2/18/25 at			All new hire dietary staff will receive thi		
		participants (Residents			education during orientation by the diet manager.	ary	
		7, #62, #109, and #106)			Administrator or designee will complete	e	
		erved was not palatable, that			test tray audits 5x week x 4 weeks,		
		ved cold and the meat was			3xweekly x 4 weeks, then weekly x 4	Lie	
	tough.				weeks, then monthly x 2 to ensure food palatable.	IS	
	b. Resident #60's qua	arterly Minimum Data Set					
	(MDS) dated 1/30/25	revealed the resident was			4. Results will be reported by the		
		required supervision for			administrator to the quality assurance		
	eating.				meeting x1 month for further resolution	as	
					needed.		

Facility ID: 20040007

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/31/2025 MAPPROVED D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345529	B. WING				24/2025	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	•_•	
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			01 CLARKS FORK DRIVE NW ALEIGH, NC 27616			
					PROVIDER'S PLAN OF CORRECTION		0.5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 804	Continued From page	a 128	F 8	04				
	During an interview w at 9:23 AM, he report	vith Resident #60 on 2/17/25 ted the food did not taste eat that was served was dry.		04	5. Date of completion: 3/25/2025			
	•	he ate his meals in his room.						
		nission MDS dated 1/23/25 was cognitively intact and for eating.						
	at 3:33 PM, she repo good daily and she st	vith Resident #85 on 2/16/25 rted the food did not taste truggled to eat her meals. she ate her meals in her						
		arterly MDS dated 11/17/24 was cognitively intact and n eating.						
	-	oses list included hemiplegia alysis/weakness of one side						
	couldn't chew well an hands to perform task served for lunch that too hard to cut with o he had dentures and to eat. During the inte Resident #74 attempt meat from the chicke get more than a small	8/25 at 1:15 PM, he said he ad could only use one of his ks. He reported the food day, the baked chicken, was ne hand, was dry, and that the chicken was too tough erview, it was observed that ted to use his fork to remove n breast but was unable to Il piece.						
	2/18/25. The test tra- 12:53 PM. At 12:57 F	leted for the lunch meal on y was plated in the kitchen at PM, the test tray left the n to the hall where Resident						

Facility ID: 20040007

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•	9	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	#74 resided, the last I last hall tray was serv of a chicken breast, r and baked beans. At Dietary Manager (DM mashed potatoes with tough and only a sma able to be pulled from surveyor attempted to mashed potatoes wer with a texture compar of the potatoes. The D too tough to cut with o mashed potatoes text During an interview w 2/18/25 at 1:25 PM, h residents had concern and the dietary depar the concerns by alteri match the residents' p During an interview w 2/22/25 at 6:22 PM, s food for the residents was aware some resic complained about the Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (ii) The facility may not re resident-identifiable to accordance with a con agrees not to use or o	hall served. At 1:16 PM, the ed. The test tray consisted mashed potatoes and gravy, 1:20 PM the surveyor and) tasted the chicken and the gravy. The chicken was Il piece of the breast was the meat when the o use only a fork. The e covered in a thick gravy able to syrup that sat on top DM agreed the chicken was only a fork and the gravy and ures were not appetizing. ith the Dietary Manager on e said he knew several hs about food palatability tment was trying to address ng the menus to better preferences. ith the Administrator on he said preparing palatable was a daily effort and she dents consistently food served. lentifiable Information 483.70(h)(1)-(5) ht-identifiable information. elease information that is o the public. lease information that is		804			3/25/25

Facility ID: 20040007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345529	B. WING				24/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	must maintain medica that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(h)(2) The fac all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to heal by and in compliance §483.70(h)(3) The fac record information ag unauthorized use. §483.70(h)(4) Medical for-	ecords. ordance with accepted is and practices, the facility al records on each resident ented; e; and ganized cility must keep confidential hed in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings,	F	842			
	() p	, ····, ····, ····, ··					

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/202 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 02/24/2025
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	•
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE NW	
			I	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 APPROPR DEFICIENCY)	BE COMPLETION
F 842	Continued From page	e 131	F 842		
1 012			F 042		
	there is no requireme	e date of discharge when			
		ars after a resident reaches			
	legal age under State				
	\$483.70(h)(5) The m	edical record must contain-			
		ion to identify the resident;			
		sident's assessments;			
	(iii) The comprehensi	ve plan of care and services			
	provided;				
	_ · · / ·	y preadmission screening			
	and resident review e				
	determinations condu				
		e's, and other licensed			
	professional's progre	logy and other diagnostic			
		equired under §483.50.			
		Γ is not met as evidenced			
	by:				
		iews, and staff, Pharmacist,		F842	
	Corporate Nurse Cor	nsultant, and Physician		1. Resident #50 medication	
	interviews, the facility	/ failed to maintain complete		administration record was corrected.	
		l records for medication		Resident # 34 abnormal labs were	
	administration (Resid			reported to the provider.	
		sing assessments and		2. Current residents are at risk	
		otification time (Resident		3. Director of Nursing or designee w	
	were reviewed.	ents whose medical records		educate current licensed nurses inclue	-
	were reviewed.			agency licensed nurses in accuracy ir medication transcription and notification	
	Findings included:			critical lab results to provider immedia	
				at time of receiving. This education be	
	1. Resident #50 was	admitted to the facility on		03/19/2025.	~
		ses including depression.		Any licensed nurse not receiving	
	Dhysisian ardars in th	uded Zeleft (brend name far		education will not be allowed to work	until
	-	uded Zoloft (brand name for		education is received.	
		pressant medication) 50 ablet a day for depression		Agency licensed nurses will receive education prior to the start of their shi	ft
	i miliurams (mu) offe t			T EQUCATION OF OF THE STATE OF THEIR STILL	n. –
		to start on 1/31/2025 at		New licensed nurses will receive	

Event ID: PM7D11

Facility ID: 20040007

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	ATE SURVEY OMPLETED
						С
		345529	B. WING			02/24/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETIO
F 842	Continued From page	e 132	F 84	2		
		a day for depression written		by the Director of Nursing of	or designee	
		on 2/1/2025 at 9:00am. The		4. Audits of the clinical or		
	order for Zoloft was d	liscontinued on 2/5/20205.		the previous 24 hours of pr		
				will be completed 5x week		
		Administration		then 3x weekly x 4 weeks,	•	
	Record (MAR) for Re	sident #50 recorded scheduled for 9:00 am and		weeks, then monthly x 2 m director of nursing or desig		
	U U U U U U U U U U U U U U U U U U U	2025 and 2/2/2025, and		complete the audits and re		
		eduled for 9:00am and		discrepancies during the m		
	•	2025 and 2/2/2025. The		meeting		
	MAR recorded Zoloft	50mg was not given on		5. Results will be reported	d by the	
	2/3/2025 to 2/5/2025	and to see progress notes.		Director of Nursing to the q assurance meeting x3 mon	-	
		on dated 2/5/2025 at 1:22		resolution as needed.		
		rded Zoloft 50mg one time a		6. Date of completion: 3/25	/2025	
		as a duplicate order. There				
		mentation in the progress				
	on 2/3/2025 and 2/4/2	Zoloft was not administered 2025.				
	On 2/21/2025 at 2:04	pm in a phone interview				
		ated she recognized the				
		Sertraline as the same				
	,	administered Resident #50				
	#50's February MAR	n day. She stated Resident				
		nt #50 both Sertraline 50mg				
		2/1/2025 and 2/2/2025. She				
		t she had marked one of the				
	medications as not a					
	Resident #50's Febru	ary MAR was not accurate.				
	On 2/21/2025 at 4:55	pm in a phone interview				
		onsultant #1, she explained				
		ed one of the Sertraline				
	-	g orders that were received				
		oloft medication card was 25 at 10:32 pm to the facility.				

If continuation sheet Page 133 of 167

					FORM): 03/31/2025 // APPROVED). 0938-0391
CIENCIES CTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	
	345529	B. WING				C 24/2025
R OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
			5	5201 CLARKS FORK DRIVE NW		
LIN CARE/NORI	n KALEIGH		F	RALEIGH, NC 27616		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG				(X5) COMPLETION DATE
 Continued From page 133 Continued From page 133 On 2/22/2025 at 3:51 pm in an interview with the interim Director of Nursing (DON), she explained Nurse #4 recorded both Zoloft 50mg and Sertraline 50mg were administered on 2/1/2025 and 2/2/2025 on Resident #50's MAR when actually only Zoloft 50 mg was administered on 2/1/2025 and 2/2/2025. She stated Nurse #4 did not administer the medications twice as recorded on Resident #50's MAR. On 2/22/2025 at 8:48 pm in an interview with the Vice President of Operations, she stated Nurse #4's documentation on Resident #50's MAR should show what medication the resident actually received. Resident #34 was admitted to the facility on 12/13/2024 with diagnoses including diabetes and end stage renal disease. 		F	842			
22/2025 at 3:51 m Director of Nu e #4 recorded bo aline 50mg were /2/2025 on Resi Ily only Zoloft 50 025 and 2/2/202 dminister the me esident #50's MA 22/2025 at 8:48 President of Ope documentation o d show what me Ily received. sident #34 was a /2024 with diagr tage renal disea lent #34's labora ated the specime I glucose monito 2025 revealed th se levels are con rams per decilite 8:00 am the rea 1:00 pm the rea 8:00 pm the rea 8:00 pm the rea 22/2025 at 7:08 22/2025 at 7:08	pm in an interview with the rsing (DON), she explained administered on 2/1/2025 dent #50's MAR when mg was administered on 5. She stated Nurse #4 did dications twice as recorded AR. pm in an interview with the erations, she stated Nurse n Resident #50's MAR dication the resident admitted to the facility on noses including diabetes and se. tory test dated 2/22/2025 en was collected at 5:19 am. ring for Resident #34 on he following (normal blood hisidered to be between 70 rr [mg/dL] to 100 mg/dL): ding was 151 ding was 151 ding was 120 tory test recorded aboratory results, glucose essium level 6.1, to Nurse #8 pm 9 pm, Nurse #8 recorded					
	A MEDICARE & I CHOICES CTION R OR SUPPLIER LTH CARE/NORT SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L nued From page (22/2025 at 3:51 m Director of Nu # 4 recorded bc aline 50mg were (22/2025 at 3:51 m Director of Nu # 4 recorded bc aline 50mg were (22/2025 at 3:51 m Director of Nu # 4 recorded bc aline 50mg were (22/2025 at 3:51 m Director of Nu # 4 recorded bc aline 50mg were (22/2025 at 3:51 m Director of Nu # 4 recorded bc aline 50mg were (22/2025 at 3:51 m Director of Nu # 4 recorded bc (22/2025 at 8:48 President of Ope (22/2025 at 8:48 President file (1) 0 pm the real (2) 0 pm the	CTION IDENTIFICATION NUMBER: 345529 ROR SUPPLIER LTH CARE/NORTH RALEIGH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) nued From page 133 22/2025 at 3:51 pm in an interview with the m Director of Nursing (DON), she explained a #4 recorded both Zoloft 50mg and aline 50mg were administered on 2/1/2025 1/2/2025 on Resident #50's MAR when Ily only Zoloft 50 mg was administered on 025 and 2/2/2025. She stated Nurse #4 did dminister the medications twice as recorded esident #50's MAR. 22/2025 at 8:48 pm in an interview with the President of Operations, she stated Nurse documentation on Resident #50's MAR d show what medication the resident Ily received. sident #34 was admitted to the facility on 1/2024 with diagnoses including diabetes and	EMEDICARE & MEDICAID SERVICES DENCIES CTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A BUILD 345529 B. WING COR SUPPLIER IDENTIFICATION NUMBER: (X2) MUL A BUILD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREF TAG nued From page 133 F 22/2025 at 3:51 pm in an interview with the m Director of Nursing (DON), she explained bit accorded both Zoloft 50mg and aline 50mg were administered on 2/1/2025 /2/2025 on Resident #50's MAR when IIV only Zoloft 50 mg was administered on D25 and 2/2/2025. She stated Nurse #4 did diminister the medications twice as recorded esident #50's MAR. 22/2025 at 8:48 pm in an interview with the President of Operations, she stated Nurse focumentation on Resident #50's MAR d show what medication the resident IIV received. sident #34 was admitted to the facility on //2024 with diagnoses including diabetes and tage renal disease. lent #34's laboratory test dated 2/22/2025 ted the specimen was collected at 5:19 am. l glucose monitoring for Resident #34 on 2025 revealed the following (normal blood se levels are considered to be between 70 rams per deciliter [mg/dL] to 100 mg/dL): 8:00 am the reading was 151 1:00 pm the reading was 111 8:00 pm the reading was 120 lent #34's laboratory test recorded ration of critical laboratory results, glucose of 928 and potassium level 6.1, to Nurse #8 22/2025 at 7:08 pm 22/2025 at 11:59 pm, Nurse #8 recorded <td>EMEDICARE & MEDICAID SERVICES SHENCIES CTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A BUILDING A BUILDING B WING CR OR SUPPLIER LTH CARE/NORTH RALEIGH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG nued From page 133 F 842 22/2025 at 3:51 pm in an interview with the m Director of Nursing (DON), she explained e #4 recorded both Zoloft 50mg and aline 50mg were administered on 2/1/2025 //2/2025 on Resident #50's MAR when IIIy only Zoloft 50 mg was administered on D25 and 2/2/2025. She stated Nurse #4 did dminister the medications twice as recorded esident #50's MAR. 22/2025 at 8:48 pm in an interview with the President of Operations, she stated Nurse focumentation on Resident #50's MAR d show what medication the resident IIy received. sident #34 was admitted to the facility on //2024 with diagnoses including diabetes and tage renal disease. In glucose monitoring for Resident #34 on 2025 revealed the following (normal blood se levels are considered to be between 70 rams per deciliter [mg/dL] to 100 mg/dL): 8:00 am the reading was 151 1:00 pm the reading was 120 Ient #34's laboratory test recorded cation of critical laboratory results, glucose of 928 and potassium level 6.1, to Nurse #8 22/2025 at 7:08 pm 22/2025 at</td> <td>IMEDICARE & MEDICAID SERVICES IPROVIDE SUBPLIENCLIA IDENTIFICATION NUMBER: A BUILDING Stasses ICTO NO THE ADDRESS, CITY, STATE, ZIP CODE SOR SUPPLIEN SUMMARY STATEMENT OF DEFICIENCIES DEFORDENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) DIRECTO TO THURSING (LON), she explained #10 DIRECTO TO THURSING (LON), she explained #22/2025 at 3.51 pm in an interview with the President of Operations, she stated Nurse #22 2025 at 8.48 pm in an interview with the President of Operations, she stated Nurse Hore and liseases Lent #34 was admitted to the facility on (2024 at 1:34 pm in an interview with the <</td> <td>OF HEALTH AND HUMAN SERVICES COMB NC UREDICARE & MEDICALD SERVICES OMB NC DENTIFICATION NUMBER: A BULDING 1 A BULDING 1 STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE SUBJUER STREET ADDRESS, CITY, STATE, ZIP CODE SUBMERY SATEMENT OF DEPORTORS CARST FORK DRIVE RW REGULATORY OR LSC DENTIFYING INFORMATION PRETX TAG CROSS-REFERENCE TO A DOT CORRECTION UP OF CONTONUS IN OF DEPORTORIES CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY WIST BE PROCEED BY FULL PRETX REGULATORY OR LSC DENTIFYING INFORMATION PRETX TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY DEFICIENCY NUMBER PRETX Street administered on D1/1/2025 PRETX 1/22025 at 3:43 Pm in an interview with the President of Operations, she stated Nurse H4 did Imministered on D1/2/2025 1/22025 at 3:449 pm in an interview with the President of Operations, she stated Nurse H4 did Imministered on D1/2/2025 1/22025 at 4:49 pm in an interview with the President of Operations, she stated Nurse H4 did Imministered on D2/2/2025 1/22024 with diagnoses including dia</td>	EMEDICARE & MEDICAID SERVICES SHENCIES CTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A BUILDING A BUILDING B WING CR OR SUPPLIER LTH CARE/NORTH RALEIGH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG nued From page 133 F 842 22/2025 at 3:51 pm in an interview with the m Director of Nursing (DON), she explained e #4 recorded both Zoloft 50mg and aline 50mg were administered on 2/1/2025 //2/2025 on Resident #50's MAR when IIIy only Zoloft 50 mg was administered on D25 and 2/2/2025. She stated Nurse #4 did dminister the medications twice as recorded esident #50's MAR. 22/2025 at 8:48 pm in an interview with the President of Operations, she stated Nurse focumentation on Resident #50's MAR d show what medication the resident IIy received. sident #34 was admitted to the facility on //2024 with diagnoses including diabetes and tage renal disease. In glucose monitoring for Resident #34 on 2025 revealed the following (normal blood se levels are considered to be between 70 rams per deciliter [mg/dL] to 100 mg/dL): 8:00 am the reading was 151 1:00 pm the reading was 120 Ient #34's laboratory test recorded cation of critical laboratory results, glucose of 928 and potassium level 6.1, to Nurse #8 22/2025 at 7:08 pm 22/2025 at	IMEDICARE & MEDICAID SERVICES IPROVIDE SUBPLIENCLIA IDENTIFICATION NUMBER: A BUILDING Stasses ICTO NO THE ADDRESS, CITY, STATE, ZIP CODE SOR SUPPLIEN SUMMARY STATEMENT OF DEFICIENCIES DEFORDENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) DIRECTO TO THURSING (LON), she explained #10 DIRECTO TO THURSING (LON), she explained #22/2025 at 3.51 pm in an interview with the President of Operations, she stated Nurse #22 2025 at 8.48 pm in an interview with the President of Operations, she stated Nurse Hore and liseases Lent #34 was admitted to the facility on (2024 at 1:34 pm in an interview with the <	OF HEALTH AND HUMAN SERVICES COMB NC UREDICARE & MEDICALD SERVICES OMB NC DENTIFICATION NUMBER: A BULDING 1 A BULDING 1 STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE SUBJUER STREET ADDRESS, CITY, STATE, ZIP CODE SUBMERY SATEMENT OF DEPORTORS CARST FORK DRIVE RW REGULATORY OR LSC DENTIFYING INFORMATION PRETX TAG CROSS-REFERENCE TO A DOT CORRECTION UP OF CONTONUS IN OF DEPORTORIES CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY WIST BE PROCEED BY FULL PRETX REGULATORY OR LSC DENTIFYING INFORMATION PRETX TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY DEFICIENCY NUMBER PRETX Street administered on D1/1/2025 PRETX 1/22025 at 3:43 Pm in an interview with the President of Operations, she stated Nurse H4 did Imministered on D1/2/2025 1/22025 at 3:449 pm in an interview with the President of Operations, she stated Nurse H4 did Imministered on D1/2/2025 1/22025 at 4:49 pm in an interview with the President of Operations, she stated Nurse H4 did Imministered on D2/2/2025 1/22024 with diagnoses including dia

Facility ID: 20040007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP		
		345529	B. WING			02/24/2025		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH			201 CLARKS FORK DRIVE NW 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	e 134	F	342				
	am by Nurse #8 reco	on dated 2/23/2025 at 1:41 rded the physician was laboratory results and there eceived.						
	of a nursing assessm	l included no documentation nent conducted for Resident of the critical lab results on						
	with Nurse #8, she st assigned to Resident the nurse covering for notified the physician 2/22/2025 upon recei critical labs and went on Resident #34. She alert, oriented, verbal voiced no complaints vital signs were obtain #8 stated she though #34's vital signs and a medical record. She e assigned another gro medication cart on 2/2 that was why the physic	22/20245. She explained sician notification was 205 at 1:41 am instead of						
	with the Interim Direc stated Nurse #8 report #34 on 2/22/2025 follo critical lab values and identified in Resident	2 pm in a phone interview tor of Nursing (DON), she rted she assessed Resident owing the receipt of the there were no changes #34. The Interim DON umentation of Resident						

Facility ID: 20040007

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C
		345529	B. WING		02/24/202
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP C	•
JNIVERS	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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPL THE APPROPRIATE DAT
F 842 F 847 SS=D	#34's vital signs on the sheet that was not par record. The Interim E documentation of the incorrect because not actually was at 7:10 p On 2/24/2025 at 2:04 Physician #1, he state the critical labs on 2/2 stated due to the bloc laboratory test was of 2/22/2025, and Resid levels were recorded time of the collection he felt the critical labs blood specimen had I red blood cells) when performed on the bloc also stated there were #34's condition report On 2/24/2025 at 2:17 Corporate Nurse Con was not a nursing ass 2/22/2025 for Resider Nurse #8 should have assessment performed medical record. Entering into Binding CFR(s): 483.70(m) Binding A If a facility chooses to representative to enter	the end of the shift report int of Resident #34's medical DON also stated time the physician was tification of the physician om on 2/22/2025. pm in a phone interview with ed the facility notified him of 22/2025 at 7:10 pm. He od specimen for the obtained at 5:19 am on lent #34's blood glucose as less than 200 after the of the blood. He indicated as were inaccurate and the nemolyzed (destruction of the laboratory test was od specimen. The physician e no changes in Resident ted on 2/22/2025. pm in phone interview with isultant #2, she stated there sessment recorded for in #34's medical record and e documented the ed on Resident #34 in the Arbitration Agreements 0(2)(i)(ii)(3)-(5) whitration Agreements of ask a resident or his or her er into an agreement for e facility must comply with all	F 84	2	3/25/2

Event ID: PM7D11

Facility ID: 20040007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		345529	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 847	§483.70(m)(1) The faresident or his or her agreement for binding admission to, or as a receive care at, the far inform the resident or his or her right not to condition of admission continue to receive car §483.70(m)(2) The far (i) The agreement is of his or her representative that he or she unders language the resident representative unders (ii) The resident or his acknowledges that he agreement; §483.70(m)(3) The ag grant the resident or h right to rescind the ag days of signing it. §483.70(m)(4) The ag state that neither the representative is requ for binding arbitration to, or as a requirement at, the facility. §483.70(m)(5) The ag any language that pro- resident or anyone elsi federal, state, or local limited to, federal and	cility must not require any representative to sign an g arbitration as a condition of requirement to continue to acility and must explicitly his or her representative of sign the agreement as a in to, or as a requirement to are at, the facility. cility must ensure that: explained to the resident and tive in a form and manner tands, including in a t and his or her	F	847	7		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03 FORM AP OMB NO. 09	PROVE
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345529	B. WING		02/24/2	2025
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
UNIVERS	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE CO THE APPROPRIATE	(X5) MPLETION DATE
F 847	Long-Term Care Omt with §483.10(k). This REQUIREMENT by: Based on record revi interviews, the facility arbitration agreement having them sign the they explicitly informe the agreement was m admission. This occur (Resident#72, and Re arbitration. Findings included: Review of the facility's which was not dated, signing the Arbitration and/or the resident's acknowledged they h agreement and that the adequately explained a. Resident #72 was a 6/5/24. Review of Resident # revealed the resident on 6/5/24. Resident #72's most of (MDS) assessment data assessment revealed An interview was con 2/18/25 at 4:50 PM.	the Office of the State oudsman, in accordance is not met as evidenced iew, and resident and staff failed to explain the to the resident prior to agreement and to ensure ed the resident that signing ot required as a condition of rred for 2 of 3 residents esident #109) reviewed for	F 8	 F847 Current residents have arbitration/declination sigrest patient □s electronic media An audit was conduct Regional Director of Cense (RDCD) for the current resensure that all had arbitrat declinations signed. This is 3/19/2025. The admissions team by the RDCD on how to urapproved script to explain process to the resident or representative. Education 3/19/2025. Any member of the admiss receiving education will new owrk until education is receiving education duritorientation process by the New admissions will be at RDCD or designee for the declination form 5 x weeks then 3x weekly x 4 weeks weeks, then monthly x 2. Results will be reported administrator to the quality meeting x3 months for fur as needed. Date of completion: 3/2 	hed in the cal record. ted by the sus Development esidents to tion or is completed by a was educated tilize the the arbitration resident⊡s completed on sion team not of be allowed to ceived. dmission team ing the e RDCD. udited by the e arbitration or ly x 4 weeks, , then weekly x 4 ed by the y assurance ther resolution	

Facility ID: 20040007

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
					5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	n KALEIGN			RALEIGH, 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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 847	been explained to her the arbitration agreen she remembered sign admission process, b papers to sign she did b. Resident #109 wa 6/20/24. Review of Resident # revealed the resident on 6/24/25. Resident #109's most (MDS) assessment did change assessment, cognitively intact. An interview was con on 2/22/25 at 4:49 PM signed upon admission she was not made aw admission. An interview was con Coordinator on 2/20/2 Admissions Coordina the facility on 8/5/24. Admissions Coordina the facility on 8/5/24. Admission prior she reads each section agreement and asked representatives to sign process. She stated reads during the expla- agreement. She report	r, she would not have signed hent. She further reported hing papers during the ut there were so many d not understand them all. s admitted to the facility on 109's arbitration agreement had signed the agreement had signed the agreement t recent Minimum Data Set ated 9/25/2024, a significant revealed she was ducted with Resident #109 <i>A</i> . She stated the forms she on were not explained and vare it was not a condition of ducted with the Admissions 25 at 11:11 AM. The tor reported she started at She stated the former tor would have been asing the arbitration dent #72 and Resident #109 to her starting. She stated on of the arbitration d residents or their n during the admissions the facility had a "script" she anation of the arbitration	F	847			

Facility ID: 20040007

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 02/24/2025
IAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
	AL HEALTH CARE/NORT			5201 CLARKS FORK DRIVE NW	
	AL HEALTH CARE/NORT	IN 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 847	Continued From page	e 139	F 84	47	
arbitration agreement she					
	questions for the resi	dent. If needed she stated			
	0	clarification about the			
	Ū	t for the resident from the dmissions Coordinator			
		a place for the resident to			
		od each section of the			
		t, including the arbitration			
	agreement.				
	The former Admission	ns Coordinator was			
	unavailable for an inte	erview.			
	The Administrator we	s interviewed on 2/22/23 at			
		strator stated she expected			
		nent to be explained to the			
		esident representative in a			
		nderstand. She reported the			
		coordinator has a script preement is explained fully.			
	-	ated she was not employed			
	at the facility until 12/	31/24.			
	Binding Arbitration Ag	-	F 84	48	3/25/25
SS=D	CFR(s): 483.70(m), 4	83.70(m)(2)(111)(1V)(6)			
	§483.70(m) Binding A	Arbitration Agreements.			
	If a facility chooses to	ask a resident or his or her			
		er into an agreement for			
	of the requirements in	e facility must comply with all n this section.			
	•				
		icility must ensure that:			
	• •	rovides for the selection of a eed upon by both parties;			
	and				
		rovides for the selection of a			
	venue that is conveni				

Event ID: PM7D11

Facility ID: 20040007

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STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY PLETED
		345529	B. WING				C / 24/2025
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH	RALEIGH, NC 27616		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 OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 848	10	e 140 n the facility and a resident	F	848			
	resolve a dispute thro	ough arbitration, a copy of					
	0 0	nt for binding arbitration and lecision must be retained by					
	the facility for 5 years	s after the resolution of that					
		ailable for inspection upon					
	request by CMS or its	s designee. Γ is not met as evidenced					
	by:						
		iew and interviews with the			F848		
	-	the facility failed to include			4 Our of the side of the basis of the second se		
		nue that was convenient to bitration Agreement.This			1. Current residents have a current arbitration/declination signed in the		
		ent #70) residents who were			patient s electronic medical record.		
	reviewed for entering	,			2. An audit was conducted by the		
	Agreement with the fa	acility.			Regional Director of Census Develop (RDCD) for the current residents to	ment	
	The findings included	1:			ensure that all had arbitration or		
	Posidont #70 was ad	lmitted to the facility on			declinations signed. This is complete 3/19/2025.	d by	
	7/23/21.	initied to the facility of			New admissions agreement was		
					completed for resident #70 An audit v	vas	
		ation Agreement signed by			conducted by the Regional Director of		
		2/24 revealed there was no			Census Development (RDCD) for the current residents to ensure that all ha		
	convenient to both pa				arbitration or declinations signed. Thi		
					completed by 3/19/2025.	- 41	
		recent Minimum Data Set lated 1/9/25 revealed he was			 The admissions team was educ by the RDCD on how to utilize the 	aled	
	cognitively intact.				approved script to explain the arbitrat		
	The Administrator wa	as interviewed on 2/22/23 at			process to the resident or resident s representative. Education completed		
		istrator stated she expected			3/19/2025.	011	
	the arbitration agreer	ment to contain all the			Any member of the admission team r		
		S. She reported the facility			receiving education will not be allowe	d to	
	changed ownership in				work until education received.		
		were on the arbitration in use. The Administrator			Any new member of the admission te will receive education during the	am	
		mployed at the facility until			orientation process by the RDCD.		

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/31/2029 MAPPROVED D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C / 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			201 CLARKS FORK DRIVE NW		
				R	ALEIGH, NC 27616		1
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 848	Continued From page	: 141	F	848	Section D of the oursent orbitration		
	12/31/24.				Section D of the current arbitration agreement states the following: The HCC shall be solely responsible for payment of the arbitration fee. The arbitration shall be conducted in a mutually agreeable venue, or, if the parties fail to agree, the city or county where the HCC is located. Each party agrees to bear their own attorneys□ fe and costs. The arbitrator(s) shall have authority to grant interim, injunctive, ar final relief. In no instance shall any awa for punitive damages exceed the amou authorized by N.C. Gen. Stat. ¿ 1D-25 as may be in effect at the time this Addendum to the Business Contract is signed, nor shall any award for noneconomic damages exceed the amount authorized by N.C. Gen. Stat. 90-21.19. The arbitrator(s)□ decision s be binding on Resident and/or Responsible Party and the HCC and s not be subject to further attack or appe except as provided by the FAA The current arbitration agreement w be utilized for all residents 4. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolutio as needed. 5. Date of completion: 3/25/2025	es ad ard unt (b) shall eal	
F 880 SS=J	Infection Prevention & CFR(s): 483.80(a)(1)		F	880			3/25/25
	§483.80 Infection Cor The facility must esta						
	7(02-99) Previous Versions Obs	olete Event ID: PM	17044		sility ID: 20040007		Page 1/2 of 1

Facility ID: 20040007

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	development and tran diseases and infection §483.80(a) Infection p program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services un- arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura	nd control program safe, sanitary and tent and to help prevent the asmission of communicable ass. orevention and control blish an infection prevention IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.71 and following ndards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other in possible incidents of se or infections should be asmission-based precautions ent spread of infections; blation should be used for a t not limited to:	F	88			

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		ID HUMAN SERVICES MEDICAID SERVICES					03/31/202 APPROVE 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE S COMPLI	ETED
		345529	B. WING	i		C 02/2	4/2025
NAME OF PR	ROVIDER OR SUPPLIER			S	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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ΞIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page	e 143	F	880			
1 000		it the isolation should be the		000			
		ble for the resident under the					
		s under which the facility					
		ees with a communicable					
		kin lesions from direct					
	contact with residents	s or their food, if direct					
		procedures to be followed					
	by staff involved in di						
	§483.80(a)(4) A system for record identified under the facility's IPCF corrective actions taken by the fa	acility's IPCP and the					
	§483.80(e) Linens.						
	Personnel must hand	lle, store, process, and to prevent the spread of					
	§483.80(f) Annual rev	/iew.					
	The facility will condu	ct an annual review of its					
	This REQUIREMENT	ir program, as necessary. is not met as evidenced					
	by: Based on record revi	iew, observation and staff			F880		
		failed to implement infection			1. The facility failed to properly disi	nfect	
	control policies and p	rocedures when staff failed			a shared glucose meter that was sha	red	
		labeled glucometer (a blood			between two residents with an appro		
	glucose meter) that w				cleaning agent. The facility failed to u		
		sidents (Resident #35) lood glucose level checked.			an approved cleaning agent for a glu meter that was stored outside of the	cose	
		can be contaminated with			resident⊡s room. The facility failed to	o don	
		eaned and disinfected after			and remove PPE when caring for a		
	anch use with an ann	roved product and			COVID-19-positive patient. The facili	-	
		-					
	procedure. Failure to	use an Environmental			failed to review and document annua		
	procedure. Failure to Protection Agency (E	-			failed to review and document annua infection control practices. The facilit failed to keep linen carts in hallways		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/31/2025 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SL COMPLE	
		345529	B. WING _				C / 24/2025
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				52	01 CLARKS FORK DRIVE NW		
UNIVERS	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	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	occurred with six resi as having a diagnosis bloodborne pathogen individually assigned the resident's room w disinfectant in accord manufacturer's instru- (Resident #32); (3) do protective equipment COVID isolation room exiting the room; (4) e of annual review of in procedures; and (5) o located in the hallway accidental contamina carts were observed o halls). These deficien residents residing in t #32 and #230). Immediate jeopardy b am when Nurse #1 w blood glucose test on glucometer and not d before and after perfor test. Immediate jeop 2/19/25 when the faci acceptable credible a jeopardy removal. Th compliance at a lowe E (no actual harm wit harm that is not imme #2, #3, #4, and #5 for employee and agency	dborne infections. This dents in the facility identified is that included one or more s; (2) disinfect an glucometer stored outside of vith an EPA-registered ance with the ctions of the glucometer on necessary personal (PPE) before entering a n and remove PPE before evidence and documentation fection control policies and cover the linen on linen carts v to reduce the risk of tion. The uncovered linen on 2 of 5 halls (300 and 400 t practices affected 3 of 127 the facility (Residents #35, began on 2/17/2025 at 5:50 as observed performing a Resident #35 using shared isinfecting the glucometer orming the blood glucose ardy was removed on ility implemented an llegation of immediate e facility will remain out of r scope and severity level of h a potential for minimal ediate jeopardy) for findings the facility's completion of y nursing staff training with ring to ensure effective plemented.	F	380	 Current residents who require finestick blood sugars received their own individual glucometers, and they were labeled and placed in an individual container. The was completed by the Director of Nursing and the Assistant Director of Nursing on 2/18/2025. Education was completed on 2/18/202 by the Director of Nursing on the appropriate cleaning agent to be used. Rooms with transmission-based precautions were audited to ensure P is available and appropriate signage is available. This was completed by the Director of Nursing on 3/19/2025, An was completed by the Director of Nursing on 3/19/2025, An was completed by the Director of Nursing on 3/19/2025, An was completed by the Director of Nursing on 3/19/2025. Education was started by the Director of Nursing on 2/18/2025 to current licensed nursing staff, including agenestaff, on proper procedure for cleaning glucometers and for proper storage of glucometers. Employees not receiving education will not be allowed to work the education is received. The Director Nursing will track the education to enst that current staff have received. Education also includes the proper cleaning technique as recommended the manufacturer guidelines. The cleaning the medication will be kept on each medication 	25 Int PE s audit sing nd ed ector cy f this until or of sure o l an rt. by uning	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/31/202 MAPPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C / 24/2025
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			201 CLARKS FORK DRIVE NW ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	manual dated 2016 p cleaning and disinfect the facility. It stated, glucose monitoring s potentially infectious transmitting blood-bo patients and healthca should be disinfected This blood glucose m be used for testing m standard precautions disinfection procedur manufacturer's instru- registered wipes for o glucometer and state wipes may be used fo glucometer used by t The cleaning and dis instructions included, Step 3: inspect for blo anywhere on the met must be thoroughly of the meter. Step 4: Clean the me cloth dampened with all external areas of the with an approved disi external areas of the back surface until vis The instructions for the	anufacturer's operator provided instructions for ting the glucometer used at in part: all parts of the ystem should be considered and are capable of rne pathogens between are professionals. The meter after use on each patient. nonitoring system may only ultiple patients when and the manufacturer's es are followed. The ctions listed approved EPA cleaning and disinfecting the d other EPA registered or disinfecting the he facility. infecting step-by-step in part: bod, debris, dust or lint ter. Blood and bodily fluids leaned from the surface of eter using a moist lint-free a mild detergent and wiping he meter including the front til visibly clean. meter, cleaning the surface infectant wipe and wiping all meter including front and ibly wet.	F	380	cart. The Director of Nursing or charge nurse will check the med carts daily to ensure that the cleaning product is present on each med cart. The Direct Nursing educated the charge nurses 2/18/2025. The Director of Nursing we educated on this process by the Administrator on 2/18/2025. Current Licensed Nurses will complet skills return demonstration on glucon cleaning and storage. This will be completed by the Director of Nursing licensed nurse will not be allowed to until return demonstration has been completed. The Director of Nursing we track the education to ensure that cut staff have received. The Director of Nursing or charge nut responsible for ensuring new admisss who require finger stick blood sugarss provided with their own individual glucometer that is labeled with their r and stored in an individual container. Director of Nursing was educated on process by the Administrator on 2/18/2025. The charge nurses are educated on this process by the Director of Nursing on 02/18/2025. New licensed nurses will receive this education and verify competencies d the orientation process by the Director Nursing or charge nurse. Agency nur will receive this education and competencies prior to the start of the shift. The charge nurses were educat on this responsibility by the Director of	o tor of on ras te a heter . Any work <i>v</i> ill rrent rse is ions are this are this ctor uring or of rses ir ted of	
	wipe was an effective	ted 2023 stated the minute virucide, bactericide, ngicide on hard non-porous			Nursing on 02/18/2025. The Director Nursing will assign the charge nurse complete this task when needed.		

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		MEDICAID SERVICES				0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	
			A. BUILDING	2	с	
		345529	B. WING		02/24	/2025
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZI		
				5201 CLARKS FORK DRIVE NW		
UNIVERS.	AL HEALTH CARE/NORT			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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 146	F 88	30		
		g the disinfectant wipe, apply	1 00	Education provided to cu	urrent staff	
		on-porous surface (the		including agency staff re		
		it to remain wet for one		transmission-based prec	• •	
	minute and allow the			appropriate PPE to use	while caring for a	
				COVID positive resident		
		am in preparation to check		by the Director of Nursin	g began on	
		glucose, Nurse #1 was		3/19/2025.		
	observed searching f			Any staff member not re- will not be allowed to wo		
	-	I stated each resident had gned glucometer to check		received.	rk unul education	
		Nurse #1 was observed		Agency staff will receive	education prior to	
		er of the 100-hall medication		the start of their shift by	-	
		cometer pouches labeled		Nursing or designee.		
	with Resident #66's,	Resident #33's and Resident		New staff will receive ed	ucation during the	
		n number upward toward		orientation process.		
		vas observed locking the		Education was provided		
		art and walking to the		including agency staff re		
		cart before returning to the		linen carts covered at all		
		art and reopening the top ipped Resident #66's,		Any staff not receiving end be allowed to work until		
		Resident # 93's labeled		received. Agency staff w		
		upward toward her and		education prior to the be		
		33's glucometer pouch.		shift.	5 5	
		led glucometer not in a		New staff will be educate	ed by the Director	
		ouch observed underneath		of Nursing during the ori	entation process.	
		meter pouch. Nurse #1		Director of Nursing or de		
		glucometer was Resident		10 resident glucometer o		
	#35's glucometer and			weeks, then 5 x 4 weeks	-	
		meter before performing a Resident #35 on 2/17/2025		4 weeks. then 3 monthly The Director of Nursing		
		was observed returning the		audit the med carts for c		
		meter to the top drawer of		3x weekly x 4 weeks, the		
		on cart without disinfecting		weeks, then weekly x 4	-	
	the glucometer.	5		monthly x 2		
				The Director of Nursing		
		am in an interview with		residents requiring gluco		
		Resident #35 did not have a		glucometers present 3x		
		ouch and there were two		then 2x weekly x 4 week		
	alucometers in Resid	ent #66's pouch earlier, and		weeks, then monthly x 2		

Facility ID: 20040007

			0.00			NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	· · ·	ATE SURVEY
			A. BUILDING			С
		345529	B. WING	WING		02/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02/24/2025
				5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AI DEFICIENCY)	PPROPRIATE	DATE
F 880	Continued From page	e 147	F 88	30		
	the glucometer that w	as not found in a		Director of Nursing or designee	to audit	
		ust have fallen out of the		10 transmission-based rooms f		
	unzipped glucometer	pouch of Resident #66. The		appropriate PPE use weekly x	4 weeks,	
	glucometer in Reside			then 5 weekly x 4 weeks, then 3		
	-	Nurse #1 stated she did not		4 weeks, then weekly x 8 week		
	know which glucomet	ter was Resident #35's and		Director of Nursing or designee	will audit	
		d glucometer that was not in		linen carts for coverings 5x wee		
	a labeled glucometer	pouch to perform Resident		weeks, then 3 x weekly x 4 wee	eks, then	
		Nurse #1 stated the reason		weekly x 4 weeks then monthly	x 2.	
	she did not disinfect t	he glucometer before		4. Results will be reported by	the	
	performing the blood	glucose was because the		Director of Nursing to the qualit	у	
	staff member who use	ed the glucometer before		assurance meeting x3 months	or further	
	she used it should ha	ve disinfected the		resolution as needed.		
	glucometer. Nurse #1	stated she did not think				
	-	glucometer after performing		5. Date of completion: 3/25/202	5	
	-	t. Nurse #1 was observed				
		pad from the top drawer of				
	, , ,	on cart and wiping the				
	unlabeled glucometer					
		pouch with the alcohol pad				
	-	abeled glucometer to the top				
		I medication cart. She				
		infected glucometers with				
		sident #35 was the only				
		ring she had to perform.				
		8 am in an interview with				
		due to Medication Aide #5				
		100-hall medication cart on				
		0 am to 7:00 pm shift, she				
	performed Resident #					
	-	d Resident #35 did not have				
		ed glucometer and when				
	performing Resident	-				
		eled glucometer that was				
		d pouch with resident's				
	name and room num					
		used for Resident #35 and				
	Resident #31, who al		1	1		1

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	individually assigned used disinfectant wipe medication cart to dis glucometer after each On 2/18/2025 at 10:4 interview with Nurse 4 the unlabeled glucom labeled with a resider on the 100-hall medic #35's glucometer on 2 the blood glucose mo Resident #31 also rec monitoring and did no assigned glucometer, Resident #35 and Re unlabeled glucometer Nurse #1 stated she v and disinfect a glucor orientation and was u instructions on how to at the facility. She rep disinfectant wipes on to clean the glucometer 2/17/2025. On 2/18/2025 at 10:3 Central Supply, she re disinfectant wipes in t stated she restocked with disinfectant wipe 2/17/2025 upon repor to 3:00pm shift. On 2/17/2025 at 6:50 Director of Nursing (E did not have an indivi for every resident rec	glucometer. She stated she es on the 100-hall infect the unlabeled in use. 2 am in a follow up phone #1, she stated she thought eter that was not in a pouch it's name and room number ration cart was Resident 2/17/2025 when performing nitoring. She stated beived blood glucose of have an individually and she had forgotten sident #31 shared the not in a labeled pouch. Was trained on how to use neter with employment nable to recall the borted there were no the 100-hall medication cart fer on the morning of 0 am in an interview with the eported there were no the central supply room. She the 100-hall medication cart s on the morning of ting to work for the 7:00am	F	880			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/31/2025 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	FIPLE	E CONSTRUCTION	(X3) DATE	
AND I LAN OF	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			C
		345529	B. WING				_ 24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH			5201 CLARKS FORK DRIVE NW		
				ł	RALEIGH, 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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page medication carts that residents. The DON s disinfected the glucor between the residents EPA-disinfectant wipe to dry for two minutes labeled glucometer po The Regional Director indicated via email on there were six current identified as having a or more bloodborne p The Administrator was jeopardy (IJ) on 2/18/ The facility provided t removal: Identify those recipier are likely to suffer, a s a result of the noncom Nurse #1 failed to ens unidentified glucomet Resident #35 and Res medication cart was o to and after use. (Res thought the glucomet unlabeled / unidentified used on Resident #31 Nurse #1 indicated th Resident #35 was ind stated she did not thir disinfecting the unlab	 a 149 were shared between stated Nurse #1 should have neter that was shared s with the facility's as and allow the glucometer before storing in resident's ouch. r of Clinical Services 1 2/18/2025 at 5:26 pm that t residents in the facility diagnosis that included one bathogens. s informed of the immediate 2025 at 2:00 pm. he following plan for IJ hts who have suffered, or serious adverse outcome as npliance. sure an unlabeled / er that was shared between sident #31 on the 100-hall cleaned and disinfected prior sident #35). Nurse #1 er was individually assigned had forgotten that the ed glucometer was also 1. e glucometer used for lividually assigned. She hk about cleaning and eled / unidentified 		880	DEFICIENCY)		
	Nurse #1 indicated th Resident #35 was ind stated she did not thir disinfecting the unlab- glucometer after perfo	e glucometer used for lividually assigned. She nk about cleaning and					

Facility ID: 20040007

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345529	B. WING			0	C 2/24/2025
NAME OF P	ROVIDER OR SUPPLIER	I	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	glucometer with alcoh Nursing stated the fac glucometer for every glucose monitoring at on the medication can residents. The DON s be cleansed with an ap be cleansed with an ap procedure. Failure to disinfectant in accord manufacturer's instru- glucometer potentially spread of blood borne current residents with having a diagnosis with blood borne pathoger The following immedia affected residents: The facility Medical D Administrator of the fa deficient practice for I process of each resid designated glucometer the current process for glucometers with no f recommendations we #35. The local county Hea Communicable Disea by the facility Adminis further recommendati	nol wipes. The Director of cility did not have a resident receiving blood nd some of the glucometers ts were shared between stated glucometers were to approved disinfectant. Can be contaminated with eaned and disinfected after roved product and use an EPA-registered ance with the ctions to disinfect a shared y exposes residents to the e infections. There are six in the facility identified as hich included one or more ns. ate actions were taken for virector was notified by the acility on 2/18/2025 of the Resident #35 and of the new lent having their own er. He is in agreement with or cleaning and storage of further recommendation. No are provided for Resident	F	880			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/31/2025 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY
		345529	B. WING			(02/2) 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				5201 CLARKS FORK DRIVE	NW		
UNIVERS	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	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
TAG F 880	Continued From page FSBS and all forty har individual glucometer. Nursing completed ar Specify the action the process or system fai adverse outcome from when the action will b Current residents who sugars received their and they were labeled container. The was co Nursing and the Assis 2/18/2025. Education was started on 2/18/2025 to curre including agency staff cleaning/disinfecting g storage of glucometer this education will not education is received. track the education to have received. Education includes ea finger stick blood sug glucometer that is lab stored in an individua cart. Education also in technique as recomm guidelines. The clean each medication cart.	e 151 ve been provided their . The Assistant Director of a audit on 2/18/2025. entity will take to alter the lure to prevent a serious n occurring or recurring, and	F 880	DE		TE	DATE
	each med cart. The D the charge nurses on	ng product is present on irector of Nursing educated 2/18/2025. The Director of d on this process by the /2025.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	5201 CLARKS FORK DRIVE NW		
UNIVERS	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	• 152	F	880			
	require finger stick ble their own individual g with their name and s container. The Directo on this process by the 2/18/2025. The charg this process by the D 02/18/2025. New licensed nurses during the orientation Nursing or charge nu nurses will receive thi of their shift. The cha on this process on 02 Nurse. The Director of charge nurse to comp Immediate Jeopardy The facility's credible jeopardy removal was A phone interview wit 2/18/2025 validated to physician of the defic was implementing ne individual glucometer the nursing staff on hi glucometer after use of the 43 residents' (4 2/18/2025) individuall currently resided in th validated each reside monitoring had an inco glucometer in a gluco their name and room	ing new admissions who bod sugars are provided with lucometer that is labeled tored in an individual or of Nursing was educated e Administrator on e nurses are educated on irector of Nursing on will receive this education process by the Director of rse on 02/18/2025. Agency s education prior to the start rge nurses were educated /18/2025 by the Director of of Nursing will assign the olete this task when needed. Removal Date: 2/19/2025 allegation of immediate s validated on 2/22/25. h the medical director on he facility had notified the ient practices that included an per resident and educating ow to disinfect the on a resident. Observation 40 plus 3 admissions since y assigned glucometers who ie facility on 2/22/2025 nt receiving blood glucose					

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	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY MPLETED
	CONNECTION		A. BUILDING	3		
		345529	B. WING			С
		345529	B. WING			2/24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE NW		
				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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 880	Continued From pag	e 153	F 88	30		
		rvice training was conducted	1.00			
ç	in regard to the use of individually assigned glucometers for resident blood glucose					
	0	fection control practices for				
		icometers. All licensed				
	-	re interviewed reported they				
		uired in-service training on				
	2/18/2025 or prior to					
		/18/2025. The educational				
	in-services stressed	using individually assigned				
	glucometers for each	resident requiring blood				
	glucose monitoring and storing each individual					
	assigned glucometer	in an individually labeled				
		th resident's name and room				
		ce training also included a				
		cturer's instructions for the				
		and disinfectant wipes				
		n of the glucometer and				
		ned demonstration of the				
		effective glucometer				
		bservation in conducting a				
		and subsequent glucometer				
		ed the task without difficulty.				
		resident glucometers were he medication carts in closed				
		n resident's name and room				
		ation cart was observed with				
		infectant wipes. There was				
		I new glucometer observed				
		cart that licensed nursing				
		h interviews the new unused				
		ailable for new admissions,				
	-	ident's individually assigned				
		emergency as needed. To				
		d of a new glucometer used				
		ter, the facility removed the				
		eters from each medication				
		e storage of the new unused				
		nedication storage rooms on				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING				C /24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 880	each unit. There were identified during eithe observations. The immediate jeopar 2/19/2025 was valida 2. The manufacturer's 10/2019 for Resident provided instructions the glucometer used a part: to minimize the n blood-borne pathoger disinfecting procedure each use. The manuf approved EPA registed disinfecting the glucoor registered wipes may glucometer used by th The cleaning and disi Resident #32's individincluded in part: Step 5: using one EP, wipe the entire surface horizontally and vertion pathogens and Step 6: Treated surface meter in a towelette. The instructions for the disinfectant wipes date wipe was an effective tuberculocide and fun- surfaces. When using the wipe to a hard, no	e no further concerns r the interviews or rdy removal date of ted. s operator manual revised #32's assigned glucometer for cleaning and disinfecting at the facility. It stated, in risk of transmitting ns, the cleaning and e should be performed after acturer's instructions listed ered wipes for cleaning and meter and stated other EPA be used for disinfecting the ne facility. nfecting procedure for dually assigned glucometer A disinfectant towelette to e of the glucometer cally to remove bloodborne ce must remain wet for the et time. Do not wrap the the disinfectant wipe, apply on-porous surface (the it to remain wet for one	F	880			

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	-	ID HUMAN SERVICES				FORI	M APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION		D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` <i>`</i>		à		PLETED
		345529	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER	545525	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	02	/24/2025
					5201 CLARKS FORK DRIVE NW		
UNIVERS	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page	e 155	F	88	0		
	On 2/18/2025 at 7:51 (agency) was observer monitoring using an ir glucometer for Reside blood glucose level, M observed cleaning Re assigned glucometer On 2/18/2025 at 7:57 Medication Aide #1, s glucometer needed to and she cleaned the g pad because she did wipes on the 300-hall On 2/18/2025 at 10:2 with Medication Aide # training less than a m using disinfectant wip after use. She stated wipes on the 300-hall did not know the disin 300-hall medication c checked the 300-hall On 2/18/2025 at 5:10 Director of Nursing, s individually assigned disinfected after each wipe. 3. The facility's policy 10/24/2024 stated in Droplet-Contract Prece the Center of Diseas criteria for discontinu -based precautions. T	am, Medication Aide #1 ed performing blood glucose ndividually assigned ent #32. After obtaining a Medication Aide #1 was esident #32's individually with alcohol wipes. am in an interview with the explained Resident #32's o be disinfected after use glucometer with an alcohol not have any disinfectant medication cart. 5 am in a follow up interview #1, she stated she received onth ago at the facility on es to clean glucometers there were disinfectant medication cart, and she offectant wipes were on the art because she had not medication cart. pm in an interview with the he stated Resident #32's glucometer needed to be use using a disinfectant for "COVID-19" dated part: to implement Special cautions until patient meets e Control and Prevention ation of transmission					

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-		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIE		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	NG .			LETED
		345529	B. WING				C 24/2025
NAME OF PROVIDER OR S	JPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSAL HEALTH CARE/NORTH RALEIGH					5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		
PREFIX (EAC			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
maintain tr entering th protective eye protect kept near tr general tra donning th gown, applif required. patient's ro face shield On 2/17/20 observed a N-95 mask On 2/17/20 precaution #230's doc observed a and eye pr inside Res Resident # protection. On 2/17/20 observed a and eye pr inside Res Resident # protection. On 2/17/20 observed a and eye pr inside Res Resident # protection.	ated 12/1/2 ansmission e patient's measures: tion, gowns he entrance sh placed e protective y mask, pu Removing om in the fill gown and 25 at 4:20 pplying an before en 25 at 4:22 s sign obse r. A three- putside Res gowns, fac otection. N ident #230 230 vital s 225 at 4:27 exiting Res d removing ind discarce (PPE) into coated in the 230's roon 25 at 4:29 she stated r COVID-1	2021 stated in part: to a based precautions before room and fundamental hand washing, use of mask, a and gloves. Supplies are e and large trash can for inside the room. When e attire: wash hands, put on it on goggles or face shield of protective attire in the trach can: gloves, goggles or d mask. am, Nurse #5 was isolation gown, gloves and tering Resident #230' room. am, there was a droplet erved posted on Resident drawer container was sident #230's door and e mask, N-95 mask, gloves urse #5 was observed 's room preparing to obtain gns not wearing eye am, Nurse #5 was ident #230's room into the g the isolation gown, gloves ling the personal protective one of two large trash cans he hallway outside of	F	880			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345529	B. WING				C / 24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	5201 CLARKS FORK DRIVE NW		
UNIVERS	ERSAL HEALTH CARE/NORTH RALEIGH			F	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				ЗE	(X5) COMPLETION DATE
F 880	#230's door. She stat available to wear and wear eye protection to room because she wa COVID-19. She expla (gown, gloves and N- Resident #230's room trash cans were locat room and she didn't w inside the room. Nurs agency nurse and hav training from the ager worked at the facility to received COVID-19 a facility. On 2/18/2025 at 5:28 Manager #1, she state and placed the wrong precautions on Resident the droplet precaution the use of a N-95 mas to enter Resident #23 signage on Resident been special droplet a She stated the require mask and face shield placed outside Resident to use and the trash of inside Resident #230' remove the PPE insid before exiting the roof On 2/18/2025 at 5:10 Director of Nursing (D #230 was admitted w	as signage on Resident ed eye protection was stated she did not need to o enter Resident #230's as fully vaccinated against ined she removed the PPE 95 mask) after exiting n because of the large grey ed outside Resident #230's vant to contaminate herself e #5 stated she was an d received infection control noy. She stated she had for one week and had not nd PPE training from the pm in an interview with Unit ed she had made an error isolation signage for droplet ent #230's door. She stated as signage did not include sk, gown or eye protection 0 room and the posted #230's door should have and contact precautions. ed PPE (gown, gloves, N-95 for eye protection) were ent #230's door for the staff cans should have been s room for Nurse #5 to le Resident #230's room m. pm in an interview with the DON), she stated Resident ith COVID-19 and she did ch isolation signage was to	F	880			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			LETED
		345529	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVERSAL HEALTH CARE/NORTH RALEIGH					5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 880	 posting the isolation p Resident #230 door. should have worn eye Resident #230's room and should have remove Resident #230's room when she started five she was informed that responsibility also, and any tasks (training, re- control. 4. Review of the facilii Control Policies and F Infection Prevention at effective date of 2/6/2 annual review. During an interview w (DON) #1 on 2/17/25 was responsible for the Control program. The had been in the DON had been unable to re- Prevention and Control In an interview with C #1 on 2/22/25 at 5:00 was currently working Prevention and Contron Nurse Consultant #11 of annual review and and Control policies at 5. Review of the facilii 	 ger #1 was responsible for precaution signage on The DON stated Nurse #5 ge protection before entering to provide resident care proved the PPE before exiting to the PPE before exiting to the PPE before exiting the the DON reported that weeks ago at the facility to infection control was here and she had not performed to prove the the transformed to infection ty's Infection Prevention and Procedures revealed an and Control Manual with an 20 with no evidence of th the Director of Nursing at 5:06 pm, she stated she position for 5 weeks and eview the Infection of Prevention and the DON #1 further stated she position for 5 weeks and eview the Infection of Policies. orporate Nurse Consultant pm, she stated the facility on their Infection of prevention and procedures. ty's Infection Prevention and by the facility on their Infection of the prevention and procedures. ty's Infection Prevention and by the facility on the prevention and procedures. 	F	880			
	5. Review of the facili Control policy and pro						

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0930 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED	
345529 B. WING C 02/24/202	2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERSAL HEALTH CARE/NORTH RALEIGH 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	(X5) DMPLETION DATE
F 880 Continued From page 159 for individual use." F 880 The clean linen cart on the 300 hall was observed on 2171/25 at 328 pm with the front cover pulled up and resting on the top of the mesh covered plastic pipe line cart. During an interview with Unit Manager #1 on 2171/25 at 330 pm, she stated all linen carts should be covered for infection control purposes. Unit Manager #1 placed the covering correctly on the linen cart. A continuous observation was made on 2/18/25 from 9:03 am until 9:10 am of the linen cart on the 400 hall. The front cover was pulled up and was resting on the top of the mesh covered plastic pipe linen cart. Clean gowns, towels, wash clothes, and blankets were observed on the cart. The maintenance staff was observed walking by pulling furniture at 9:05 am and Physical Therapy staff was observed walking by with bagged trash in hand 49:09 am. Another NA with a plate and cup in hand was observed walking by at 9:09 am. The linen cart front covered was closed by a NA at 9:10 am. During an interview on 2/28/25 at 9:35 am with NA #5, she stated the linen carts should be covered atter retrieving the items needed for resident care for infection control prevention. The clean linen cart on the 300 hall was observed for a second time on 2/21/25 at 12:29 pm with the front covering on top of the linen cart. During an interview with Nursing Assistant (NA) #3 on 2/21/25 at 12:39 pm sets tasted the linen	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345529	B. WING _				C 24/2025	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH			201 CLARKS FORK DRIVE NW ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE			
F 880	Continued From page carts are supposed to use due to infection of immediately placed th correctly. During an interview w Manager on 2/18/25 a linen carts on the hall towels, wash clothes, residents. She furthe should be covered wh In an interview with th Corporate Nurse Con 5:00 pm, the Administ the linen carts to be of staff were not using th Consultant #1 indicated	e 160 be covered when not in ontrol prevention. She he covering on the linen cart with the Housekeeping at 3:00 pm, she indicated the ways held clean gowns, and blankets for the r indicated the linen carts hen not in use by the staff. he Administrator and sultant #1 on 2/22/25 at trator stated she expected overed when the nursing hem. The Corporate Nurse ed they were working on the		380	DEFICIENCY)			
F 881 SS=F	CFR(s): 483.80(a)(3) §483.80(a) Infection p program. The facility must esta and control program (a minimum, the follow §483.80(a)(3) An anti that includes antibiotic system to monitor and This REQUIREMENT by: Based on facility poli staff interviews the fa antibiotic stewardship antibiotic usage in the	o Program prevention and control blish an infection prevention IPCP) that must include, at ving elements: biotic stewardship program c use protocols and a ibiotic use. is not met as evidenced cy review, record review and cility failed to implement an	F	881	F881 1. The facility failed to implement an effective antibiotic stewardship program one or more areas, resulting in the potential for infection transmission.	n in	3/25/25	

Event ID: PM7D11

Facility ID: 20040007

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE (CONSTRUCTION	r –	NO. 0938-039 TE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G) co	MPLETED	
						С		
		345529	B. WING			02/24/2025		
NAME OF PI	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				5201 CLARKS FORK DRIVE NW				
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		RA	ALEIGH, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 881	Continued From page	e 161	F 88	21				
			1 00	,	2 Current residents are effected by	hio		
	facility.				 Current residents are affected by t practice. 	.1115		
	The findings included	1:			3. Education completed by the Direct	tor		
					of Nursing to the nursing leadership tea			
	Review of the facility			on antibiotic stewardship and surveillar				
	Stewardship Program	n, effective date 10/24/22			This was completed on 3/25/2025.			
	revealed the following				Any new nursing leadership member n	ot		
		n is designed to promote the			receiving education will not be allowed	to		
		ntibiotics, monitoring, and			work until education received.			
	-	cal antimicrobial outcomes,			Any new nursing leadership member w			
	reduce antibiotic resi	stance, to the extent			receive education during the orientatio	n		
	possible."				process by the Director of Nursing or designated Infection preventionist.			
	During an interview v	vith the Director of Nursing			An audit of progress notes and order			
	÷	at 5:06 pm, she stated she			listings will be completed by the nursin	a		
		he Infection Prevention and			leadership team to ensure that new	3		
		e DON #1 further stated she			antibiotics have been identified infectio	n		
	had been in the DON	I position for 5 weeks and			screening and antibiotic timeouts are			
	there was not an Anti	ibiotic Stewardship Program,			completed. This will happen 5 x weekly			
		the time to start one. When			4 weeks, then 3 x weekly x 4 weeks, the	nen		
	-	been monitoring and			2x weekly x 4 weeks, then weekly x 8			
		thin the facility, she replied			weeks.			
		he had just learned there was			4. Results will be reported by the			
		or Antibiotic Stewardship on			Director of nursing or Infection			
	the computer, but she	ש המע חטו עשפט וו.			preventionist to the quality assurance meeting x3 month for further resolution	1.25		
	In an interview with C	Corporate Nurse Consultant			needed.	43		
) pm, she stated the facility			needd.			
		g on their infection control			5. Date of completion: 3/25/2025			
	program which includ	-			·			
	Stewardship Program	n. The department heads in						
	-	gs had discussions about the						
		tibiotics used in the facility.						
		ection control program was						
		d worked as long nursing						
	input the information							
		ections within the facility. Consultant #1 did not have						
		e tracking or trending of						

Facility ID: 20040007

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION		TE SURVEY MPLETED	
		345529	B. WING		02/24/2025		
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP		DDE		
UNIVERS	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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 881	Continued From page		F 88	31			
F 914 SS=D	infection within the fa Bedrooms Assure Fu CFR(s): 483.90(e)(1)	ll Visual Privacy	F 9 [.]	14		3/25/25	
	§483.90(e)(1)(iv) Be o assure full visual priva	designed or equipped to acy for each resident;					
	 §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced 						
	interviews with reside to ensure full visual p	ns, record review, and ent and staff, the facility failed rivacy was available for 1 of) reviewed for the privacy		F914 1. Room 318 privacy curta replaced to ensure full priva completed by 3/25/2025 2. Audit was completed of privacy curtains to ensure fu	icy. This will be f current		
	The findings were:			in place. Audit was complet administrator or designee o	ed by the n 3/19/2025.		
	An observation on 2/16/25 at 10:54 AM of Room #318 revealed that the privacy curtain would not close to provide full visual privacy to the resident. There was approximately 24 inches of the head of the bed and the resident visible from the door. An observation on 2/22/25 at 1:12 PM revealed the privacy curtain did not close fully around the bed. Upon closer inspection it was noted the curtain connectors got stuck where the two tracks were joined since the curtain connectors did not			 Any privacy curtains not in p 3/25/2025. 3. The administrator educ current housekeeping depar current maintenance depart privacy curtain length and th 	ated the rtment and the ment on		
				 maintain privacy. This bega 3/19/2025. Any housekeeping or mainteeping or mainteeping education will to work until education is re- 	n on enance staff not be allowed		
	line up with the secor	nd track. There was nes of the head of the bed		Any new employee will rece during the orientation proce 4. Administrator or design rooms weekly x 4 weeks, th	eive education ss. nee will audit 20		

Event ID: PM7D11

Facility ID: 20040007

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31 FORM APPRO OMB NO. 0938-	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345529	B. WING		02/24/2025	
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP COD		
	AL HEALTH CARE/NORT			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)	I SHOULD BE COMPLE	
F 914	Continued From page	163	F 91	4		
1 014	In an interview on 2/2		F 91	weekly x 4 weeks, then 5 roo	ms weekly	
		Room #318 said the privacy		x4 weeks, then 5 rooms mont		
	curtain had not been	able to be completely pulled		ensure privacy curtains are pr		
	closed for a "long tim			complete privacy. 5. Results will be reported b	w the	
	remember how long. remember telling any	one about the curtain but		Administrator to the quality as		
	said the staff knew.			meeting x1 month for further i		
	In an interview on 2/2	2/25 at 3:31 PM, the Activity		needed. 6. Date of completion: 3/25/20	125	
		pmething in a resident's				
	room was broken or o	didn't work, the staff were				
		ing maintenance through the				
		ion. She said she had not urtain was not closing.				
		Maintenance Logs for 2024 ument the privacy curtain in o be fixed.				
	Attempts to interview Director were unsucc	the former Maintenance essful.				
		2/25 at 5:31 PM, the Interim aid the privacy curtain in				
	Room #318 should ha	ave been reported for repair				
	so that complete visu provided.	al privacy could have been				
	In an interview on 2/2					
		e was not aware the privacy				
		needed to be fixed and was Maintenance Director was				
F 940 SS=E	Training Requiremen	ts	F 94	0	3/25/25	
	§483.95 Training Rec					
	A facility must develo	p, implement, and maintain				

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		ND HUMAN SERVICES			PRINTED: 03/31/20 FORM APPROVE OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED C	
		345529	B. WING		02/24/2025
IAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0====0=0
JNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		201 CLARKS FORK DRIVE NW	
				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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTIC
F 940	Continued From pag	e 164	F 940		
		program for all new and	1 040		
		als providing services under			
	-	ement; and volunteers,			
		expected roles. A facility			
		amount and types of training			
	-	a facility assessment as			
	-	. Training topics must			
	include but are not lin	nited to- F is not met as evidenced			
	by:	I is not met as evidenced			
	-	iew and staff interviews, the		F940	
		ment an effective training		1. The facility failed to implement	an
	•	aff received required training		effective training program to ensure	
	and to maintain docu	mented evidence of trainings		received the required training.	
		sistants (NA #2, NA #8, NA		2. The human resources manage	
		s practice had the potential		conducted an immediate audit of all	
	to affect all residents			current staff to assess completion o	
	The findings included	4.		required training for calendar year 2	.025.
	The infulfigs included	1.		This was completed on 3/19/2025. Current staff to have all required tra	ining
	A review of the 2024	annual education records		for 2025 completed using the Relias	
		ty revealed no documented		electronic training system by 3/25/2	
		unication, resident rights,		All current agency staff will complete	
	compliance and ethic	cs, behavioral health,		orientation training acknowledgeme	nt by
	infection control train			3/25/2025	
		PI training were conducted		The facility hired a staff developmer	
	for the staff.			coordinator on 2/18/2025 to oversee	
	a. NA #9's personnel	file revealed no		mandatory training program of the factor the factor of the	
		mmunication, resident rights,		The facility established a 12-month	
	compliance and ethic			calendar for required training throug	Jh
	infection control or Q present.	API training in 2024 through		Relias electronic training system on 3/19/2025.	
	A mhana internieu			3. Education completed to current	
		as conducted on 2/21/25 at		employees by the Director of Nursir designee on following the Relias	ig or
		She stated she had worked mately 4 years. NA #9		electronic training learning system	
		dementia and abuse training		calendar on 3/25/2025 and complet	ing
		not recall training related to		2025 required education by 3/25/20	•

Event ID: PM7D11

Facility ID: 20040007

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/31/202 RM APPROVE IO. 0938-039
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVE COMPLETED	
		345529	B. WING			C 02/24/202	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	L HEALTH CARE/NORT			52	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 940	communication, reside ethics, behavioral heapolicies and procedur done in 2024 through b. NA #11's personnee documentation of com compliance and ethic infection control and of through present. During a phone intervat at 4:00 pm, he stated abuse training in Sep the date. He further s any training in commu- compliance and ethic infection control polic training in 2024 throu c. NA #2's personnel documentation of com compliance and ethic infection control or Q/ present. A phone interview wa 11:35 am with NA #2. received dementia ca September 2024 but communication, reside ethics, behavioral heap policies and procedur through present.	ent rights, compliance and alth, and infection control res or QAPI training being present. I file revealed no inmunication, resident rights, s, behavioral health, QAPI training in 2024 riew with NA #11 on 2/21/25 he received dementia and tember but could not recall stated he had not received unication, resident rights, s, behavioral health, and ies and procedures or QAPI gh present. file revealed no inmunication, resident rights, s, behavioral health, and API training in 2024 through s conducted on 2/21/25 at She stated she had re and abuse training in does not recall any training ent rights, compliance and alth, and on infection control res or QAPI training in 2024	F	940	Any employee not up to date on requeducation will not be allowed to work Agency staff will receive orientation training acknowledgment at the begin of their shift. Any new employee hired will receive education during the orientation proc A Weekly audit will be completed by Staff Development Coordinator or designee on the Relias learning educ with staff completion. This audit will the completed weekly x 12 weeks, then monthly x 2. The Director of Nursing audit the Staff Development Coordinator □s agency files weekly x weeks, then monthly x 2 for newly scheduled agency staff to ensure the have completed the orientation trainin acknowledgment. 4. Results will be reported by the S Development Coordinator or Director Nursing to the quality assurance meet x3 months for further resolution as needed 5. Date of Completion 3/25/2025	nning ess. the cation be will 12 y ng taff	
	d. NA #8's personnel	file revealed no					

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	2: 03/31/2025 1 APPROVED 2: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY LETED
		345529	B. WING				(02/:	C 24/2025
NAME OF PF	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		•=	
	AL HEALTH CARE/NORT			ŧ	5201 CLARKS FORK DRIVE NW			
				F	RALEIGH, NC 27616			
(X4) ID PREFIX TAG			ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
F 940	Continued From page		F	940				
		nmunication, resident rights, s, behavioral health, and QAPI training in 2024						
	•	to interview NA #8 on It she was unavailable for						
		5 at 5:06 pm. She stated a facility since December,						
	Consultant #1 on 2/22							
	at 5:00 pm, she stated have a Staff Develop the staff educational t	e Administrator on 2/22/25 d the facility did not currently nent Coordinator nurse and raining was the irector of Nursing (DON) #1.						

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