STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	115 WHITE ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to offer the use of glassware/cups to residents who received milk in paper cartons during 2 of 2 meal services in the dining room. Findings included: During a meal service observation in the facility's main dining room on 4/6/16 at 12:35pm, 15 of 27 cognitively impaired residents were served and consumed milk from eight ounce cartons. Residents were served other beverages, such as iced tea and coffee in beverage glasses/cups; but were not offered the use of beverage glasses/cups for their milk. In the facility's main dining room on 4/7/16 at 12:35pm, 13 of 26 cognitively impaired residents were observed being served and consuming milk from eight ounce cartons without being offered the use of beverage glasses/cups. During an interview on 4/7/16 at 1:10pm, The Dietary Manager stated that beverage cups (coffee cups) were available in the dining room. During an interview on 4/7/16 at 1:47pm, the Director of Nursing revealed the facility would	F 241	F0000 This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. 1. All cognitively impaired residents affected by the alleged deficient practice during the facility's meal service are offered the use of beverage glasses/cups for their milk. The Nursing Staff were all inserviced by 4/15/16 regarding the procedure to offer all resident beverage glasses/cups for their milk. No negative outcome was identified by the alleged deficient practice. 2. All residents at the facility have been identified as having the potential to be affected by the alleged deficient practice	5/5/16

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

Electronically Signed | 04/29/2016

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F 241	Continued From page 1 comply with the federal regulation and start serving beverage cups/glasses with the milk cartons.	F 241	during the meal services. All residents are now offered beverage glasses/cup for their milk. No negative outcome was identified by the facility from the alleged deficient practice. 3. The Director of Nursing inserviced all nursing staff regarding the procedure to offer all residents beverage glasses/cups for their milk. All newly hired nursing staff will be trained to the procedure. The Director of Nursing or Supervisor will monitor one meal services daily beginning 5/2/16 for one month and three times per week for two months. The audit results will be recorded on a Quality Improvement Monitoring Tool to assure compliance. 4. The audits will be reviewed monthly by the Director of Nursing and the findings will be reported to the Quality Assurance/Performance Improvement Committee monthly for 3 months for further review and recommendations to assure proper compliance. The Administrator will be responsible to assure compliance of all audits.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and	F 253	1. A Hall sides of corridor missing and	5/5/16

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F 253	Continued From page 2 record reviews, the facility failed to provide a maintained, safe, and comfortable interior on 5 of 6 resident halls (Hall A rooms 101, 103, 105,106 and 110, Hall B rooms 120,122, and 123, Hall C, Hall D rooms 131, 132 and 136, Hall E and common area Nurse ' s Station and Main dining room). Findings included: Upon entrance to the facility on 4/4/2016 and throughout the survey until 4/7/2016 at 12:30pm, the following areas were observed to be in need of repairs: 1.) Hall A There was missing and peeling paint on both sides of Hall A. Baseboards were in need of repair on both sides of Hall A. The door to room 101 had holes and chipped wood were in need of repair. The door to room 103 had paint chipped and deep scratches that were rough to touch. The corner of lower wall in room 105 near the bathroom had missing dry wall, exposed metal and a hole at the bottom of the wall near the baseboard were in need of repair. The door to room 106 had paint chipped and deep scratches that was rough to touch. The corner of the baseboard in room 110 was missing near the bathroom door and exposed a hole. The bathroom paint was missing down to the wood.	F 253	peeling paint has begun to be painted/repaired. However, painting at the top wall of the hall will be completed by 5/5/16 but bottom walls of hall will not be completed by 5/5/16. Facility is installing korogard sheets at the bottom of the walls and the korogard is scheduled to ship from the supplier on 5/25/16 and installation will be completed no later than 6/14/16. A Hall baseboards on both sides of the hall will be repaired by 5/5/16. Room 101 door will be repaired by 5/5/16. Room 103 door will be repaired by 5/5/16. Room 105 lower wall near bathroom will have missing drywall replaced, exposed metal repaired and the baseboard repaired by 5/5/16. Room 106 door will be repaired by 5/5/16. Room 110 missing baseboard near bathroom door and bathroom wall will be painted down to the wood by 5/5/16. B Hall sides of corridor missing and peeling paint has begun to be painted/repaired. However, painting at the top wall of the hall will be completed by 5/5/16 but the bottom wall of the hall will not be completed by 5/5/16. Facility is installing korogard sheets at the bottom walls of the hall and korogard is scheduled to ship from the supplier on 5/25/16 and installation will be completed	

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F 253	Continued From page 3 2.) Hall B Hall B has a scuffed wall with missing and peeling paint on both sides of the hall. The baseboard was in need of repair. The resident's floor ' s edging was chipped and rough to the touch in several room on this hall. The door to room 114 had deep scratches and were rough to touch. The floor in room 120 are in disrepair. The door edging in the bathroom was chipped and rough to touch. Paint were peeling off the wall. The door to room 122 had deep scratches and the floor was in disrepair. The door edging in the bathroom was chipped and rough to touch. The paint were peeling off the wall. The door edging in room 123 ' s bathroom was in disrepair. It had chipped wood which was rough to touch and paint was peeling off the wall. 3.) Hall C Hall C had missing and peeling paint on the right ride of the hall and many baseboard were in need of repair. The main dining room had missing and peeling paint on the wall near the TV and all baseboards were in need of repair. The walls surrounding the Nurses Station had missing and peeling paint and all baseboards were in need of repair.	F 253	no later than 6/14/16. The baseboards and chipped/rough floor edging will be repaired by 5/5/16. Room 114 door will have deep scratches repaired by 5/5/16. Room 120 floor will be repaired; the chipped door edging and peeling paint on the wall will also be repaired by 5/5/16. Room 122 door will have deep schraches; the chipped door edging and peeling paint on the wall will be repaired by 5/5/16. Room 123 chipped bathroom door and peeling paint on the wall will be repaired by 5/5/16. C Hall sides of corridor missing and peeling paint has begun to be painted/repaired. However, painting at top wall of the hall will be completed by 5/5/16 but bottom walls of the hall will not be completed by 5/5/16. Facility is installing korogard sheets at the bottom walls of the hall and korogard is scheduled to ship from the supplier on 5/25/16 and installation will be completed no later than 6/14/16. The baseboards will be repaired by 5/5/16. Main dining room missing/peeling paint and baseborads will be repaired by 5/5/16. Nurses station walls will have missing and peeling paint and baseboards repaired by 5/5/16.	

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F 253	Continued From page 4 4.) Hall D Hall D had missing and peeling paint on both sides of the hall. Doors to residents ' rooms had scratches. Several door frames had rough edges and missing and peeling paint. All baseboards were in need of repair. The wall in room 131 had scrape marks near the Resident ' s bed with missing and peeling paint throughout the room. The door to the bathroom had missing and peeling paint. The wall in room 132 had scuffed marks. The door to bathroom had holes on it. The bathroom door in room 136 had several holes on it with missing and peeling paint. 5.) Hall E Hall E had missing and peeling paint on both sides of the hall. Doors to residents ' rooms had scratches. Door edges were visibly splintered and rough to the touch in several rooms. Baseboard were in need of repair. Wood was chipped off the doors also. On Hall E by the Nourishment Center on the wall was large brown stains, rough to touch with peeling and missing paint around it. The baseboard was in need of repair. An interview with the Maintenance Director on 4/6/2016 at 3:30pm revealed that he had repair logs with repairs and concerns from staff and residents. During an interview with the Administrator on 4/6/2016 she indicated a requisition for Paint/Cove base was submitted for	F 253	D Hall side of corridor missing and peeling paint has begun to be painted/repaired. However, painting at the top wall of hall will be completed by 5/5/16 but bottom wall of the hall will not be completed by 5/5/16. Facility is installing korogard sheets the the bottom wall for the hall and korogard is scheduled to ship from supplier on 5/25/16 and installation will be completed no later than 6/14/16. The scratches on doors, rough edges and missing/peeling paint on door frames and all baseboards will be repaired by 5/5/16. Room 131 wall near residents bed and bathroom door will have missing/peeling paint repaired by 5/5/16. Room 132 scuff marks on the wall will be painted and the holes in the bathroom door will be repaired by 5/5/16. Room 136 bathroom door will have missing/peeling paint and holes in it repaired by 5/5/16. E Hall corridor missing and peeling paint has begun to be painted/repaired. However, painting at the top wall of the hall will be completed by 5/5/16 but the bottom wall of the hall will not be completed by 5/5/16. Facility is installing korogard sheets at the bottom walls of the hall and korogard is scheduled to ship from the supplier on 5/25/16 and installation will be completed no later than 6/14/16. The scratches/rough/splinter and chipped resident room doors and	

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F 253	Continued From page 5 repairs and the facility to be painted. The Administrator revealed the requisition had not been approved, however it was submitted on 3/21/2016. The Maintenance Director revealed all repairs in the repair logs had been completed except the issues with the front door bell in the lobby. During a review of the facility maintenance work repair logs they had no work orders for any items needing repairs that were listed above. The Nurses Station repair logs on 4/6/2016 at 4pm revealed no concerns and issues with the names and room numbers listed above. Also there were no concerns or issues with the peeling and missing paint throughout the facility addressed in the repair logs. An interview, and subsequent walk-through, was conducted on 4/7/2016 at 12:30pm with both the Maintenance Director and the Administrator. The Maintenance Director indicated maintenance work orders were located at the Nurse's Station at the Center of the building, staff knew how to and could fill out the book if they noticed repairs that needed to be made and that he had completed everything in the book except the doorbell. The Maintenance Director indicated at the end of the tour, that the items identified on the walk through were not all the issues or concerns with residents ' rooms and the facility. He also indicated that improvement/renovation needed to be done in the overall building. The Administrator indicated that she knew the facility needed repairs but she was not aware of the holes in the residents' room. The Administrator also revealed that maintenance on	F 253	baseboards will be repaired by 5/5/16. E Hall Nourishment Room outside of the door will have the stain and rough to touch area on the wall and missing/peeling painted repaired by 5/5/16. All baseboards will be repaired by 5/5/16. 2. All residents have the potential to be affected by the alleged deficient practice. An audit of all the facility environment will be conducted by 5/5/16 and all environmental issues will be scheduled to have repairs made within 60 days. A Quality Improvement Monitoring Tool will be used to monitor repairs needed. 3. All staff will be inserviced regarding how to request a maintenance request work order by 5/5/16. All work orders will be addressed by the Maintenance Director daily. Administrator to monitor all work order repairs are being completed timely. 4. All Department Managers will make daily rounds (Monday - Friday) beginning 5/4/16 to monitor facility's environment ongoing and make note repairs needed on a Quality Improvement Tool and items will be discussed at each morning department manager meeting. Audit findings of daily rounds will be presented monthly times three months by the Administrator to the Quality Assurance/Performance Improvement Committee for further review/recommendations to assure proper	

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F 253	Continued From page 6 the resident doors would begin next Thursday On 4/7/2016 at 1:30pm after interviewing and doing a walk -through of the facility with the Administrator, and the Maintenance Director at 12:30pm, the Administrator provided a document titled, " Repairs Needed to Doors " dated April 6, 2016. That was done during the survey. During an interview with Administrator on 4/7/2016 at 3pm revealed that her expectation of the facility was to fix the repairs of the issues brought to her attention and maintenance staff by the surveyor as soon as possible.	F 253	compliance. The Administrator will be responsible to ensure compliance of all audits.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		5/5/16

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F 356	Continued From page 7 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to maintain daily posting of Nurse Staffing that included the facility name, the total worked hours and posting the facility Daily Staffing in an area that could be seen or located by the residents, staff and visitors for the four days of the recertification survey 4/4/2016, 4/5/2016, 4/6/2016 and 4/7/2016. Findings Included: During a record review on 4/7/2016 of the Medicare/Medicaid Daily Census sheet dated April 5 through April 7 indicated that the posting used by the facility did not include the facility name, the total number of hours worked for licensed and unlicensed staff on each shift. During tour on 4/7/2016 at 2pm, the location of the daily staffing could not be found. On 4/7/2016 at 2:30pm the daily staffing sheet was located on the Administrator office door. The Administrator ' s office door was open and the daily staffing sheet was located within. The daily staffing sheet was not easily seen or located by resident, staff and visitors. The daily staffing sheet did not include the facility name, the total number of hours worked for licensed and unlicensed staff on each shift. During an interview with the Director of Nursing	F 356	1. The dsily nursing staffing information sheet was corrected as of 4/18/16 to also include the facility name ant the total number of hours worked by licensed and unlicensed nursing staff on each shift. The sheet was relocated from the Administrator's office door to the bulletin board outside the nurses station. It is readily accessible to resident and visitors and is in a clear and readable format. The new form will be used ongoing daily. No negative outcome was identified by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. No negative outcome was identified by the alleged deficient practice. 3. The Administrator, Director of Nursing or the Supervisor will audit daily to assure the nurse staffing information sheet is posted at the nurses station and is in a clear and readable format with the facility name, the current date, the total number and actual hours worked by licensed and unlicensed nursing staff and the current	

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F 356	Continued From page 8 (DON) on 4/7/2016 at 3:30pm, she stated that " we had used this daily staffing sheet for 5 year " . The DON indicated that she would make the changes.	F 356	facility census. A Quality Improvement Monitoring Tool will be completed daily by the Director of Nursing, Administrator or Supervisor for three months to assure compliance daily. 4. Audit findings of daily quality improvement monitoring will be presented monthly times three months by the Administrator of Director of Nursing to the Quality Assurance/Performance Improvement Committee for further review/recommendations. The Administrator will be responsible to ensure compliance of all audits.	