STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	**410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526**

(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
E 000	Initial Comments An unannounced recertification and complaint survey was conducted 11/12/2019 through 11/16/2019. The facility was found in compliance with the requirement CFR.483.73, Emergency Preparedness. Event ID E02R11.	E 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		12/7/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 583	Continued From page 1 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure a resident's medical information was confidential when a kiosk wall chart was observed on and visible to the public for 1 of 1 residents reviewed for and confidentiality (Resident #84). Findings included: Review of the medical record of Resident #84 indicated the resident was admitted to the facility 10/24/2019 with cumulative diagnoses which included Atrial Fibrillation and Chronic Venous Insufficiency. The resident's admission Minimum Data Set (MDS) dated 10/31/2019 indicated the resident was cognitively intact. A continuous observation was conducted on 11/13/2019 and revealed the following: At 10:45 AM on 11/13/2019, the wall kiosk was observed on in the 700 resident hallway. The kiosk screen was showing Resident #84's face, name and medical and care information. No staff were observed on the hall at this time. Information clearly visible on the kiosk screen to anyone who walked by the screen included the resident's do not resuscitate (DNR) status and care areas which included the resident had bowel training on 11/13/2019 at 2:00 PM and bath day 11/13/19 at 2:00 PM. Other areas showing for	F 583	The kiosk showing Resident #84's medical information was immediately turned off by nursing assistant (NA) #1 on 11/13/19 when she became aware the kiosk had not shut down when she stopped documenting ADLs so she could answer a call light. An immediate in-service regarding protecting residents' health information began on 11/13/19 and continued until all NAs and nurses were educated by the Director of Nursing (DON), the Assistant DON and/or the Unit Manager. Education completed 12-6-2019. Any nursing staff who did not receive the education by 12-6-2019 will not be allowed to work until the education is received. Education included closing the kiosk when leaving the kiosk and closing computers when documentation has been completed. Education regarding protecting a resident's health information will be included during the orientation of all new hires. Audits of kiosks on all halls will be conducted at random times on random shifts 7 times per week x 2 weeks, then 5 times a week x 2 weeks. Audits will continue 3 x per week and continuing until QAPI team determines the deficient practice is resolved. Results of the random audits will be recorded on an audit sheet to include the hall, shift and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 583	Continued From page 2 11/13/2019 at 2:00 PM included activities of daily living (ADL) performance dates and times. At 10:58 AM nursing assistant (NA) #1 was observed turning the kiosk off. In an interview with NA #1 on 11/13/2019 at 11:00 AM, the NA stated the wall device was a kiosk for charting on residents. She also stated it should not have been left on showing the resident and her personal information. During the continuous observation, several staff members were observed walking on the hall and passing directly by the kiosk prior to NA #1 turning it off at 10:58 AM. In an interview with the facility Director of Nursing (DON) on 11/14/2019 at 12:40 PM, the DON stated by not turning the kiosk off when it was not in use, the facility staff failed to protect the resident's medical information from public view.	F 583	time of day. Any staff member found to have left the kiosk or the computer open with visible medical information will be immediately re-educated. Repeated offenses by the same staff member will result in corrective action. The audits will be completed by the Administrator, DON, ADOM, UM or nursing supervisors. Administrator will ensure compliance. Results of the audit will be presented monthly until resolution to the Quality Improvement Committee by the DON.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of functional status for 1 of 27 sampled residents. (Resident #45) Findings included: Resident #45 was admitted to the facility on	F 641	The facility failed to locate and present ADL flow sheet necessary to demonstrate accuracy of one quarterly MDS assessment prior to completion of annual health survey visit resulting in citation for deficient practice. The flow sheet supporting the accuracy of the assessment has since been located and is now an accessible part of the medical	12/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 641	Continued From page 3 6/21/17 with anemia, heart failure, hypertension, benign prostate hypertrophy, neurogenic bladder, diabetes mellitus, thyroid disorder, dementia, anxiety and depression listed as diagnoses. The annual MDS dated 2/17/2019 noted resident #45 was cognitively intact and needed limited assistance of one person with transfers and ambulation. Quarterly MDS assessments followed with resident #45 coded to require extensive assistance with one and two persons for transfers without documentation of a change in resident #45 condition. A review of the care plan for resident #45 revealed a risk for falls was reviewed and dated on 2/26/2019 as ongoing; and a fall was dated for 9/8/2019 without injury with a referral to therapy. The occupational therapy notes dated 9/17/2019 revealed resident #45 received therapeutic exercises to strengthen both upper extremities for functional transfers using toilet and arm rest until 10/7/2019. The last MDS quarter assessment dated 10/7/2019 coded resident #45 as needing extensive assistant with two persons assist. An interview was conducted with resident #45 on 11/12/2019 at 9:42am and resident #45 admitted experiencing a fall in the bathroom when transferring from the toilet to the wheelchair. Resident #45 further noted being independent in wheelchair to bed and toilet transfers. A review of the nurse's notes on 11/14/2019 at 2:27pm revealed resident #45 was independent in transfers from bed to wheelchair and toileting and propelled self in the wheelchair in the	F 641	record. All residents are potentially affected since all residents are expected to receive an accurate quarterly MDS ADL assessment. The Regional MDS Consultant will audit 10 percent of quarterly assessments for the past 30 days and verify that ADL assessment is accurate and supported by accurate ADL documentation. If any inaccuracies are identified in the audit, they will be corrected, and additional training will be provided as warranted. The MDS nurse was educated by the Clinical Reimbursement Lead Consultant on 12-6-2019. Education included ADL coding, data collection of ADL coding, and accurate reflection of residents ADL abilities/needs for assistance. The MDS nurse was educated to ensure nursing assistants are proficient in accurately coding the functional abilities of residents. Audits for ADL accuracy will be conducted by the Administrator, DON, ADON, and/or the Regional MDS consultant to include 25% of the quarterly MDSs per week x 2 weeks, then 10% of the quarterly MDSs per week x 4 weeks and continuing until the QAPI Committee determines the deficient practice is resolved. Results of the audits will be recorded on an audit tool with the type of assessment, date of assessment and note any inaccuracies found. Inaccuracies will be corrected and the MDS resubmitted if needed. Any continued inaccurate coding of the MDS will result in corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	**410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526**

(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 641	Continued From page 4 hallway. An interview with the MDS coordinator on 11/15/2019 at 11:33am revealed the MDS coding for transfers for resident #45 as extensive assistance with two persons on 10/7/2019 was inaccurate. The MDS coordinator noted the resident was not independent and should be coded as requiring limited assistance with one person. Interview with nursing assistant #3 on 11/15/2019 at 12 :05pm revealed resident #45 was independent in transfers from wheelchair to bed and toilet. Interview with nurse #1 on 11/15/2019 at 12:10pm revealed resident #45 was independent in transfers from wheelchair to bed and toilet. An interview was conducted with the administrator on 11/16/2019 at 2:27pm. The administrator stated residents need to be accurately assessed in their functional status.	F 641	Administrator will ensure compliance. Results of the audit will be presented to the Quality Improvement Committee monthly x 2 months or until the QAPI Committee determines the issue is fully resolved.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		12/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 655	Continued From page 5 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a baseline care plan within 48 hours with measurable objectives and timetables to address the immediate needs for 1 (Resident #188) of 24 residents reviewed for baseline care plans.	F 655	Resident #188 discharged from the facility on 3-13-19. All newly admitted residents are required to have a baseline care plan. Accordingly all residents are at risk of not having a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 655	Continued From page 6 The findings included: Resident #188 was admitted to the facility on 2/21/19 and discharged on 3/13/19. The resident's diagnosis included heart disease of native coronary artery, muscle weakness, hypertension, chronic obstructive pulmonary disease, osteoarthritis, neuropathy, gastric esophageal reflux disease, and major depressive disorder. The Minimum Data Set (MDS) dated 2/18/19 revealed the resident was cognitively intact. The resident required extensive assist with bed mobility, transfers, and toilet use. The resident also needed limited assistance with eating. A record review of the closed record found a blank paper copy of the baseline care plan. An interview with the Assistant Director of Nursing at 10:00am on 11/15/19 stated she did the baseline care plan on admission or the next day. On 11/15/19 at 12:23pm, a phone interview with the admitting nurse (Nurse #2) for resident #188 stated she did the paper care plan on new resident admissions. When asked if she remembered doing the paper copy of the baseline care plan for resident #188, she stated she didn't remember. On 11/14/19 at 3:34pm, an interview with the Director of Nursing stated it's the admitting nurse's responsibility to do the baseline care plan upon admission.	F 655	baseline care plan upon admission. Director of Nursing will audit all new admissions for past 30 days. If any baseline care plans are found to be missing or incomplete, a baseline care plan will be prepared by the interdisciplinary team for residents still in the facility. The MDS nurse and the Interdisciplinary Care plan team were educated by the Administrator on 12-6-2019. Education included items that were required to be included in a 48-hour baseline care plan to include, but not limited to the resident□s minimum healthcare information to properly care for the resident, initial goals based on the admission orders, physician orders, dietary orders, discharge planning and PASARR recommendations, if applicable. A licensed nurse will initiate the baseline care plan on admission. The resident□s admission information, including the baseline care plan will be reviewed in the clinical meeting the day after admission. Items to care for the resident will be added as needed. For any resident admitting on a Friday, the baseline care plan will be reviewed by Sunday by the weekend supervisor or another licensed nurse. The IDT team will review all admissions from Friday, Saturday and Sunday on Monday morning during the clinical meeting. Results of the admission chart audits will be recorded on a resident census with the date of review and initials of the reviewer. Any omissions of baseline care plans that are discovered will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	**410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526**

(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 655	Continued From page 7	F 655	immediately corrected, and the admitting nurse will receive additional education. Any repeated omissions will result in corrective action. Audits will continue for 3 months or until the QAPI Committee determines the deficient practice is resolved. Administrator will ensure compliance. Results of the audit will be presented to the Quality Assurance Committee by the DON, ADON or MDS Coordinator during the monthly QAPI meeting x 3 months or until resolution.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interview, the facility failed to dispose of a disposable razor into a sharp container for 1 (resident #77) of 2 sampled residents reviewed for accidents. (#45, #77) Findings Included: Resident #77 was admitted to the facility on 2/13/2018 with anemia, atrial fibrillation, hypertension, diabetes mellitus, neurogenic bladder and depression listed as current	F 689	Resident #77 was not injured when his razor was thrown in the trash. Razor was removed from trash and placed in sharps container. Nursing assistant (NA) #2 was educated immediately on 11/14/19 when the Director of Nursing became aware of the incident. The NA was able to verbalize the razor should have been placed into the sharps container. Education for all NAs was started on 11/14/19 and was completed on 12-6-2019. Education	12/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 689	Continued From page 8 diagnoses. A comprehensive minimum data set (MDS) assessment dated 7/29/2019 revealed the resident was cognitively intact and required extensive assistance of one person with personal hygiene and dressing. On 11/14/2019 at 10:20am, nursing assistant #2 was observed discarding a used disposable razor into the trash can in resident #77 room. Nursing assistant #2 removed the clear plastic trash bag from the trash can, tied a knot at the top of the trash bag and exited resident # 77 room into the hallway. Nursing assistant #2 was stopped in the hallway after exiting resident #77 room on 11/14/2019 for an interview. Nursing assistant #2 admitted to throwing the disposable razor into the trash and when asked how disposable razors were disposed, the nursing assistant recalled in a sharp box and not the trash. An interview conducted on 11/15/2019 at 12:05pm with nursing assistant #3 revealed disposable razors were disposed in the sharp containers. An interview with nurse #1 conducted on 11/15/2019 @ 12:10pm revealed disposable razors were disposed in sharp containers. The Director of Nursing (DON) stated during an interview on 11/16/2019 @ 10:18am sharp containers were in the soil utility rooms and on the nursing medication carts for the disposal of disposable razors.	F 689	consisted of informing NAs where any sharp object should be discarded. Education was conducted by the DON, ADON and the unit manager. Random observations of NAs providing personal hygiene will occur 5 x week x 1 week, 3 times per week x 1 week and 1 time per week x 4 weeks and continuing until the QAPI Committee determines the deficient practice is resolved. Observations will be performed by the DON, ADON, UM and or any licensed nurse. Results of the audit will be maintained on an employee list with the date of observation and the initials of the observer. If a NA does not discard of a sharp object safely and properly, immediate re-education will occur by the licensed nurse that observed. Continued incidents of improper disposal of a sharp object will result in corrective action. Results of the observations will be presented to the QAPI committee by the DON, ADON and/or UM x 2 months or until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 689	Continued From page 9 On 11/16/2019 at 2:22pm, the DON was unable to provide a facility policy for disposable of sharps.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to label and date opened food items in the dry storage area. Findings included: During the initial tour of the facility kitchen on 11/12/2019 beginning at 8:48AM, there were food items observed in the dry storage area that were without labels and dates. These items included: a 20 lb. bag of cornmeal that was opened and stored in plastic bin. There was no date on the cornmeal or the bin to document the date the	F 812	Opened and re-sealed food items observed in dry storage with missing dates were discarded. Dietary staff were in-serviced on 11-12-19 by the Dietary Manager. Education included teaching staff to place an open date on all opened food items. Education started on 11-12-19 and was completed with all dietary staff on 12-6-19. The DM and/or the RD will make random audits of the dry storage area 5x/week x 2	12/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	**410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526**

(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 812	Continued From page 10 cornmeal had been opened. There was a bag of seafood breader located in a plastic bin that had been opened and was not labeled or dated. There was no date on the bag or the bin to indicate when the bag of seafood breader had been opened. Also observed was a 5 lb. bag of tricolor rotini pasta that had been opened. The bag of pasta was not labeled or dated. There was also a 5 lb. bag of graham cracker crumbs that had been opened but was not labeled or dated. At 9:36AM on 11/12/2019, the Dietary Manager stated that dietary staff usually label and date all opened food items. She reported all opened food items were supposed to have a label and date on them to indicate when the food item was opened.	F 812	weeks, 3x/week x 2 weeks and then weekly for 5 months or until QAPI Committee determines deficient practice is resolved. Any items found not labeled will require staff re-education by the DM and/or the RD. Any staff trends identified will result in corrective action. Results of the audits will be presented to the QAPI committee by the DM x 6 months or until resolution. Administrator will ensure compliance.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that were put into place following the recertification survey of 2/15/2019. This was for a deficiency originally cited during the recertification survey of 2/15/2019 and was subsequently recited on the current recertification and complaint survey of 11/16/2019. The	F 867	Opened and re-sealed food items observed in dry storage with missing dates were discarded. Dietary staff were in-serviced on 11-12-19 by the Dietary Manager. Education included teaching staff to place an open date on all opened food items. Education started on 11-12-19 and was completed with all dietary staff on 12-6-19. The DM and/or the RD will make random	12/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 11/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	**410 S JUDD PARKWAY SE** **FUQUAY VARINA, NC 27526**

(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 867	Continued From page 11 repeated deficiency was in the area of food procurement and storage. The two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F812: Based on observations and staff interviews, the facility failed to label, and date opened food items in the dry storage area. In an interview on 11/16/2019 at 2:45 PM, the facility Administrator stated the QAA committee does identify and address issues that require plans to correct deficiencies. The facility staff had a large turn over since the previous survey, and the Administrator stated there were a lot of issues to be corrected.	F 867	audits of food storage areas 5x/week x 2 weeks, 3x/week x 2 weeks and then weekly for 5 months or until QAPI Committee determines deficient practice is resolved. Any items found not labeled will require staff re-education by the DM and/or the RD. Any staff trends identified will result in corrective action. Results of the audits will be presented to the QAPI committee by the DM x 6 months or until resolution. Administrator will ensure compliance.	