DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING ______ B. WING ______	04/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to assess the use of a restraint (hip straps) and failed to assess for the use of the least restrictive device for one (1) of three (3) residents with physical restraints (Resident #107). Findings included: Resident #107 was admitted to the facility 12/29/11. Cumulative diagnoses included: personal history of fall, and right hip fracture 3/19/11. A Quarterly Minimum Data Set (MDS) dated 4/2/12 indicated Resident #107 was severely impaired in cognition and daily decision-making. Extensive assistance of two people was required for bed mobility and transfers. Ambulation did not occur and total dependence was required with locomotion on and off the unit. Balance was impaired in that Resident #107 was only able to stabilize with staff assistance on surface to surface transfers. No restraints were documented as being used at the time of the assessment. A care plan dated 1/11/12 and reviewed 4/11/12 stated Resident #107 had a history of falling. Falls occurred on 1/29/12, 2/5/12 and 2/25/12.	F 221	F-221 Resident # 107 expired on 5/12/12 Residents with any type of restraint has been identified by Director of Nursing or Unit Manager on 5/14/12. Six residents were identified including One resident that is on a trial To attempt to discontinue use Of a self release seatbelt. All assessments were complete. Inservices with licensed nurses and Physical Therapist have been conducted by the Staff Development Coordinator on 5/14/12 to educated On proper assessments needed for each Resident with a restraint and that the least restrictive has been trialed and documented quarterly and/or with significant changes in residents condition. The Interdisciplinary team which includes the Director of Nursing, Unit Manager, Social Workers, Dietary Manager, Therapy Manager and MDS Cordinators, reviewed all assessments and ensured that all residents have the least restrictive, careplans were also updated to reflect current restraint.	5/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Baldwin
TITLE: Administrator
(X6) DATE: 5/16/12

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F 221	Continued From page 2 On 4/26/12 at 9:34 AM, the Physical Therapist stated Resident #107 was evaluated by therapy on 2/28/12 for positioning issues. She stated Resident #107 could not tolerate sitting in the wheelchair because of the pain in her hip. Also, increased agitation was noted by the nursing staff when she was in the chair. Resident #107 was more comfortable in the broda chair because it was padded and she could get relief from back pain. She stated that the hip straps had been used since the implementation of the broda chair. The Physical Therapist said the hip straps were optional and did not have to be used with the broda chair. A review of the physical therapy notes revealed no documentation in the therapy notes that any attempts had been made to use the broda Chair without the hip straps. t On 4/26/12 at 10:25 AM., Administrative staff #2 stated the broda chair with the hip straps was considered a positioning device and not a restraint because Resident #107 was unable to walk. The straps were used for safety because Resident #107 might slide out of the chair and the use of the hip straps would remind Resident #107 that she could not get up. On 4/26/12 at 11:55 AM., Administrative staff # 1 stated the hip straps were attached to the Broda chair and could not be removed. An observation of Resident #107 in the Broda chair revealed the straps were removable. Administrative staff #1 stated she did not know they were optional and could be removed.	F 221		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425		

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F 425	Continued From page 3 drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation and staff interview, the facility failed to date an opened medication (one multidose vial of Novolog insulin) for one (1) of two (2) medication carts (100/200 hall) and failed to discard fifty-seven (57) expired hemoccult reagent slides (reagent used to test for blood in feces). The findings include: The facility's policy on "Preparation for Medication Administration revised 11/1/2011 was reviewed. The policy stated "3. Vials and ampules of injectable medications. Procedures: b. The date opened and the initials of the first person to use the vial are recorded on multidose vials (on the	F 425	F-425 Novolog vial and Hemocult slides were discarded by the Director of Nursing on 4/25/12. Refrigerator, med carts and medication rooms were checked by the Director of Nursing on 4/25/12, and again on 4/26/12 by the Staff Development Coordinator to ensure no other items were opened and not dated or expired. Licensed nurses were inserviced on proper storage of medications on 5/14/12 by Staff Development Coordinator. New hires will receive the same inservice during the orientation process by the Staff Development Coordinator or Director of Nursing. Audits will be done weekly for four weeks, then monthly for three months using medication storage audit tool by the Staff Development Coordinator/Director of Nursing or Unit Manager of the refrigerators, storage room and med carts to ensure compliance. Results of the audits will be reviewed at the facility monthly QA meetings by the QA Committee.	5/15/12

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F 425	Continued From page 4 vial label or an accessory label affixed for that purpose)." The manufacturer's instruction for storage and stability of Hemoccult test cards stated, in part, "When hemoccult test cards and developer are stored properly, they are stable until the expiration date printed on the box and pouches." 1. An observation on 4/25/2012 at 10:30AM. revealed one opened multidose vial of Novolog insulin in the 100/200 hall medication room refrigerator. The pharmacy had dispensed the medication on 04/10/2012. There was no date that indicated when the medication was opened. On 4/25/2012 at 10:35 AM., nurse #1 stated the insulin vial should have been dated when it was opened. On 4/25/2012 at 10:45 AM., Administrative staff #1 stated the facility policy was to date the insulin vial when it was opened. She discarded the insulin vial. 2. An observation on 4/25/2012 at 10:30 AM. revealed fifty-seven (57) hemoccult slides (a reagent used to test for blood in feces) located in the 100/200 hall medication room with an expiration dated of 10/11 (October 2011). On 4/25/2012 at 10:45 AM., Administrative staff #1 stated the hemoccult slides should have been discarded. She discarded the fifty-seven (57) hemoccult slides.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 5 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	F-441 Resident # 188 was discharged on 5/8/12. Sign was placed on the door of resident #39 on 4/25/12 by the Unit Manager. Therapist that was observed not utilizing proper hand washing was disciplined on 5/14/12 by Therapy Manager Residents on isolation have been identified by the Director of Nursing on 5/14/12. There are currently three residents On isolation. Isolation signs are Taped to the doors of these residents. Direct care staff including nurse nursing assistants and therapist have been inserviced on proper handwashing by the Staff Development Coordinator on 5/14/12. Direct care workers and In-Direct care workers have also been inserviced on appropriate signage as identified by the Center for Disease Control by the Staff Development Coordinator on 05/14/12 .Employees include Dietary, Housekeeping, CNA's, nurses Therapist, Social Workers, Activity Staff and office staff. New hires will receive the same inservice during orientation by the Staff Development Coordinator or Director of Nursing.	5/15/12

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F 441	Continued From page 6 by: Based on the review of the facility's policy, observations and staff interviews, the facility staff failed to wash hands between contact with a resident on isolation (Resident #188) and (Resident #191), and failed to post contact precautions signs for two (2) of three (3) residents (Resident # 39) who had an infectious condition. Findings included: Facility Guidelines for Initiation of Precautions from the Infection Control Manual (version dated 8/2005) stated, in part, " iii. Contact precautions, in addition to standard precautions, should be used for residents known or suspected with microorganisms that are easily transmitted by direct or indirect contact. Examples included Clostridium Difficile (bacteria that causes diarrhea and more serious intestinal conditions). 1. Resident #188 was admitted to the facility on 4/20/12. A record review revealed that on 4/23/12 a physician's order diagnosed Resident #188 with Clostridium Difficile (C-diff), an infectious condition that causes the development of bad bacteria in the intestines, leading to diarrhea. On 4/24/12 at 10:50 am, Resident #188 was observed, being transported back to his room in a wheelchair by a rehabilitation staff. Outside of the door to his room, hung a sign that read "Contact Precautions", which prompted anyone entering the room to perform hand hygiene before entering and before leaving room. Once Resident #188 was parked in the middle of the floor, the rehabilitation staff, quickly exited the room, and was not observed to wash her hands. She then	F 441	Audit tools on proper handwashing and CDC signage will be done. Audits will be done weekly for four weeks, then monthly for three months by the Staff Development Coordinator/Director of Nursing or Unit Manager to ensure compliance. Results of the audits will be reviewed at the facility monthly QA meetings by the QA Committee.	5/15/12

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F 441	Continued From page 7	F 441		

went across the hall, and entered the room of Resident #191. She was observed assisting him with repositioning his legs on his foot rest, then brought him to the hallway and began to transport him to therapy.

On 4/24/12 at 10:55am, the Rehabilitation Staff was interviewed. She stated that she was expected to wash her hands when entering a room with a contact isolation sign posted, but admitted that she did not do this. She then went to a sink and washed her hands, before resuming transporting Resident #191 to therapy.

2. Resident # 39 was readmitted to the facility 4/17/12. A physician's order dated 4/17/12 stated Resident # 39 had a diagnosis of C-diff (clostridium difficile) and was on contact precautions.

During the initial tour on 4/23/12 at 11:00 AM., a personal protective equipment (PPE) cart was noted outside of Resident #39's room. There was no sign outside the door to indicate what type of contact precautions should be used.

An observation on 4/24/12 at 12:15 PM., revealed a PPE cart was outside of Resident #39's room. No contact precautions sign was noted outside the door.

On 4/25/12 at 6:25 AM, a PPE cart was noted outside of Resident #39's door. No contact precautions sign was noted outside the door. Nurse #2 stated the PPE cart was for Resident #39 who had a diagnosis of C-diff.

On 4/25/12 at 8:00 AM., Administrative staff #3

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F 441	Continued From page 8 stated an isolation cart (PPE cart) with a sign was placed outside of the room when a resident was determined to require isolation/ contact precautions. She stated there should have been a sign on the isolation cart. She did not know why it was not there and stated it must have been moved. On 4/25/12 at 9:30 AM., Administrative staff #1 stated there should have been a sign placed on the isolation cart when it was placed outside of Resident #39's room.	F 441		

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1. This STANDARD is not met as evidenced by: A. Based on observation and staff interview on 05 15 2012 the staff did not know about the master door release switch located at the nurses station 42 CFR 483.70 (a).	K 038	K038 Upon interview, Any staff member will be able to correctly identify the master door release switch. The maintenance director will inservice all staff as to the location of the master door release switch located at the nurses stations. Monthly safety committee department inspection sheets will include the staffs knowledge of the door release switch. Results of the monthly safety committee inspections will be reported to and monitored by the QA committee monthly for 6 months The in-service for the staff will be completed by June 29th 2012.	6/28/12
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 05/15/2012 the facility had not preformed the five (5) year obstruction test on the dry sprinkler system. B. Based on observation on 05/15/2012 there was a sprinkler head in the Chemical Storage room in the kitchen that had paint on it. This head must be replaced. 42 CFR 483.70 (a)	K 062	K062 A: A five year obstruction test will be performed on the dry sprinkler system. The safety committee members will be inserviced by the maintenance director to look for other safety issues during their monthly inspections. Safety committee inspection findings will be reported at the monthly safety committee meeting, and any repairs needed will be addressed. Results of the safety committee meeting will be monitored at the monthly QA meeting for 6 months. The Dry sprinkler system obstruction test will be performed by June 28th 2012. → over	6/28/1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Baldwin	Administrator	5/31/12

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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 05/15/2012 the facility had not preformed the five (5) year obstruction test on the dry sprinkler system. B. Based on observation on 05/15/2012 there was a sprinkler head in the Chemical Storage room in the kitchen that had paint on it. This head must be replaced. 42 CFR 483.70 (a)	K 062	cont B: The sprinkler head in the Kitchens chemical storage room will be replaced with a new sprinkler head. The safety committee members will be inserviced by the maintenance director to look for other sprinkler head issues during their monthly inspections. Safety committee inspection findings will be reported at the monthly safety committee meeting, and any repairs needed will be addressed. Results of the safety committee meeting will be monitored at the monthly QA meeting for 6 months. The sprinkler head in the Kitchens chemical storage room will be replaced by June 28th 2012.	6/28/12

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