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

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A BUILDING			RVEY ED
		345529	B. WN	G	· · · · · · · · · · · · · · · · · · ·	04/2	6/2012
	ROVIDER OR SUPPLIER AL HEALTH CAREINOR	TH RALEIGH		520	T ADDRESS, CITY, STATE, ZIP CODE I CLARKS FORK DRIVE LEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCEO TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) RIGHT TO PHYSICAL RESTRA		F	221	-221		man . and .
	physical restraints im discipline or convenie	right to be free from any sposed for purposes of ence, and not required to			esident # 107 expired on 5/1		5/15/12
	by: Based on observation and staff interviews,	T is not met as evidenced on, medical record review the facility falled to assess	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	h N S C T	esidents with any type of res as been identified by Directo Jursing or Unit Manager on 5 ix residents were identified II one resident that is on a trial o attempt to discontinue use	or of /14/12. ncluding	A ANT THE REAL PROPERTY AND THE PROPERTY A
	assess for the use of for one (1) of three (3 restraints (Resident # Resident #107 was a 12/29/11. Cumulativ	(hip straps) and failed to it he least restrictive device it he least restriction. Findings included: admitted to the facility included: and right hip fracture		li P C	of a self release seatbelt. If assessments were complet asservices with licensed nurse; hysical Therapist have been anducted by the Staff Develo acrdinator on 5/14/12 to edi an proper assessments neede	s and pment ucated	
	A Quarterly Minimum 4/2/12 indicated Res Impaired in cognition Extensive assistance for bed mobility and occur and total depellocomotion on and of impaired in that Resistabilize with staff as surface transfers.	n Data Set (MDS) dated ident #107 was severely and daily decision-making. For of two people was required transfers. Ambulation did not not not not experience was required with the unit. Balance was dent #107 was only able to sistance on surface to to restraints were guised at the time of the		R th to a re te o D N al	esident with a restraint and not the least restrictive has be lialed and documented quart and/or with significant change esidents condition. The Intercent which includes the Direct Nursing, Unit Manager, Societary Manager, Therapy Mail DS Cordinators, reviewed all and ensured that all residents east restrictive, careplans were reflect current restraint.	een erly es in disciplinary tor lal Workers, nager and assessments have the	
	stated Resident #107	11/12 and reviewed 4/11/12 7 had a history of falling. 19/12, 2/5/12 and 2/25/12.				The second secon	
ABORATORY	DIRECTOR'S OR PROVIDER	SUBPLIER REPRESENTATIVE'S SIGNATUR	Ė	1	TITLE		(X6) ĐẠTE

Any deficiency statement ending with an eaterisk (*) 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.

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WNG 345529 04/26/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE UNIVERSAL HEALTH CARE/NORTH RALEIGH RALEIGH, NC 27618 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) . TAG TAG DEFICIENCY) Continued From page 2 F 221 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. 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 425 483.60(a),(b) PHARMACEUTICAL SVC -F 425 SS=D | ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'''	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED	
		345529	B. WING _		04/26/2012		
	OONDER OR SUPPLIER	TH RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 6201 CLARKS FORK DRIVE 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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 425	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 42	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.		5 Isln	
				on proper storage of medion 5/14/12 by Staff Develor Coordinator. New hires we the same inservice during orientation process by the Development Coordinator Director of Nursing. Audits will be done weekly weeks, then monthly for the months using medication audit tool by the Staff Development Coordinator/Director of Nursing Medication audit Manager of the refrigestorage room and medicate ensure compliance. Results of the audits will be reviewed at the facility model meetings by the QA Committee.	opment vill receive the e Staff r or y for four chree storage velopment lursing or gerators, rts to		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0						
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			

CORRECTION	IDENTIFICATION NUMBER:		LDING		COMPLETED	
345629		8. WI	1G		04/26/2012	
OVIDER OR SUPPLIËR		•	1			
UNIVERSAL HEALTH CARE/NORTH RALEIGH			i			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOUL	(X5) COMPLETION DATE	
vial label or an access purpose)." The manufacturer's in stability of Hemoccult "When hemoccult tesstored properly, they a expiration date printed. 1. An observation on revealed one opened insulin in the 100/200 refrigerator. The phan medication on 04/10/2 that indicated when the Con 4/25/2012 at 10:33 insulin vial should have opened. On 4/25/2012 at 10:44 #1 stated the facility prial when it was open insulin vial. 2. An observation on revealed fifty-seven (freagent used to test fithe 100/200 hall mediexpiration dated of 10 On 4/25/2012 at 10:44 #1 stated the hemoccult slides. 483.65 INFECTION Contraction of the contraction of the contraction of the contraction of the contraction dated.	struction for storage and test cards stated, in part, t cards and developer are are stable until the d on the box and pouches." 4/25/2012 at 10:30AM. multidose vial of Novolog hall medication room macy had dispensed the 2012. There was no date are medication was opened. 5 AM., nurse #1 stated the re been dated when it was 50 AM., Administrative staff colicy was to date the insuling ed. She discarded the 4/25/2012 at 10:30 AM. 67) hemoccult slides (a por blood in feces) located in cation room with an 4/11 (October 2011).					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE REGULATORY	AL HEALTH CARE/NORTH RALEIGH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 483.65 INFECTION CONTROL, PREVENT	A BUILD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 vial label or an accessory label affixed for that purpose)." 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She discarded the insulin vial stated the 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. She discarded the fifty-seven (57) hemoccult slides. 483,65 INFECTION CONTROL, PREVENT	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE \$201 CLARKS FORK DRIVE RALEIGH, NC 27816 SUMMARY STATEMENT OF DEFICIENCIES (EACH OBEICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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., 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 sildes (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 sildes should have been discarded. She discarded the fifty-seven (57) hemoccult sildes. STREET ADDRESS, CITY, STATE, ZIP CODE S20 (CARKS FORK ORK VE RALEIGH, NC 27816 PROKIDER ORK ABLEICH PROKIDER ORK ABLEICH PROKIDER ORK ABLEICH RALEICH, NC 27816 PREFIX PROKIDER ORK ABLEICH PROKIDER ORK ABLEICH RALEICH, NC 27816 PREFIX PREFIX TABLEICH NC 27816 PREFIX PREFIX TABLEICH, NC 27816 PREFIX RALEICH, NC 27816 PREFIX PROKIDER ORK ABLEICH TABLEICH RALEICH PROKIDER ORK ABLEICH TABLEICH PROKIDER PREFIX TABLEICH PROKIDER ORK ABLEICH TABLEICH PROKIDER ORK ABLEICH TABLEICH TABLEICH PROKIDER ORK ABLEICH TABLEICH T	A SULLINES JAMES 10 JUNIOR OR SUPPLER AL HEALTH CARE/NORTH RALEIGH SUMMARY STATEMENT OF DEPICIENCIES (EACH CORRECTION AND THE PRECEDED BY PULL REQULATORY OR LISC IDENTIFYMOR INFORMATION) Continued From page 4 vial label or an accessory label affixed for that purpose)." The manufacturer's instruction for storage and stability of Hermocoult test cards stated, it part, "When hemocoult test cards and developer are stored properly, here are stored properly, here box and pouches." 1. An observation on 4/25/2012 at 10:30 AM. revealed one opened multidose vial of Novolog Insulin in the 100/200 hall medication commendation and school of the facility policy was to date the insulin vial should have been dated when it was opened. On 4/25/2012 at 10:45 AM., Administrative staff it stated the facility policy was to date the insulin vial. 2. An observation on 4/25/2012 at 10:30 AM. revealed fifty-seven (57) hemocoult sildes (a reagent used to test for blood in feces) located in the 100/200 hall medication crown with an expiration dated of 10/11 (October 2011). On 4/25/2012 at 10:45 AM., Administrative staff it stated the hemocoult sildes should have been discarded. She discarded the finy-seven (57) hemocoult sildes. A SULLINES STATEM ADDRESS, CITY, STATE, 2P CODE. Satistic ARKE FORK DRIVE RALEICH, 2

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OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03									
STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CIJA IDENTIFICATION NUMBER:	1''		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUIL	A. BUILDING					
		345529	B. WIN	G		04/26	3/2012		
NAME OF PR	ROVIDER OR SUPPLIER			STRE					
HMM/#De.	AL HEALTH CARE/NORT	U DAI EICH		52	01 CLARKS FORK DRIVE				
UNIVERSA	AL REALIN CAREMONI			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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	FD BE	(X5) COMPLETION DATE		
F 441	Continued From page	3.5	F	441	F-441		\$15/12		
		blish and maintain an	i i		Resident # 100				
		gram designed to provide a			Resident # 188 was discharged 5/8/12. Sign was placed on the	d on			
		mfortable environment and evelopment and transmission			door of resident #39 on 4/25/	10 l			
	of disease and infecti				the Unit Manager. Therapist th	TS DA			
	(a) Infection Control F			į	was observed not utilizing prop	per			
		blish an Infection Control			hand washing was disciplined o	on			
	Program under which	rols, and prevents infections	ł		5/14/12 by Therapy Manager				
	in the facility;	iois, and prevents intections	i		·				
		cedures, such as isolation,			Residents on isolation have been	∍n			
	should be applied to	an individual resident; and			Identified by the Director of				
	1	d of incidents and corrective			Nursing on 5/14/12.				
	actions related to infe	ections.			There are currently three reside On isolation. Isolation signs are	ents			
	(b) Preventing Spread	d of Infection			Taped to the doors of these res	idonte			
	(1) When the Infection		ļ		-abed to the 10013 01 (11636 163	iuents.			
	determines that a res	ident needs isolation to	Ì		Direct care staff including nurse	2			
	1 '	finfection, the facility must			nursing assistants and therapist				
	isolate the resident.	webitit amplayoon with a			have been inserviced on proper				
	(2) The facility must p	prohibit employees with a se or infected skin lesions		- 1	handwashing by the Staff	٠			
		ith residents or their food, if			Development Coordinator on 5,				
	direct contact will tran	nsmit the disease.			Direct care workers and In-Dire				
	(3) The facility must r	equire staff to wash their			workers have also been inservio				
		ct resident contact for which			appropriate signage as identifie				
	hand washing is indic professional practice.		1		Center for Disease Control by				
	professional practice.	•			the Staff Development Coordina				
	(c) Linens				on 05/14/12 .Employees include	e Dietary,			
	Personnel must hand	lle, store, process and	1		Housekeeping, CNA's, nurses Therapist, Social Workers, Activ	· · ·			
	1	s to prevent the spread of			Staff and office staff.	ıty			
	infection.				New hires will receive the same				
	:		1		inservice during orientation by				
					the Staff Development Coordina	tor			
	This REQUIREMENT	is not met as evidenced			or Director of Nursing.				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WI	ie		04/26/2012	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/NORTH RALEIGH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREF TAG	R.	EET ADDRESS, CITY, STATE, ZIP CODE ROT CLARKS FORK DRIVE ALEIGH, NC 27616 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X6) COMPLETION DATE
F 441	Continued From page by: Based on the review observations and staffailed to wash hands resident on isolation ((Resident #191), and precautions signs for residents (Resident # condition. Findings in Facility Guidelines for from the Infection Con 8/2005) stated, in par in addition to standard used for residents knownicroorganisms that a direct or indirect controllection Constridium Difficile (band more serious interest with the Clostridium Difficile (band more serious interest with Clostridium infectious condition the foad bacteria in the diarrhea. On 4/24/12 at 10:50 a observed, being trans wheelchair by a rehall door to his room, hun Precautions", which part is parked in the micrehabilitation staff, queries in the mi	of the facility's policy, if interviews, the facility staff between contact with a Resident #188) and failed to post contact two (2) of three (3) if 39) who had an infectious included: In Initiation of Precautions introl Manual (version dated it, "iii. Contact precautions, if precautions, should be bown or suspected with hare easily transmitted by inct. Examples included fracteria that causes diarrhea finantial conditions). In admitted to the facility on few revealed that on forder diagnosed Resident intestines, leading to fund, Resident #188 was financed back to his room in a financed back to his room in a financed anyone entering franch hygiene before entering franch hygiene hy	! !	441	Audit tools on proper handwash and CDC signage will be done. Audits will be done weekly for foweeks, then monthly for three months by the Staff Developmer Coordinator/Director of Nursing Unit Manager to ensure compliance. Results of the audits will be reviewed at the facility monthly QA meetings by the QA Committee.	ning our nt g or ance.	3/15/12

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

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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	
		345529	B. WING		04/2	6/2012
	NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/NORTH RALEIGH			EET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 441	went across the hall, Resident #191. She was the repositioning his brought him to the hall him to therapy. On 4/24/12 at 10:55al was interviewed. She expected to wash her room with a contact is admitted that she did to a sink and washed transporting Resident #39 was 4/17/12. A physiciant Resident #39 had a collostridium difficile) a precautions. During the initial tour personal protective econoted outside of Resident #39 had a collostridium difficile apprecautions.	and entered the room of vas observed assisting him legs on his foot rest, then llway and began to transport m, the Rehabilitation Staff stated that she was hands when entering a solation sign posted, but not do this. She then went her hands, before resuming #191 to therapy. Treadmitted to the facility sorder dated 4/17/12 stated diagnosis of C-diff	F 441			
	a PPE cart was outsic No contact precautior the door. On 4/25/12 at 6:25 At outside of Resident # precautions sign was	24/12 at 12:15 PM., revealed the of Resident #39's room. It is sign was noted outside the door. When the door. The cart was for Resident the door.				
	On 4/25/12 at 8:00 Af	M., Administrative staff #3			i	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG 345529 04/26/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6201 CLARKS FORK DRIVE** UNIVERSAL HEALTH CARE/NORTH RALEIGH RALEIGH, NC 27616 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 441 | Continued From page 8 F 441 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.

PRINTED: 06/22/201	2
FORM APPROVE	
OMB NO. 0938-039	1

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/GLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION

A BUILDING 01 - MAIN BLDG (X3) DATE SURVEY COMPLETED

345529

B. WING

YAG

05/15/2012

NAME OF PROVIDER OR SUPPLIER

UNIVERSAL HEALTH CARE/NORTH RALEIGH

STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX

DEFICIENCY)

(X5) COMPLETION DATE

6/28/12

6/28/1

K 038 SS=D

(X4) ID

PREFIX

TAG

NFPA 101 LIFE SAFETY CODE STANDARD

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

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 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 19.7.6, 4.6.12, NFPA 13, NFPA periodically. 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)

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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.

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.

-7 over

LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE Baldary 1) 14 helle

TITLE

Pacility ID: 20040007

(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguerds provide sufficient protection to the petients. (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 regulate to continued program participation.

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/22/2012 APPROVED . 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CO	(X3) DATE S COMPLI	(X3) DATE SURVEY COMPLETED	
-		345529	B. WING	·		05/1	5/2012
	ROVIDER OR SUPPLIER SAL HEALTH CARE/N	ORTH RALEIGH		5201 CI	DDRESS, CITY, STATE, ZIP CODE LARKS FORK DRIVE GH, NC 27618		
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
SS≟D K 062 SS=D	Exit access is arran accessible at all time 7.1. 19.2.1 This STANDARD is A. Based on observing 42 CFR 483.70 (a). NFPA 101 LIFE SAR Required automatic continuously maintaic condition and are in periodically. 19.7. 25, 9.7.5 This STANDARD is A. Based on observing the struction test on the B. Based on observing a sprinkler hear	resprinkler systems are aligned in reliable operating spected and tested and	K 06	8: 8: 8: 8: 8: 9: 9: 9: 9: 9: 9: 9: 9: 9: 9	sprinkler head in the king ical storage room will be a new sprinkler head. safety committee members rviced by the maintenance ook for other sprinkler not their monthly inspective ty committee inspection be reported at the montitude meeting, and any reported at the montitude meeting, and any reported at the monitude of the safety commit be monitored at the moning for 6 months. sprinkler head in the king storage room will be une 28th 2012.	will be e director head issues ions. findings hly safety epairs needs tee meeting thly QA	le les lez
ABODATOR	Digestania on provin	ED/CIIDDI IED DEDDESENTAYN/FIS SIC	(ASTINE		THE		(XA) DATE

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.