STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345529	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 6/13/2013

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to document blood glucose results for one (Resident #8) of six (6) sampled residents with Diabetes. The findings included:

Resident #8 was admitted to the facility 10/31/08 and last readmitted 7/1/11. Cumulative diagnoses included: Diabetes.

A review of Resident #8's medical record revealed a physician's order dated 4/4/13 for accuchecks (test for blood sugar) daily at lunchtime. Sliding scale insulin was ordered as follows: Novolin R 100 units/ ml. (milliters). BS (blood sugar) - 110 divided by 40 + number of units injected sub-Q (subcutaneous) three times daily before meals.

A review of Resident #8's April Medication Administration Record (MAR) revealed the following dates with no blood sugar results-4/8/13, 4/15/13, 4/16/13, 4/18/13, 4/29/13 and 4/30/13.

A review of Resident #8's May MAR revealed the following dates with no blood sugar results-5/7/13, 5/8/13, 5/22/13, 5/27/13, 5/29/13 and 5/30/13.

A review of Resident #8's June MAR revealed no blood sugar results for 6/5/13, 6/6/13 and 6/7/13.

On 6/12/13 at 10:51AM., Nurse #2 stated the MAR was the only place she documented the blood sugar results. She stated it must have been "human error" when the results were not documented. Nurse #2 stated she must have written the results on another sheet of paper and forgot to transcribe them to the MAR.

On 6/12/13 at 11:33 AM., Administrative staff #1 stated she expected the doctor's order to be followed and the blood sugar results to be documented on the MAR at the time it was obtained.

The above isolated deficiencies pose no actual harm to the residents

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	345529	A. BUILDING _____ B. WING _____	06/13/2013

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

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F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the medication error rate was less than 5% as evidenced by 3 errors (Residents #119 & #116) of 25 opportunities for error, resulting in an error rate of 12%. Findings included: 1. Resident #116 was admitted to the facility on 10/15/12. On 6/11/13 at 4:56 PM, Resident #116 was observed during the medication pass. Nurse #1 was observed to prepare and to administer the medications via G-(gastrostomy) tube. Nurse #1 was not observed to flush the tube with water prior to administering the medications. On 6/11/13 at 5:10 PM, Nurse #1 was interviewed. She stated that the doctor's order did not indicate to flush the tube with water before administering the medications and she was just following the order. 2a. Resident #119 was admitted on 5/20/13. On 6/12/13 at 4:33 PM Nurse #4 was observed during medication pass. Nurse #4 was observed	F 332	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 332 On 6/11/2013, resident #116 had a clarification order written after consulting her physician to flush g-tube before and after medication administration versus solely after medication administration. No adverse reactions had occurred to the resident due to the manner in which the old order was written. Although the nurse for the resident was following the physician's order as written, she was in-serviced on 6/11/2013 by the nursing supervisor on flushing a g-tube before and after medication administration. All other residents with g-tubes orders were reviewed by the Director of Nursing on 6/12/2013 and noted to have flush orders written for before and after medication administration according to protocol.	

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

Michelle Baldwin, Administrator — 7/5/13 (revise plan)

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.

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F 332	Continued From page 1 to administer prednisone acetate ophthalmic solution, 1 drop in Resident #119 ' s left and right eyes. On 6/12/13 at 4:40 PM Nurse #4 was interviewed and she acknowledged that the eye drops she gave Resident #119 at 4:33 PM on 6/12/13 were only to be given in the resident ' s left eye. She stated that giving the eye drops in both eyes was a medication error. 2b. Resident #119 was admitted on 5/20/13. Review of the physician ' s orders dated 5/20/13 revealed an order for prednisone ophthalmic solution 0.12%, 1 drop to be instilled in the left eye 4 times a day. On 6/12/13 at 4:33 PM Nurse #4 was observed during medication pass. Nurse #4 was observed to administer prednisone acetate ophthalmic solution 1% eye drops to Resident #119. On 6/12/12 at 5:45 PM Administrative Staff #2 stated that she had confirmed with the pharmacist that prednisone acetate ophthalmic solution 1% and prednisone ophthalmic solution 0.12% were not the same strength and therefore giving the 1% eye drops to Resident #119 was a medication error.	F 332 F332 continued F 332 continued	Resident #119 was evaluated by her physician and found not to have any harm from the Prednisone 1% eye drop vs. the 0.12% given in both eyes and from receiving the higher dosage. The correct dosage was ordered from pharmacy by the Director of Nursing on the evening of 6/11/2013. The nurse making the error was in-serviced the evening of 6/11/2013, on eye drop administration and verifying correct medication. The pharmacy was notified of the error on 6/11/2013 for follow-up on how the wrong eye drop was dispensed. A subsequent in-service will be held by our pharmacy nurse consultant on medication administration on July 9th at 2pm. Areas of in-service include: 5 Rights of medication administration, proper documentation of medication administration, reading medication orders entirely, following medication order directions clearly, eye drop administration protocol, medication via gastrostomy tube protocol, ordering and receiving medications from pharmacy, missing medications, omissions, physician follow-up, reporting errors and verifying correct medications. This is a mandatory in-service for all nurses and medication aids that are on payroll (full-time, part-time and prn) and routinely administer medications to residents. Nurses and medication aids unable to attend this in-service will not be able to work until they have reviewed hand-out information and can verbalize understanding of the in-service material that was given on July 9th, 2013	7/9/2013
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			

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F 356	Continued From page 2 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. 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, review of facility staffing sheets and staff interview, the facility failed to post accurate data on the daily nurse staffing form. The findings included: On 6/10/13 the posted " Report of Nursing Staff Directly Responsible for Resident Care " form included for the 7AM-3PM shift: 3 RNs	F332 continued	In addition to the training, each full, part-time and prn nurse and medication aid will be followed for a med pass of 25 opportunities over the next 2 months. Each nurse will have to demonstrate a medication error rate less than 5%. Med pass observations will be conducted by the Director of Nursing, Staff development coordinator, shift supervisor, pharmacy consultant and licensed pharmacist. These observations will occur on all shifts and for all nurses and medication aids (full-time, part-time and prn) Nurses and medication aids unable to achieve a medication error rate less than 5% will be re-educated immediately by the observer (DON, SDC, Pharmacist, and Supervisor) and observed again for an opportunity to achieve a medication error rate less than 5%. If , after re-education, the observation exceeds an error rate greater than 5% , the nurse or medication aid will not be able to continue employment.	7/9/2013

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F 356	Continued From page 3 (Registered Nurses), 6 LPNs (Licensed Practical Nurses) and 13 CNAs (Nursing Assistants). During the initial tour of the facility on 6/10/13 at 11AM, the licensed nursing staff assigned to directly care for the residents was observed to include no RNs. The staff postings for 6/11/13 and 6/12/13 also included 3 RNs on the 7-3 shift but none were assigned direct care. The staff member (Administrative Staff #1) responsible for the posting was interviewed on 6/13/13 at 4:08 PM. She indicated that she had no real instructions on whom to include on the posting so she included the RNs since they were on duty. They served as director of nursing, minimum data set coordinator and staff development coordinator. During an interview on 6/13/13 at 4:20 PM, Administrative Staff #2 acknowledged that administrative nurses were included on the posting.	F332 continued	Routine med pass monitoring will occur monthly over the next 12 months to evaluate facility progress. This monitoring will occur via med pass observations by the Director of Nursing, Staff development coordinator or consulting pharmacist. These med pass observations will occur at least once monthly, and randomly on any shift. All nurses and medication aids (full-time, part-time, and prn) are subject to these observations. These observations will monitor a med pass of 25 opportunities. These observations will occur on all shifts and for all nurses and medication aids (full-time, part-time and prn) Nurses and medication aids unable to achieve a medication error rate less than 5% will be re-educated immediately by the observer (DON, SDC, Pharmacist, and Supervisor) and observed again for an opportunity to achieve a medication error rate less than 5%. If , after re-education, the observation exceeds an error rate greater than 5% , the nurse or medication aid will not be able to continue employment.The med pass observation will reviewed monthly by the Director of Nursing and the Staff development coordinator. The Director of Nursing will present the audits to the QA committee monthly for 12 consecutive months for interdisciplinary team evaluation.	7/9/2013
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency 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			

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F 425	Continued From page 4 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 record review and staff interview, the facility failed to administer a medication as ordered for 1 of 10 residents (Resident #87) reviewed for unnecessary medications. The findings included: Resident #87 was admitted to the facility on 4/25/08. Diagnoses included atrophic vaginitis. Physician orders for June 2013 included Vagifem (a hormonal treatment for vaginal inflammation) 10 mcg (micrograms) 1 tablet inserted vaginally every Tuesday and Friday. The original order date was 6/17/11. Review of the May MAR (Medication Administration Record) indicated Resident #87 received the Vagifem as ordered. The June MAR included Vagifem every Tuesday and Friday but lacked initials to indicate the resident had received any doses.	F 356	The facility currently employs one receptionist. This individual works Monday thru Friday. Education was provided to this individual on 6/14/2013 by the Director of Nursing on daily direct care staff posting. Another in-service was provided to the receptionist on 7/5/2013 by the Administrator. The weekend supervisor will be responsible for posting staffing on Saturday and Sunday. The Director of nursing will in-service the Weekend supervisor on 7/7/2013. In the event the receptionist is not on duty, the Administrator will be responsible for posting direct staffing. Weekly auditing of staff posting will occur over the next two months to ensure that the Direct Staff posting information is correct. The audits will be reviewed by the Administrator and presented by the Administrator to the QA committee monthly for interdisciplinary team evaluation. F 425 The physician was consulted for resident #87. A new order was received and noted on 6/13/2013 to discontinue the Vagifem. One to one education was provided to the nurse making the omissions to the Vagifem on 6/13/2013 by the Supervisor and again on 6/14/2013 by the Director of Nursing and the Staff Development Coordinator. The nurse was educated on the proper process of ordering/re-ordering medications and notifying the physician if a medication is unavailable.	7/8/2013

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F 425	Continued From page 5 During an interview on 6/13/13 at 3:20 PM, Nurse #1 acknowledged that she had not given the Vagifem in June because the supply had run out the end of May. Nurse #1 stated that she should have contacted the pharmacy, should have documented on the MAR that the medication was not given because it was unavailable and should have notified the physician. Nurse #1 stated she had no explanation for why she failed to take any action. During an interview on 6/13/13 at 4:17 PM, Administrative Staff #2 indicated she expected nurses to document on the MAR if a medication was not given and why, and to notify the physician.	F 425	F425 continued: The Director of nursing reviewed 60% of the nurse making the omissions Medication Administration Records from recent and previous months. No other omissions or patterns were found. Nurses on medication carts confirmed on 6/14/2013 that they had all medications needed for residents at current or their carts or available in the E-Kit (back up medication kit). The nurse making the omissions will be a part of the in-service process that all the nurses will go thru individually and collectively. This in-service will be conducted by the nurse consultant on July 9, 2013	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F425 continued	Carts will be audited weekly by the night shift charge nurses for missing. The charge nurse auditing the carts on nights will be responsible for faxing pharmacy notification of missing medications. The nurses will notify their unit managers if the medication is not received after being ordered. This audit will be performed weekly on Tuesday starting July 9th 2013. All full-time, part-time and prn nurses and medication aids will be educated on July 9th on routine cart checks for missing medications. The Director of Nursing will review the weekly audit and present the information to the QA committee for Interdisciplinary team evaluation for 3 months	7/9/2013

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F 431	Continued From page 6 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to date Prostat (a protein supplement) when opened on 2 (300 and 400 medication carts) of 4 medication carts observed. Findings included: On 6/12/13 at 11:45 AM, the medications carts on 300 and 400 halls were observed. An opened and undated bottle of Prostat was observed on each medication carts. The instruction on the bottle of the Prostat read in part " discard 3 months after opening, record date opened on the bottom of the container. " On 6/12/13 at 11:50 AM, Nurse #3 was interviewed. She stated that Prostat was good until the expiration date, so it didn ' t need to be dated when opened.	F 431	F431 All bottles of Prostat were checked for dates, discarded if not dated, and new bottles opened. This check was performed on 6/13/2013 by the unit managers and the Director of Nursing. All nurses are being educated on dating Prostat. This in-service has been ongoing individually with nurses and medication aids since 6/13/2013 by the Director of Nursing and the Staff Development Coordinator. All full-time, part-time and prn nurses and medication aids are being in-serviced. This information will be reiterated at the in-service held on July 9 the 2013 by the pharmacy nurse consultant. This is a mandatory in-service for all nurses and medication aids that are on payroll (full-time, part- time and prn) and routinely administer medications to residents. Nurses and medication aids unable to attend this in-service will not be able to work until they have reviewed hand-out information and can verbalize understanding of the in-service material that was given on July 9th. Pharmacy rounds are performed monthly by the Pharmacy tech. Round sheets will be reviewed by the pharmacy technician and the Director of Nursing. These round sheets, that audit for expired meds and date checks will be presented to the QA committee monthly by the Director of Nursing for 6 months for interdisciplinary team evaluation	7/9/2013

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	345529	A. BUILDING 01 - MAIN BLDG B. WING	07/16/2013

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register ~~at 42 CFR 483.70(a), using the 2000 Existing~~ Health Care section of the LSC and its referenced publications. This building is Type V (211) ~~construction, one story, with a complete~~ automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K018 It is the practice of this facility ~~to assure that all doors close correctly in their frames and~~ positively latch as required. The maintenance director will Inspect all doors in the facility And repair any problems found,	8/3/13
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD Is not met as evidenced by:	K 018	The door to the chemical storage And dry storage in dietary have Been repaired to properly shut and latch on 7-17-2013. The door in the dining room on the east side of the building was repaired to shut and latch on 7-18-2013. The maintenance director will Inspect all facility doors at least Monthly to ensure proper operation As part of the preventative Maintenance program. Findings will be reported to the Quality assurance committee Monthly for three months.	

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

Michelle Baldwin — Administrator — 7/24/13

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K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: 1. door to chemical storage room in kitchen would not latch. 2. day room door would not latch. 3. door on east side of dining room would not latch. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 018	K076 It is the practice of this facility To comply with NFPA 99 concerning medical gas storage. The three full oxygen tanks that were mixed with the empty tanks were immediately relocated to the full tank rack. The Staff Development Coordinator will in-service nursing staff on proper oxygen storage procedures. In-service will be completed by 8-2-2013. Maintenance director will monitor Storage racks for proper use daily And document findings. Findings will be reported to Quality Assurance committee monthly for Three months.	8/3/13
K 076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: oxygen storage room on 100 hall, has full cylinders stored in empty cylinder rack..	K 076		

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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 01 - MAIN BLDG B. WING _____	07/16/2013

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
K 076	Continued From page 2 42 CFR 483.70(a)	K 076		