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	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/North Raleigh	5201 Clarks Fork Drive NW Raleigh, NC 27616

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with staff, the facility failed to complete an admission Minimum Data Set (MDS) assessment within 14 days of admission for 1 of 3 residents reviewed for MDS assessments (Resident #89).The findings included: Resident #89 was readmitted to the facility on [DATE] with diagnoses including cerebral vascular accident (stroke). An admission MDS assessment with an Assessment Reference Date (ARD) of 8/6/25 was noted to be in process when reviewed on 8/20/25. In an interview on 8/20/25 at 2:03 PM, the MDS Coordinator stated the MDS assessment should have been done within 14 days after admission. He stated the MDS was not completed due to the volume of MDS assessments the facility had pending and they were trying to hire another full time MDS nurse. In an interview on 8/20/25 at 3:34 PM, the Administrator stated Resident #89's MDS assessment should have been completed on time. She stated because they were needing another full time MDS nurse, the corporate office had been helping part-time and another part-time employee had been hired, but not all the assessments were up to date yet.

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.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and facility staff interviews, the facility failed to accurately code a Minimum Data Set Assessment for Antipsychotic Medication Review for 1 of 5 residents reviewed for unnecessary medications (Resident #117).The findings included: Resident #117 was admitted to the facility on [DATE] with diagnoses which included dementia with delusions. A review of Resident #117's July 2025 Medication Administration Record (MAR) documented Quetiapine Fumarate 0.5 milligrams (mg) was administered 7/7/25, 7/8/25 and 7/10/25 through 7/30/25. A review of Resident #117's admission Minimum Data Set Assessment (MDS) dated [DATE] revealed she received antipsychotic medications. The Antipsychotic Medication Review was coded as not receiving antipsychotics on a scheduled or routine basis. During an interview with the Regional MDS Consultant on 8/6/25 at 10:30 a.m., she stated the MDS should have indicated Resident #117 had received antipsychotic medications on a regular basis, and this had been an error. She verified the Minimum Data Set Assessment was inaccurate and that antipsychotic use should have been coded correctly. During an interview with the Administrator on 8/7/25 at 2:00 pm, she stated the MDS assessments should have been coded accurately to reflect the use of antipsychotics.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to remove a box which contained 40 bisacodyl (a laxative) suppositories that were expired in 1 of 3 medication storage rooms (Unit 2 Medication Storage Room) reviewed for medication storage and labeling. The findings included: An observation of Unit 2 Medication Storage Room on 8/7/25 at 9:49 am revealed an opened box of bisacodyl suppositories, originally containing 40 suppositories, with an expiration date of 4/2025. In an interview with the Unit Manager #2 on 8/7/25 at 9:49 am, she stated the opened box of expired bisacodyl suppositories should have been discarded in April 2025. During an interview with the interim Director of Nursing (DON) on 8/7/25 at 2:00 pm, she stated the nursing staff was responsible for regularly checking the medication storage rooms and removing expired medications. The Administrator was interviewed on 8/7/25 at 2:00 pm and she indicated all nursing staff were responsible for regularly checking the medication storage rooms and removing expired medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and staff interviews, the facility failed to implement infection control policies and procedures when Nurse #1 failed to apply all the required Personal Protective Equipment (PPE) before entering a room with a resident on contact precautions. This occurred for 1 of 7 staff observed for infection control practices.The findings included:The facility's Infection Prevention and Control Program policy last revised on 2/6/2020 read in part: for patients documented as suspected to be infected with highly transmissible important pathogens for which additional precautions beyond standard precautions are needed to interrupt transmission, contact precautions may be utilized for diseases that have multiple routes of transmission that can be transmitted by direct contact or when performing patient care activities that require touching the resident.Review of the facility's contact precautions signage read in part: All healthcare personnel must: Clean hands before entering and when leaving room. Wear gloves when entering room and remove before leaving room. Wear a gown when entering room and remove before leaving.A review of Resident #89's physician order dated 8/5/25 revealed an order for contact isolation precautions related to conjunctivitis (an inflammation of the conjunctiva, the thin, transparent membrane covering the white part of the eye and the inner surface of the eyelids) for 10 days.An observation on 8/5/25 at 9:13 am of Resident #89's room revealed a sign posted on the right side of the door Contact Precautions. A storage cart was located outside the resident's room beside his door containing PPE to include gloves and gowns.An observation was conducted on 8/5/25 at 2:57 pm of Nurse #1. Nurse #1 was observed administering medications to Resident #89 via gastrostomy tube (a tube inserted in the abdomen to provide nutrition and medications) with no gloves or gown on for contact precautions. During an interview on 8/5/25 at 3:11 pm with Nurse #1, she stated she did not realize Resident #89 was on contact precautions. Nurse #1 indicated she was busy on the unit; however, she knew she was supposed to wear PPE for a resident on contact precautions. In an interview with Unit Manager #1 on 8/5/25 at 3:00 pm, she stated Nurse #1 should have had her PPE on going in to Resident #89's room.The Staff Development Coordinator (SDC) nurse was interviewed on 8/5/25 at 3:01 pm. The SDC nurse stated the facility had on-going in-services for infection control prevention on transmission-based precautions (TBP).During an interview on 8/7/25 at 2:00 pm with the interim Director of Nursing (DON), she stated Nurse #1 had been in-serviced on this day on infection control prevention and PPE usage. The interim DON further stated Nurse #1 should have had her PPE on for a resident on contact precautions.In an interview on 8/7/25 at 2:00 pm with the Administrator, she stated her expectations were the nursing staff to read the signs on the residents' doors prior to entering the rooms and use the appropriate PPE supplies indicated by the signage posted.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and resident and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the pneumococcal vaccinations for 4 of 5 residents (Resident #37, #67, #98, and #118) and offer annual influenza vaccine for 1 of 5 (Resident #118) residents reviewed for immunizations.The findings included:The facility policy for Pneumococcal Vaccination with the effective date 8/4/2023 read in part Vaccinations against pneumonia will be offered to center patients as indicated. Contraindications for receiving a pneumococcal vaccination were severe allergy to any component of the vaccine. Patient pneumococcal vaccine tracking will be maintained by the Infection Preventionist using the Immunization Tracking in the electronic medical record.The facility policy for Influenza Vaccination with the effective date 5/1/2023 read in part Influenza vaccine should be offered annually. The optimal time to administer influenza vaccine is in late September or early October of each year. The center will check the immunization status of patients admitted during flu season. Those who have not had a flu vaccine will be offered one upon admission unless contraindicated. The patient influenza vaccine tracking will be maintained by the Infection Preventionist using the Immunization Tracking in the electronic medical records.1. Resident #37 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis and gout.The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was cognitively intact and was coded as being offered and declining the pneumococcal vaccine.Review of Resident #37's immunization record revealed no documentation that he had been offered, given, or refused the pneumococcal vaccine. An interview was completed on 8/7/2025 at 10:30 am with Resident #37. Resident #37 stated he was unable to recall if he was offered the pneumococcal vaccine by the facility and declined it. An interview was completed on 8/7/2025 at 2:05 pm with the Quality Assurance Nurse. The Nurse verified she was responsible for ensuring facility residents were offered and received the pneumococcal and influenza vaccine. The Quality Assurance Nurse revealed she began working at the facility approximately 1 1/2 months ago. The Nurse stated she audited all residents' medical records to verify who had not been offered or received the influenza and pneumococcal vaccinations. The Quality Assurance Nurse revealed she contacted all residents and their responsible parties that had no documentation of vaccinations in their medical record to obtain their consent or refusals for them. The Nurse stated she was now at the point of obtaining Physician orders to administer the vaccinations. An interview was completed on 8/7/2025 at 3:33 pm with the Administrator. The Administrator stated there had been a recent change in leadership that contributed to residents not being offered and receiving vaccinations timely. 2. Resident #67 was admitted to the facility on [DATE] with diagnoses that included arthritis and asthma. The annual MDS assessment dated [DATE] revealed Resident #67 was cognitively intact and was coded as not receiving her pneumococcal vaccination. Review of Resident #67's immunization record revealed no documentation that she had been offered, given, or refused the pneumococcal vaccine. An interview was completed on 8/7/2025 at 2:05 pm with the Quality Assurance Nurse/Infection Preventionist. The Nurse verified she was responsible for ensuring facility residents were offered and received the pneumococcal and influenza vaccine. The Quality Assurance Nurse revealed she began working at the facility approximately 1 1/2 months ago. The Nurse stated she audited all residents' medical records to verify who had not been offered or received the influenza and pneumococcal vaccinations. The Quality Assurance Nurse revealed she contacted all residents and their responsible parties that had no documentation of vaccinations in their medical record to obtain their consent or refusals for them. The Nurse stated she was now at the point of obtaining Physician orders to administer the vaccinations. An interview was completed on 8/7/2025 at 3:33 pm with the Administrator. The Administrator stated there had been a recent change in leadership that contributed to residents not being offered and receiving vaccinations timely. 3. Resident #98 was admitted to the facility on [DATE] with diagnoses that included asthma and congestive heart failure. The annual MDS assessment dated [DATE] revealed Resident #98 was cognitively intact and was coded as being offered and declining the pneumococcal vaccination. Review of Resident #98's immunization record revealed no documentation that she had been offered, given, or refused the pneumococcal vaccine. An interview was completed on 8/7/2025 at 10:40 am with Resident #98. Resident #98 stated she was unable to recall if she was offered the pneumococcal vaccine by the facility and declined it. An interview was completed on 8/7/2025 at 2:05 pm with the Quality Assurance Nurse/Infection Preventionist. The Nurse verified she was responsible for ensuring facility residents were offered and

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and resident and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the COVID-19 vaccinations for 1 of 5 residents (Resident #67) reviewed for immunizations.The findings included:The facility policy for COVID-19 vaccination with the effective date 3/11/2024 read in part Vaccinations against COVID-19 will be offered to center patients as indicated. Contraindications for receiving the COVID-19 vaccination include severe allergic reaction to any component of the vaccine. COVID-19 vaccination tracking will be maintained by the Infection Preventionist or designee. Resident #67 was admitted to the facility on [DATE] with diagnoses that included arthritis and asthma. The annual MDS assessment dated [DATE] revealed Resident #67 was cognitively intact and was coded as not being up to date for the COVID-19 vaccination. Review of Resident #67's immunization record revealed no documentation that she had been offered, given, or refused the COVID-19 vaccination. An interview was completed on 8/6/2025 at 12:07 pm with Resident #67. The Resident revealed she was unable to recall being offered the COVID-19 vaccination. An interview was completed on 8/7/2025 at 2:05 pm with the Quality Assurance Nurse/Infection Preventionist. The Nurse verified she was responsible for ensuring facility residents were offered and received the COVID-19 vaccination. The Quality Assurance Nurse revealed she began working at the facility approximately 1 1/2 months ago. The Nurse stated she audited all residents' medical records to verify who had not been offered or received the COVID-19 vaccination. The Quality Assurance Nurse revealed she contacted all residents and their responsible parties that had no documentation of the vaccination in their medical record to obtain their consent or refusals for them. The Nurse stated she was now at the point of obtaining Physician orders to administer the vaccinations. An interview was completed on 8/7/2025 at 3:33 pm with the Administrator. The Administrator stated there had been a recent change in leadership that contributed to residents not being offered and receiving vaccinations timely. The facility provided the following corrective action plan with a completion date of 8/1/2025.1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.The facility failed to document and/or administer immunizations and/or vaccinations for residents in the electronic medical record (EMR). 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.On July 8, 2025, the Infection Preventionist (IP) reviewed all residents' EMR for immunizations and/or vaccinations. Out of the 114 residents in-house, 33 were vaccinated, 29 refused, 23 received partial vaccination, 24 consented and had not yet received the vaccination, 3 voicemail messages were left for consent from the Resident Representative with no return call, and 2 unable to reach the guardian for the COVID vaccination. Out of the 114 in-house residents, 37 refused, 40 were vaccinated, 4 voicemail messages were for consent from the Resident Representative with no return call, 2 have consented, and 31 were not eligible based on their admission date and/or received prior to admission the Influenza vaccination. Out of the 114 in-house residents, 40 refused, 24 were vaccinated, 41 have consented, and 9 voicemail messages were left for consent from the Resident Representative with no return call for the Pneumococcal vaccination. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.The Staff Development Coordinator Nurse initiated education on July 8, 2025, to all licensed nurses to document available immunizations and/or vaccinations upon admission and was completed on July 31, 2025. Any that has not received the education by July 31,2025, will be educated prior to the start of his/her next scheduled shift. All newly licensed nurses will be educated during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.Include dates when corrective action will be completed.On July 8, 2025, the newly hired Infection Preventionist (IP) was educated by the Regional Director of Clinical Services on immunization/vaccination requirements and documentation standards. The Infection Preventionist (IP) will review each new admission and administer the vaccination and/or immunization per the consent and document the administration in the EMR. The Infection Preventionist (IP) will audit all new admissions for immunization/vaccination documentation and/or administration daily, Monday through Friday for 12 weeks. Monitoring began on July 8, 2025, and initial results of these audits were reviewed on July 31, 2025, during the facility's Quality Assurance Performance Improvement (QAPI) meeting. The continued audits will be reviewed at the Quarterly QAPI meeting for 3 meetings for further problem resolution if needed. The Administrator will review the results of the weekly audits to ensure any