PRINTED: 11/13/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	I DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING_			C 11/20/2015	
NAME OF PR	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				19	95 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		LI	LLINGTON, NC 27546		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253 SS=E	maintenance services sanitary, orderly, and This REQUIREMENT by: Based on observatio interviews with staff at to provide maintenance secure a leaking toile Rooms (Rooms 30 and The findings included On 11/18/15 at 11:00 of rooms 30 and 28, restrong urine smell. To observed unstable with brown substance. Resident #68 resided quarterly Minimum Darevealed he was coground the toilet was There was usually be floor around the toilet Resident #68 stated to since he was admitted was afraid to get on the state of the sand to get on the sand to since he was admitted was afraid to get on the sand to since he was admitted was afraid to get on the sand to since he was admitted was afraid to get on the sand to sand	ide housekeeping and a necessary to maintain a comfortable interior. T is not met as evidenced ans, record review and and resident the facility failed be services by failing to a for 2 of 2 Residents' and 28). AM the adjoining bathroom evealed that the toilet had a ne base of the toilet was the a 2 inch dark yellow In room 30 and his ata Set (MDS) dated 8/14/15 nitively intact. AM Resident #68 stated his	F2	253	Submission of this response to the statement of deficiencies does not constitute an admission that the deficiencies exist and/or were correctly cited or required correction. On November 18, 2015, the flange and seal were replaced on the toilet betwee rooms 30 and 28. After replacement, the floor was bleached and cleaned to remove any remaining odor. Toilets throughout the facility were inspected by the Maintenance Director assure they were secured and sealed. Other toilets were found to be defective and were repaired between 11/24/2015 and 12/01/2015. On 12/14/15 the Administrator and Maintenance Director in-serviced curre facility staff on the timely notification of identified repairs to the facility Maintenance Director. A form entitled Work Orders will be located at the nurse station, front office, and receptionist, to be available to staff to complete and place in a tray located at nurse station for the Maintenance	to	12/21/15
ABORATORY	about the toilet not be they had not told anyo when someone would	sing stable and the odor but one. The resident stated I take him to the bathroom			Director and/or assistant to retrieve and ensure repairs are completed timely.		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/17/2015

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.

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED: `		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C 1/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	1/20/2013	
				1995 EAST CORNELIUS HARNETT BO	ULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 253	Continued From page	e 1	F 2	53			
	toilet would turn over really scary when you rocking." On 11/18/15 at 11:31	cause he was afraid the The resident stated, "It is usit on the toilet and it was AM the house keeping staff		All toilets will be checked were months by the Maintenance I ensure to toilets are in good Maintenance Director will me facility Administrator to review and work orders completed for weeks: then, monthly x 2 m	Director to repair. eet with the w the repairs or the week x		
	leaking." She stated toilet and there was to stain around the base stated there was a howhere the toilet was I smelled so bad and so odor was still very striloose. She stated Reseasistant got him up to on the toilet but Resid so wobbly that he was	toilet was "wobbly and she had tried to clean the wo inches of dark brown to of the toilet. She further ble in the back of the toilet eaking. She stated it he had tried bleach but the long because the toilet was sident #68's usual Nursing with assistance and sat him dent #68 complained it was		6 weeks; then, monthly x 2 m The facility Maintenance Director/Administrator will co summary of monthly monitor and this summary will be pre facility monthly Quality Assur Improvement Committee me review, discussion and/or ne changes to ensure continued	mplete a ing efforts sented at the rance eting for eded		
	Assistant (NA #1) staresident very often but (11/18/15). NA #1 staresident very often being very often but (11/18/15) at 11:54. Manager stated no or commode was loose process was for staff he picked them up date of the picked them up dat	ted she did not care for the ut he was assign to her today ated Resident #68 had told a was loose but she had enance. AM the Maintenance he had told him that the until now. He stated that the to fill out a work order and					

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F 253 F 254	told her that the resid and that is why it got	and the maintenance man ent sat on the toilet too hard	F 253		12/21/15	
SS=B	GOOD CONDITION	ide clean bed and bath				
	by: Based on observatio and staff interview the	ne linen cart.		Damaged or stained linen in Room 26 Bed A, was removed on 11/18/2015 ar replaced with unstained and undamage linen on 11/18/15. An inventory of all linen was completed 11/18/2015. All stained and damaged	d ed	
	for September 2015 that the linen had state that the linen had state On 11/16/15 at 10:29 26 Bed A was observed holes and on the left area that was so thin was observed through On 11/18/15 at 9:38 A were observed with hin the laundry cart to resident halls. The late laundry was laundered washed between 11:00 laundry was returned	AM the fitted sheet in Room ed with small dime sized side of the bed a 5 by 5 inch and worn the bed mattress		linen was discarded from resident room linen carts, and laundry. A linen order was placed on 11/18/2015 and receive on 11/19/2015. Laundry and Housekeeping were in-serviced on 11/19/2015 by the Housekeeping Supervisor to assure residents were be provided with unstained and undamage linen. Nursing staff was in-service on 12/15/15 by the DON to assure resider were being provided unstained/undamaged linen. Started 11/20/15 linen has been inspec daily by laundry staff before being sent resident rooms. Nursing will monitor lindaily prior to use in resident rooms; will remove and return any stained/ damaged.	eing ed hts	

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					95 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON	LILLINGTON, NC 27546				
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F 254	Continued From page	÷ 3	F 2	254			
	She stated the other	staff folded the linen and she			linen to laundry for disposal.		
	had holes. She state discard any linen with stained linen.	ed sheets were soiled and d she had been instructed to holes and to rewash any			The facility Housekeeping Supervisor/Administrator will complete summary of monthly monitoring efforts and this summary will be presented at		
	stated the facility was did not clean their ow another facility. At the cleaned the linen at n Manager further state the other facility laund while folding it and if the linen rewashed. If the then the linen was to were any holes in the discarded. The nursi for the residents were holes and replace with	the Housekeeping Manager in a transition in which they n laundry at the facility but at e other facility laundry staff ight. The Housekeeping di the was his expectation for dry staff to check the linen there were stains to have the e stains did not come out be discarded. Also if there linen it should also be ng staff when providing care e to check for stains and h clean sheets or linen. M in Room 26 Bed-A quarter			facility monthly Quality Assurance Improvement Committee meeting for review, discussion and/or needed changes to ensure continued complian	ce.	
	Spread. On 11/18/15 at 11:23 (NA#3) stated she ha seen the holes in the when there were hole had stains she should replace it with anothe condition.	AM Nursing Assistant d made Bed A and had not bed spread. She stated is in the linen or if the linen d discard the bed spread and r bed spread in good n 11/19/15 3:20 PM the					
F 323	Director of Nursing (D	OON) stated her expectation e linens in good condition esident care.	F 3	323			12/21/15

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				20/2015	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE		20,2010	
					95 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLI	NGTON			LLINGTON, NC 27546			
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F 323	Continued From pag	e 4	F3	323				
SS=J	HAZARDS/SUPERV	ISION/DEVICES						
	as is possible; and e	ure that the resident as as free of accident hazards ach resident receives an and assistance devices to						
	by: Based on record revelopment facility failed to preversidents (Resident #	riew and staff interviews, the ent 2 of 4 cognitively impaired #22 and Resident #116) who behaviors from exiting from upervised.			Resident #116 was assessed and four to be without injury. The attending MD and RP were notified. A wanderguard was implemented for safety. Wanderguard was placed on Resident #116 s right ankle on 10/11/15.			
	The findings included	d:			Resident assessed for placement of wanderguard on 11/19/15 and noted			
	Resident #116 left th was found by a visitor the facility. The resid failed to activate the Immediate Jeopardy Resident #22 left the was found outside at room exit door failed battery. Immediate 11/19/15 at 9:45 AM at 10:07 AM when th implemented a credit	began on 10/11/15 when e facility unsupervised and or in the front parking lot of ent's wanderguard bracelet alarm system on the door. began on 11/12/15 when facility unsupervised and night by staff. The dining to alarm due to a dead Jeopardy was identified on and was removed 11/20/15 e facility provided and ble allegation of compliance. but of compliance at a lower evel of D (an isolated			wanderguard had been moved to wheelchair. Wanderguard removed frow wheelchair and reapplied to resident #116 sright ankle. Nursing staff was it serviced by the ADON on 11/19/15 regarding placement of wanderguards manufacturer squidelines. Wanderguards manufacturer squidelines was seen added the MAR a nurses will check placement every shift starting 3-11 shift 11/19/15. Resident #116 has had no other exit seeking ever since 10/11/15 Resident # 22 was assessed and found be without injury. The attending physicial	n per ard nd i ents		
	deficiency, with no a more than minimal h	ctual harm with potential for arm that is not Immediate monitoring of systems put in			& RP were notified and frequent monitoring by staff as to location was implemented. Maintenance was called			

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			71. 501251	_		، ا	2
		345213	B. WING			l	20/2015
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				1	995 EAST CORNELIUS HARNETT BOULEVARD		
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F 323	Continued From page	e 5	F	323			
	place and completion	of employee training.			to check the alarm and battery was		
	The findings included				replaced by maintenance. Resident #	22	
	1. Resident #22 was	originally admitted to the			has had no further exit seeking events		
		Resident #22's diagnoses			since 11/12/15.		
	included Cognitive De						
		y Disorder and Muscle			A 11 0 1 1 1 1		
	Weakness.	0.04/04/15 at 4:15 DM road			All Current residents were reassessed	on	
	in part: "At 9:45 AM a	n 04/04/15 at 4:15 PM read			11/20/15 by the ADON to identify any residents who are at high risk for		
		ought Resident #22 to the			wandering behavior. Residents identifi	ed	
	. •	resident had seen Resident			as having exit seeking behaviors have		
		zeway door that connects			new and/or updated Care plan complet		
	the LTC (long term ca	are) to the assisted facility			11/20/15 by MDS nurse. CNA Care		
	_	he door did not sound. The			Guides have been updated and review	ed	
		ound Resident #22 sitting			with staff to ensure they are aware of		
		returned her to the "C" hall.			residents with a high risk of wandering	on	
		he was "looking for her r discomfort. Q (every) 15			11/20/15 by the ADON.		
		nitiated. Resident received			All residents currently with a wandergu	ard	
	Xanax 0.25 PO (by m				have been assessed for wanderguard	ara	
		ecked for placement and			placement. All wanderguards are place	d	
		ON (Director of Nursing),			on residents as recommended by the		
	Administrator, and me	ember of the Maintenance			manufacturer as of 11/19/15. As of		
	was notified of the inc				11/19/15 any resident experiencing an		
		as notified at 10:30 AM.			unsafe wandering event will be		
		sitting at the nursing station			immediately re-assessed and intervent		
	, ,	nember. Will continue to			put in place. The DON/Administrator w	III	
	Staff Nurse #5.	stress." Note written by			be notified for follow-up.		
					Newly admitted residents will be asses	sed	
	Nursing note dated or	n 09/15/15 at 7:05 PM read			by the admitting nurses for safety risk		
		ought back in from outside			within 24 hours of admission with		
		e) where she had been			appropriate inventions and care planning	ng	
		ay (breezeway) beside			for any resident assessed as high risk.		
		ng off door alarm. Nurse			The DON/designee will complete a 24		
		en responding to alarm			hour admission chart review during the		
		ee what had set it off when there. Resident was given			A.M. clinical meeting to ensure all MD orders, admission assessments and at		
	_	time and put on g (every) 15			risk assessments have been completed		

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UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546				
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F 323		nours. She then sat quietly in	F 3:	correctly and timely.				
	DON (Director of Nur responsible party. 7: of doctor). 10:15 PM cooperative at this tir functioning. Resider respirations even and minute checks contir Nurse #6. Review of elopement 10/13/15 revealed "e review indicated elop interventions of freque personalization of roo			The Maintenance Director rein-service training by the Adn 11/18/15 on the new procedured Maintenance will check the works daily for functioning ar findings on the Door Alarm Comonitoring tool. (2) Maintenatheck the voltage of batteries alarm on all door alarms 4 x workshall be battery life by using a meter a manufacturer secommend changing battery when reading voltage or less. Maintenance document his finding on the Incheck monitoring tool.	ministrator on ure of (1) wanderguard and document check unce will s and audible weekly for and follow ation of ng is 7.0 will Door Alarm			
	11/06/15 indicated R cognitively impaired a behavior occurring 1 also indicated the resussistance of one petransfer, dressing an assistance of one pelocomotion. The resunct steady, only able assistance. The resirequire a wheelchair	•		Any wanderguard box not fur properly will be corrected imr documented by maintenance All wanderguard boxes were 11/19/15 by maintenance and properly. All doors alarms were audited maintenance and documented battery voltage over 7.0. The Administrator will monito Maintenance Door Alarm Chedaily x 4 weeks; then, weekly months to ensure compliance.	mediately and e. audited d are working d 11/19/15 by ed with all or the eck sheets / times 3			
	Seeking/Wandering: dated 11/12/15, 10:4 nurse was pushing re and made writer awa the dining room outsi knees knocking on the seeking on the seeking of the seeking was seeking	ed "Report of Resident Exit Missing From Facility" 0 PM read in part "B hall esident down hall to her room are that resident was behind ide of the facility on her he window. Resident had ining area, door did not		Two notebooks were created WC that contains photos of a identified as high risk for wan 11/19/15. The notebooks will at the receptionist desk and restation to ensure staff is able any resident with a high risk to the station to ensure staff.	all residents ndering on Il be located nurse⊡s to identify			

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TO WILL OF TH	NOVIBER OR COLL FIELD			1995 EAST CORNELIUS HARNETT BO			
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546	OLLVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 7 oken. Resident had gotten	F 3	23 wandering. MR will review ar	nd update		
	out of wheelchair and	d had mud on her clothes esident was not hurt. Nurse		notebooks as needed.	·		
	made CNA (certified the situation and CNA put her into bed. Act (every) 15 minute che care/intervention has further events."	nursing assistant) aware of A cleaned resident up and ion taken: Resident on q ecks. A new plan of been completed to prevent n 11/12/15 at 11:42 PM read		The DON/designee will moni wanderguard placement of the residents weekly x 4weeks at to MARs documentation on wanderguards. If any discreptioned, the nurse will be identified reeducated and counseled be DON/designee.	he identified and compare pancies are tified,		
	room this pm, resider come in. Resident w and brought back into CNA's notified. DON called and notified all wanderguard on and are in working order. at first sight." Note w	as found outside of dining on twas banging on door to as assisted into wheelchair o building, C Hall nurse and I (Director of Nursing) was so. Resident does have also personal alarm which No apparent injuries noted written by Staff Nurse #7.		Training was completed by the 11/19/15 with all current staff wandering or Elopement includentification of resident wan behavior, creating a safe environment residents. Any staff not available training will not be allowed to training is complete. All newless	f on unsafe luding, idering vironment and t for able for this o work until ly hired		
	2015 indicated that the 78 degrees Fahrenheit. indicated that it raine	d on November 10, 2015.		employees will receive this tr orientation. Training was completed by the Clinical Director and DON with employees on elements of F a Safe Environment and Ade	he Regional ith current 323 Providing equate		
	on 11/18/15 addresses "Resident has exit see was found outside of with no injuries. Goa building unattended to Approaches: Person Check functioning of Check placement per PRN (as needed). O diversional activities	eking behavior. Resident dining room on 11/12/15 I: Resident will not leave		Supervision for Residents or The training included identific residents at risk, creating a senvironment, identifying and unsafe items in the environment interventions and providing a supervision. Any staff not averthis training will not be allowed until training is complete. All employees will receive this training t	cation of safe reporting nent; adequate vailable for ed to work newly hired		

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F 323	Continued From page	e 8	F	323				
		family of attempts to leave			The DON/designee will review the 24 h	our		
		minute checks indefinitely.			report, physician □s telephone orders a			
		d. RP (responsible party)			resident incident reports daily to ensure			
	notified. MD (medica				that all potential adverse events regard			
	,	Director of Nursing) notified.			resident care and safety are addressed	-		
	Maintenance in to fix	door."			and appropriate interventions are in pla	ice.		
					The facility DON/designee will bring all			
	Observation was mad	de of the resident on			incident/accident reports, physician			
		in her room sitting up in			telephone order, nursing 24-hour repor	t,		
	wheelchair waiting for				and resident medical records of any			
	wanderguard attache	ed to the back of the	· · ·		ent			
	wheelchair.				to the Morning/Clinical Team Meeting.			
	Duning on intervious	- 44/40/45 -+ 7:45 AM NA			This meeting will include members of the			
		on 11/18/15 at 7:45 AM, NA			facility inter-disciplinary Team (nursing			
		S indicated that she has seen front area and look out the			dietary, social services, administrator). Residents will be reviewed and medica	ı		
		further stated that she was			records will be audited to ensure accur			
		the hall that the resident is			and complete documentation. If there			
	_	ite checks due to trying to			any discrepancy or need for follow up i			
	exit the facility.	g			the resident medical record the			
	,				DON/designee will provide follow up w	th		
	During an interview o	n 11/18/15 at 8:30 AM, the			the licensed nurses, physically provide			
	MDS Coordinator ind	icated that the resident does			assessment visit with resident, and			
	wander throughout th	ne facility and a wander			ensure accurate, complete documenta	tion		
	guard was placed for	safety.			and interventions are provided for that			
	Observation was made	de on 11/18/15 at 10:00 AM			resident.			
	of resident sitting in w	wheelchair behind the nurse's			The facility will conduct an interdiscipling	nary		
	station drinking a sod	la and the wander guard was			weekly standards of care meeting (SO	C)		
	attached to the back	of wheelchair.			to review residents at risk for safety			
					incidents. Members of the			
	_	on 11/18/15 at 10:10 AM,			interdisciplinary team include but is not			
		nat she has not seen the			limited to the Director of Nursing,			
	,	e building. Nurse #8 further			Rehabilitation, and Social Work. This	.,		
		nt was put on Q 15 minute			meeting will include input from the facil	-		
	checks for exiting out	of the dining room door.			psychological group and attending MD applicable, on current interventions and			
	During an interview o	n 11/18/15 at 10:15 AM, NA			any necessary changes to the resident			
		has not seen the resident try			care to ensure residents are receiving			

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F 323	Continued From page	9	F3	323			
	to exit the building. No resident does wheel the throughout the building	IA #7 further stated that the nerself in wheelchair			appropriate and timely interventions. The DON/designee will submit the minutes of the weekly SOC to the Regional Clinical Director x 3 months for	or	
	Social Worker stated herself in wheelchair only tries to exit the fa	n 11/18/15 at 10:18 AM, the that the resident does wheel throughout the facility and acility if she has a Urinary			DON will submit summary of the weekl SOC with all the evidence of training,	-	
	Assistant Director of I the resident may go t easily redirected. The	n 11/18/15 at 10:20 AM, the Nursing (ADON) stated that o the door to look out but is e ADON further stated that			audits, monitoring and trends to month Quality Assurance and Performance Improvement meeting for review, discussion and/or needed changes to ensure continued compliance until resolved.	У	
	building.	resident try to exit the			The Administrator/Maintenance Director will submit a summary of all monitoring		
	the resident sitting up area visiting with a fa was made of the wan resident's wheelchair During an interview o	de on 11/18/15 at 2:30 PM of in wheelchair in the foyer mily member. Observation derguard attached to the on the back. n 11/18/15 at 3:50 PM, NA w the resident sitting up in			efforts regarding operation of Door Alarms and wanderguard system, including work orders of completed repairs to the monthly Quality Assurance and Performance Improvement meetin for review, discussion and/or needed changes to ensure continued complian until resolved.	g	
	her wheelchair rolling	around on the hall at 10:15 en she was made her last					
	Maintenance Director room door alarm syst battery. The Mainten he checks the battery Thursday and does n battery is changed. Tindicated that he has in the past to check the	n 11/18/15 at 5:00 PM, the indicated that the dining em uses a 9 volt heavy duty ance Director further stated if life by sound every ot keep a log when the The Maintenance Director a meter and has not used it he life of the battery. The instated he would contact the					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345213	B. WING			C 11/20/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	EVARD	11/20/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	instruction. The Ma stated that the dinin in with the wandergy door will alarm when Maintenance Director changed the battery dining room exit door AM when he was not #22 was found outs. Observation was madoor on 11/18/15 at and door was alarm. During a telephone PM, Nurse #9 indicated the too the room doorway that the resident was to her wandering the stated that the nurse banging noise and for the dining room door the glass door with a stated that the reside was no apparent inj (NA) got the resider and cleaned up and Nurse #9 said she control the too the stated that the resider and cleaned up and Nurse #9 said she control the too the stated that the resider and cleaned up and Nurse #7 stated that the resider and nurse #7 stated that the resider and nurse #7 stated that the resider and nurse #7 stated that the nurse for the for the form of	any for manufacturer's intenance Director further g room door alarm is not tied uard system, the dining exit in it is opened. The or further stated that he on the alarm system for the or on 11/13/15 around 12:30 otified at home that Resident	F3	23		

NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE LILLINGTON (X4) ID PREFIX (EACH ODEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 11 resident on her knees outside the dining room door banging on the door with a rock. Nurse #7 stated she yelled for help and she went out another door about 10 feet away from the resident wheelchair wheelchair was about 6 feet away from her stuck in the mud. Nurse #7 said she checked the resident white she was outside and she was able to stand. The resident was put in her wheelchair and rolled back into the facility. Nurse #7 said the weather outside was damp and the air was brisk. Nurse #7 stated said she immediately called the DON. During an interview on 11/19/15 at 7:55 AM, housekeeping staff #2 revealed that she saw Resident #22 attempt to go out of the door near the kitchen area on last week and she redirected Resident #22.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE LILLINGTON (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 11 resident on her knees outside the dining room door banging on the door with a rock. Nurse #7 stated she yelled for help and she went out another door about 10 feet away from the resident while she was outside and she was able to stand. The resident was about 6 feet away from her wheelchair and rolled back into the facility. Nurse #7 said the weather outside was damp and the air was brisk. Nurse #7 stated said she immediately called the DON. During an interview on 11/19/15 at 7:55 AM, housekeeping staff #2 revealed that she saw Resident #22 attempt to go out of the door near the kitchen area on last week and she redirected Resident #22.			245242				l	-
UNIVERSAL HEALTH CARE LILLINGTON (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK) TAGK COntinued From page 11 resident on her knees outside the dining room door banging on the door with a rock. Nurse #7 stated she yelled for help and she went out another door about 10 feet away from her resident. Nurse #7 stated that the resident wheelchair was about 6 feet away from her stuck in the mud. Nurse #7 said she checked the resident while she was outside and she was able to stand. The resident was put in her wheelchair and rolled back into the facility. Nurse #7 said the weather outside was damp and the air was brisk. Nurse #7 stated said she immediately called the DON. During an interview on 11/19/15 at 7:55 AM, housekeeping staff #2 revealed that she saw Resident #22 attempt to go out of the door near the kitchen area on last week and she redirected Resident #22.			345213	B. WING			11/	20/2015
CALLINGTON, NC 27546 CALLINGTON CALLINGTON, NC 27546	NAME OF P	ROVIDER OR SUPPLIER						
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 11 resident on her knees outside the dining room door banging on the door with a rock. Nurse #7 stated she yelled for help and she went out another door about 10 feet away from her resident. Nurse #7 said she checked the resident while she was outside and she was able to stand. The resident was put in her wheelchair and rolled back into the facility. Nurse #7 said the weather outside was damp and the air was brisk. Nurse #7 stated said she immediately called the DON. During an interview on 11/19/15 at 7:55 AM, housekeeping staff #2 revealed that she saw Resident #22 attempt to go out of the door near the kitchen area on last week and she redirected Resident #22.	UNIVERSA	AL HEALTH CARE LILLIN	NGTON					
F 323 Continued From page 11 resident on her knees outside the dining room door banging on the door with a rock. Nurse #7 stated she yelled for help and she went out another door about 10 feet away from the resident. Nurse #7 stated the weelchair was about 6 feet away from her stuck in the mud. Nurse #7 said she checked the resident while she was outside and she was able to stand. The resident was put in her wheelchair and rolled back into the facility. Nurse #7 said the weather outside was damp and the air was brisk. Nurse #7 stated said she immediately called the DON. During an interview on 11/19/15 at 7:55 AM, housekeeping staff #2 revealed that she saw Resident #22 attempt to go out of the door near the kitchen area on last week and she redirected Resident #22.					L	LILLINGTON, NC 27546		
resident on her knees outside the dining room door banging on the door with a rock. Nurse #7 stated she yelled for help and she went out another door about 10 feet away from the resident. Nurse #7 stated that the resident wheelchair was about 6 feet away from her stuck in the mud. Nurse #7 said she checked the resident while she was outside and she was able to stand. The resident was put in her wheelchair and rolled back into the facility. Nurse #7 said the weather outside was damp and the air was brisk. Nurse #7 stated said she immediately called the DON. During an interview on 11/19/15 at 7:55 AM, housekeeping staff #2 revealed that she saw Resident #22 attempt to go out of the door near the kitchen area on last week and she redirected Resident #22.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
Observation was made on 11/19/15 at 10:30 AM of the area where the Resident #22 was found and there was 12 foot cement sidewalk that goes out from the dining room exit door. Observation was of the construction site which was about 40 feet from the dining room exit door. Review of the manufacturer's instructions dated on December 23, 2014 read in part "Parts breakdown depiction: 9 volt battery. Low battery alert: Simultaneous siren chirps and red LED flashes occur at 45 seconds intervals when the battery reaches approximately 7 volts. "The Maintenance Director had the manufacturer's instruction sent to facility on 11/19/15. Review of the manufacturer's manual, titled "Code Alert, Senior Living Solutions, Wander Management Transmitters, User Guide,"release	F 323	resident on her knees door banging on the of stated she yelled for hanother door about 10 resident. Nurse #7 st wheelchair was about in the mud. Nurse #7 resident while she was to stand. The resider and rolled back into the weather outside was Nurse #7 stated said DON. During an interview of housekeeping staff #2 Resident #22 attempts the kitchen area on land Resident #22. Observation was made of the area where the and there was 12 food out from the dining rowas of the construction feet from the dining rowas of the construction feet from the dining rowas of the construction sent to face the sent was approximated to the sent sent to face the manuface of the man	door with a rock. Nurse #7 help and she went out of feet away from the lated that the resident to 6 feet away from her stuck of said she checked the las outside and she was able in the facility. Nurse #7 said the damp and the air was brisk. Is he immediately called the on 11/19/15 at 7:55 AM, or revealed that she saw or to go out of the door near last week and she redirected on 11/19/15 at 10:30 AM Resident #22 was found of cement sidewalk that goes om exit door. Observation on site which was about 40 or exit door. acturer's instructions dated of read in part "Parts of yolt battery. Low battery of siren chirps and red LED econds intervals when the oximately 7 volts. "The or had the manufacturer's ility on 11/19/15. acturer's manual, titled oxing Solutions, Wander	F	323			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	' '	COMPLETED		
		345213	B. WING			C 11/20/2015		
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	•	1172072010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 323	When the code water a resident's ankle, but at each door to a 4 to Failure to do so may because they will be door detects the trainmanual, read in partial or the back of the character of the character of the back of the back of the character of the	7, read in part, "Warning: ch (wanderguard) is placed on e sure to adjust the antennae to 5 ft. range to the ankle. 7 allow a resident to elope e closer to the door when the asmitter." Also pg. 9 of the ch, "Note: To monitor a resident to the transmitter to the seat thair as the metal on the chair e transmitter's signal. #4 that the transmitter is in a fronthe resident's wrist or interview on 11/19/15 at 10:33 m the manufacturer of the watch, stated the code watch elet) should not be placed on a wheelchair because it could insmitter's signal. 11/20/15 at 9:06 AM, the ted that it is her expectation frector use the alarm system auctions and change the gistering 7 volts by using the	F 32	23				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 11/20/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/20/2013	
UNIVERS	AL HEALTH CARE LILL	INGTON		1995 EAST CORNELIUS HARNETT BOULEVA LILLINGTON, NC 27546	ARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 323	of Daily Living, Residents assistance with trans A Nursing Note date part, "Informed per subuilding. Writer notice wheelchair outside of Wheeled back into far placed on right wrist. Staff Nurse #1. Review of a docume Assessment - Report Seeking/Wandering: revealed: "7/18/15 12:45 PM-1 resident out of building sitting in wheelchair lot. Wheeled back in indicated that the resident out of building sitting in wheelchair lot. Wheeled back in indicated that the resident wheeled back in indicated that the resident. A Nursing Note date part, "Resident aler bed in wheelchair, point of the resident had bracelet. Placed back was written by Staff During an interview of Supervisor# 1, stated elopement incident of did not work that often noted on Resident # report of 7/18/15 as supervisor. During an interview of Nursing Assistant #1 Resident # 116 elopid	s, and in the area of Activities dent #116 required limited sfers and used a wheelchair. d 7/18/15 at 7:04 PM, read in staff seeing resident out of ed resident sitting in if building in parking lot. acility. Wanderguard bracelet "The note was written by nt titled "Elopement t of Resident Exit Attempting to leave facility" Informed per staff of seeing ing. Writer noticed resident outside of building in parking to facility. "The document sident did not have on a he action taken by the facility ent of wanderguard bracelet d 7/19/15 at 6:27 PM, read in t, some confusion. Out of ropelling within facility. I removed wanderguard k onto right ankle." The note	F 32	3		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		345213	B. WING			11/	20/2015
NAME OF PR	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
LININ/EDO/	NI HEALTH CARE LILLIA	NOTON		-	1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON			LILLINGTON, NC 27546		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	a 14		222			
1 020	1 0	, 14		323			
	elopement incident.	OM an affart was made to					
		PM an effort was made to					
		1 who retrieved Resident					
	#116 from the parking						
	-	eport on 7/18/15. Staff Nurse					
	her telephone was dis	ployed with the facility and					
	nei teleprione was dis	sconnected.					
	The resident was disc	charged to the hospital on					
		Imitted to the facility on					
	7/23/15.						
		t recent Quarterly Minimum					
	_	d 10/6/15, Resident #116's					
	, ,	ntal Status (BIMS) was 00,					
		t # 116 was cognitively					
		y impaired decision making					
		ehavior, Resident #116 was					
	coded, with no wande	ering behaviors, and in the					
	area of Activities of Da	aily Living, Resident #116					
	required extensive as	sistance with transfers and					
	used a wheelchair.						
	A Nursing Note dated	l 10/11/15 at 8:15 PM, read					
		dent's family member was					
		n hallway to nurse and					
	stated resident was s	itting outside. Registered					
	Nurse supervisor and						
	•	and stated to start every 15					
		lent #116's responsible					
	person/family membe						
	_	II. Night nurse made aware.					
		t in room at this time." The					
	note was written by S						
	Review of a document						
	Assessment Report of						
	revealed:	Attempting to leave facility "					
		Another resident family					
		•					
	outside in parking lot.	dent back in stated she was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	COMPLETED	(X3) DATE SURVEY COMPLETED	
		345213	B. WING		11/20/20)15	
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	•	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COM	(X5) IPLETION DATE	
F 323	Continued From pag	e 15 Ited the facility's security	F 32	3			
	alarm did not sound, monitoring device wa at the time the reside building. However, the action taken by the resident's where A Nursing Note date in part, "Resident wi On every 15 minute written by Staff Nurse Review of Resident 10/14/15, read in partordered, Wandergua secure alarm per pol facility protocol. Obstrequently." During an interview of Nurse #2 stated she on 10/11/15 when ar member brought Resident was at the control of the co	and the resident's as observed on the resident ent was found outside of the ne device was not working. The facility included to check abouts every 15 minutes. In device 10/12/15 at 8:07 AM, read thout attempt to leave facility. The note was ee #4. #116's Care Plan dated the theorem as red. Check functioning of icy. Check placement per erve resident's whereabouts on 11/18/15 at 3:10 PM Staff was doing a medication pass nother resident's family sident #116 back into the					
	Resident #116 in her medication cart and #116 was found sittin parking lot. Staff Nur see a wanderguard but she recalled the on the resident's who not know how long Finissing. Staff Nurse remember which sta work with the resider facility while unsuper she did know whether exit seeking behavior. Staff Nurse medication in the staff nurse work with the resider facility while unsuper she did know whether exit seeking behavior. Staff Nurse medication in the staff nurse was a staff nurse with the staff nurse with the staff nurse was a	the family member pushed in wheelchair down to the sinformed her that Resident and in her wheelchair in the see #2 said at first she did not pracelet on Resident #116, wanderguard bracelet was elelchair. She stated she did the sident #116 had been at #2 said she did not fit member was assigned to not the day she exited the evised. Staff Nurse #2 said ar or not Resident #116 had ar and she had not observed aiting any exit seeking at #2 explained she did not the shall a lot and that she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	· ,	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C 1/20/2015	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP COI 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DE	1120/2010	
(X4) ID PREFIX TAG			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 323	came in to do the ince Resident #116 wands she did not know who sounded when Reside During an interview of Nursing Assistant #4 work with Resident # never wandered outs Resident #116 wands her wheelchair near of Assistant #4 said he not he worked on 10, #116 exited from the During an interview of family member that a in the parking lot and the facility, revealed into the facility from of family member state outside near benches not recall taking any During an interview of Assistant Director of known Resident #116 behavior and she wo was wearing a wands she had never seen of Assistant Director of Resident #116's incic Supervisor, she did in Nurse #2 about the in 10/11/15. During an interview of Director of Nursing (I to call her about ever Assistant Director of October and she was	and. She stated when she ident report staff told her ered a lot. She relayed that either or not the door alarm lent #116 exited the facility. In 11/18/15 at 5:55 PM, revealed he was assigned to 116 and the resident had eide of the building. He stated ered, but she usually sat in the nursing station. Nursing could not recall whether or 11/15, the day Resident facility. In 11/18/15 at 4:18 PM, the ellegedly saw Resident #116 took her to the staff nurse in the brought residents back outside all the time. The day that some residents sat in front of facility, but he did	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		· /	(X3) DATE SURVEY COMPLETED			
		345213	B. WING		,	C 11/20/2015
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	•	11/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	incident of 10/11/15 The DON revealed of Resident #116 exite The DON revealed of Resident #116 was eloped from the faci said she realized Resident #16 was eloped from the faci said she realized Resident was eloped from the faci wanderguard bracel DON said after Resident was at ris responsible person initiate fifteen minute expected supervisor her. During an interview Maintenance Directed door and side door a wanderguard syste checked doors once open the door, set of the door. He said he bracelet, walk up to alarm. The Maintena wanderguard bracel while he tested the bresident with a wand close to the door in sound. The Maintena wanderguard bracel a wand	stated she found out about the on Monday after the incident. The one notified her when different the facility in October. Staff should have known a wanderer because she lity in July 2015. The DON esident #116 was a wanderer not's last assessment. She found out Resident #116 had	F 3.	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		345213	B. WING			1	20/2015
	ROVIDER OR SUPPLIER	NGTON	1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546	1102	20/2013
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	door would lock when set off the door alarm for staff to turn off the Maintenance Director wanderguard bracele Restorative Aide. During an interview of facility Restorative Aide indicating that she test wanderguard bracele she always held the twanderguard bracele on the tester until it be she tested the wander revealed that she won next to the wanderguard bracele would come on to ind working. She revealed work, she would retest at the front door. Review of the manufation of the manufation of the tested watch a resident's ankle, be at each door to a 4 to	the a system in which the in the resident's wanderguard in the resident's wanderguard in the said there was a code alarm once it sounded. The infurther revealed individual its were tested weekly by a support of the presented documentation at the presented documentation at the standard standard in 11/20/15 at 11:40 AM, a support of the presented documentation at the standard in th	F	323			
	because they will be of door detects the transmanual, read in part, in a wheelchair, attacor the back of the chacan interfere with the	closer to the door when the smitter."Also pg. 9 of the "Note: To monitor a resident h the transmitter to the seat air as the metal on the chair transmitter's signal. #4 at the transmitter is in a					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION IG	_	(X3) DATE SURVEY COMPLETED
		345213	B. WING _			C 11/20/2015
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, S 1995 EAST CORNELIUS H LILLINGTON, NC 2754	HARNETT BOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 323	ankle." During a telephone in AM a Technician from wanderguard code w. (wanderguard bracele the metal portion of a interfere with the transport of the metal portion of a interfere with the transport of the metal portion of a interfere with the transport of the metal portion of a interfere with the transport of the metal portion of a interfere with the transport of the metal portion. The was attached to the lower wheelchair near the repuring an interview of Maintenance Director of the metal of	terview on 11/19/15 at 10:33 at the manufacturer of the atch, stated the code watch et) should not be placed on wheelchair because it could smitter's signal. In on 11/19/15 at 9:45 AM, tting in her wheelchair in the inderguard bracelet was right corner, metal portion of ight wheel. In 11/19/15 at 3:27 PM, the revealed he used a it to test doors. The rependent the front double while he had a wanderguard He stated he usually had a est the door and the alarm distance. After the alarm the code to stop the alarm. Eactor said he would have to the for the alarm to go off. He was sitting in front of the into sound, however if door while the resident was the alarm would sound. AM Resident #116 was are wheelchair up the hallway.	F3	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _		1	C /20/2015
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		STREET ADDRESS, CITY, STATE, ZIP COD 1995 EAST CORNELIUS HARNETT BOU LILLINGTON, NC 27546	E	72072010
(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)	I SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From page		F 3	23		
	wheel.	etal brace near the right				
	observed at the hallw Work office, sitting in residents. The reside	PM Resident #116 was yay entrance near the Social wheelchair next to other int's wanderguard bracelet in wheelchair on the metal wheel.				
	observed propelling harea. Another resider wheelchair. Both resi wheelchairs through administrative offices station. Resident #11 on the right side of he	PM, Resident #116 was ner wheelchair to the lobby not was following her in her dents propelled their the lobby area past the and back to the nurse's 6's wanderguard remained er wheelchair, on a metal f wheelchair near the right				
	Staff Nurse #3 stated Resident #116's hall (7:00AM-3:00PM). Stand down the hall. Stand down the hall. Stand down the hall. Stand down the building of the time Resident areas. Staff Nurse #3 was not one to be must be relayed Resident wanderguard braceled one anymore becaus exit the facility. Staff Inot observed Resider seeking behaviors, w	the said Resident #116 could wheelchair and could go up the stated Resident #116 go by herself. She said most #116 sat in the common B revealed Resident #116 conitored for her whereabouts. It #116 used to have a set, however, she did not have the she had not attempted to Nurse #3 revealed she had not #116 exhibiting any exit as not aware Resident #116 and was not aware the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING				C 20/2015
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON		1995 E	T ADDRESS, CITY, STATE, ZIP CODE AST CORNELIUS HARNETT BOULEVARD NGTON, NC 27546	·	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Nursing Assistant #5 wandered up and do she never wandered stated Resident #110 nurse's station and verification near lunch time. In resultant Nursing Assistant #5 number of residents checks and Resident to check frequently, seen Resident #116 Assistant #5 said what 116 to be checked for times out of ten, Resonurse's station. Nursing she started work ever would tell them which checked more frequent name never came upstated she was not at the facility while unsured the facilit	on 11/19/15 at 12:09 PM, if, revealed Resident #116 with halls in the facility and outside of the facility. She is sat in her wheelchair at the was usually around that area beference to supervision, is stated they had a certain on every fifteen minute it #116 was never on the list She stated she had never try to open doors. Nursing en it was time for Resident # in toileting, she revealed, nine sident #116 would be at the ing Assistant #5 stated when ery morning, the charge nurse in residents needed to be ently and Resident #116's in Nursing Assistant #5 iware Resident #116 exited supervised in July 2015 and surther revealed she did not stebook with a list of residents and had exit seeking no one had discussed the with the nursing assistants. ment notebook on 11/19/15 at Resident #116's exit seeking	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING	(.	(X3) DATE SURVEY COMPLETED				
		345213	B. WING _			C 11/20/2015
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		
(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 CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	(X5) COMPLETION DATE
F 323	to the parking lot. The door to the van drop of was fifty feet. The disparking lot was anoth During an interview of facility Social Worker of Resident #116's eletime she heard about yesterday in a staff ma resident eloped from rurse would call the felopement. The Social residents go up and oknew Resident #116 did not know the residents yesterday. She revea always hang out near Social Worker further would be put on 24 he would be discussed of meetings. During an interview of Minimum Data Set (Minimum Data Set (Minimum Data Set) (Minimum Da	PM, the Maintenance t Maintenance man the from the facility doorway de distance from the front off area in the parking lot, tance straight to the second the fifty feet. In 11/19/15 at 2:14 PM, the stated she did not recall any opements. She said the first the elopements was the elopements was the elopements was the facility, the assigned family to let them know of an fall Worker stated all flown hallways. She said she thad a chair alarm but she dent had a wanderguard until fled Resident #116 would the nurse's station. The said usually elopements our nursing reports and fluring morning staff In 11/19/15 at 2:25 PM, the flDS) Coordinator stated she #116's first elopement in as when the wanderguard	F3	323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 11/20/2015	
	ROVIDER OR SUPPLIER	NGTON		1	STREET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546	111/2	20/2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Resident #116 not to behaviors and the wa on her ankle. She furth was staff would report of Nursing, the Assist to her. The Administration staff to document elogreport and notify the form the Administrator saic communicated with Nelopements. During an interview of Facility Medical Direct the wanderers but it houring Quality Assurate revealed QA should hand "we could have detriment to the resident environment and the The Administrator was Jeopardy on 11/19/15. The facility provided the Allegation on 11/20/1. Problem/Incident: 1) Resident # 116 we without injury. Staff #116's exiting the facility. Resident #116 were notified. The for resident #116 was staff without injury. Staff #116's exiting the facility were notified. The for resident #116 was staff would report was staff would re	d her expectation was for have any more exit seeking inderguard would be placed ther stated her expectation it elopements to the Director ant Director of Nursing, then ator's expectation was for beenent on the 24 hour family and medical director. It divides they usually lursing Assistants about a said not been discussed ince (QA) meetings. He have looked at wandering fixed it before it became a lents. It has to be a safe safety of the patients." Is notified of the Immediate of at 8:45 AM. The following Credible of at 10:18 AM. The following Credible of the driveway to the front as brought back inside the of was assessed and found to fit was alerted to resident lity, the attending MD and are intervention implemented	F	3323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C I 1/20/2015	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP COD 1995 EAST CORNELIUS HARNETT BOU LILLINGTON, NC 27546	E	11/20/2013	
(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	(X5) COMPLETION DATE	
F 323	precautionary measure wanderguard. Residexit seeking events seekin	location x 72 hours as re after placement of the ent #116 has had no other ince 10/11/15. It discovered on her knees de the dining room door at 5. She was assisted back using staff and assessed with e attending physician & RP cility investigation revealed: It is CNA had checked resident lent was in her w/c in m on DR door was found to staff tested by opening the 12 was placed on 15 min resident 's location as a re. (4) Maintenance was a larm and battery was by maintenance. Resident her exit seeking events since	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C I 1/20/2015	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	on 10/11/15 has work seeking events. Resplacement of wander noted wanderguard has wheelchair. Wanderguard has wheelchair and reappankle. Nursing staff won 11/19/15 regarding wanderguards. Wandbeen added the MAR placement every shift Potential Residents: All Current residents 11/20/15 by the ADO who are at high risk find Residents identified a behaviors have a new completed 11/20/15 the Guides have been upstaff to ensure they a high risk of wandering. Two notebooks were pictures of all resident wandering on 11/19/10 located at the receptistation to ensure staff resident with a high residents currently been assessed for wanderguards are plarecommended by the 11/19/15. As of 11/19/15 newly assessed for the risk behaviors within 24 has of 11/19/15 any reexiting seeking events.	wanderguard implemented ked with no other exit ident assessed for guard on 11/19/15 and had been moved to guard removed from polied to resident #116's was in serviced by the ADON gracement of derguard placement has and nurses will check at starting 3-11 shift 11/19/15. Were reassessed on Not identify any residents or wandering behavior, as having exit seeking wand/or updated Care plan by MDS nurse. CNA Care podated and reviewed with a ground 11/20/15 by the ADON. Created that contain the hats identified as high risk for 15. The notebooks will be onist desk and nurse's fis able to identify any isk for wandering. We with a wanderguard have ander guard placement. All faced on residents as a manufacturer as of admitted residents will be of wandering /exit seeking hours of admission.	F 32	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING		,	C 11/20/2015	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 323	Training will be compunsafe wandering or identification of resid creating a safe environment for resid of wanderguards on wheelchair by the AE not available for this work until training is Maintenance will chefor functioning and d Alarm Check monitor box not functioning pimmediately by main received in-service tr 11/18/15. All wander 11/19/15 by maintenance will che and audible alarm or for battery life by usin manufacturer's recorbattery when reading Maintenance will doo Door Alarm Check m received in-service tr 11/18/15. All doors a by maintenance and voltage over 7.0. Monitoring: The facility will condustandards of care me behavior that will rev wandering and/or elebeginning 11/23/15. interdisciplinary team the Director of Nursin	will be notified for follow-up. Deleted with all current staff on Elopement including, ent wandering behavior, comment, providing a safe dents and proper placement the resident and not their DON on 11/19/15. Any staff training will not be allowed to complete. Eck wander guard boxes daily occument finding on the Door ring tool. Any wanderguard properly will be corrected tenance. Maintenance raining on this procedure on guard boxes were audited ance and are working eck the voltage of batteries and Il door alarms 4 x weekly and a meter and follow mendation of changing is 7.0 voltage or less. Eument his finding on the conitoring tool. Maintenance raining on this procedure on alarms were audited 11/19/15 documented with all battery eleting regarding wandering iew any resident with unsafe opement seeking behavior	F 3:	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			20/2015
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		
(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 CORRECTION ((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490 SS=J	necessary changes to residents are receiving interventions. The credible allegation at 11:30 AM as evide staff related to their bounderstood how to identify the residents at risk for elunderstood how to identify the residents at risk for work when wanderguard bounderstood how often audible alarms check wanderguard sensor accuracy of alarming addition updated care assessments were venotebooks. Observation wanderguards and we effectively. 483.75 EFFECTIVE ADMINISTRATION/R A facility must be admenables it to use its refficiently to attain or practicable physical, well-being of each residentify sadministration and enforce adherence instructions for the approximation of the	ent interventions and any of the resident care to ensure any of the resident care to ensure any appropriate and timely on was verified on 11/20/15 enced by: interview of all eing able to identify depement and verifying staff entify, report and monitor randering. Interview staff on exest are to be checked for any voltage of batteries and ed on doors and how often doors would be checked for and proper placement. In explans, care guides and erified as well as elopement of anderguard system working existences effectively and maintain the highest mental, and psychosocial sident. The is not met as evidenced item and staff interviews, the infailed to have available	F 3		t to s by on	12/21/15

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CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				CIVID INC	<u>, 0930-039 i</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		345213	B. WING			11/3	20/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINIVEDO	AL UEALTU CARELILLI	NCTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LI	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
					DETICIENCY)		
F 490	Continued From page	e 28	F	490			
	system which resulte	d in an immediate jeopardy			not having Policies and Procedures in		
		impaired residents (Resident			place for checking door alarms per		
		16) who exhibited wandering			manufacturer s recommendations and	1	
	behaviors from exiting	· ·			not ensuring the wanderguards were o		
	unsupervised.	g the facility wrine			the resident rather than their wheelcha		
	1	began on 10/11/15 when			Resident #22 has had no exit seeking		
		e facility unsupervised and			events since 11/12/15. Maintenance w	ш	
		r in the front parking lot of			check wanderguard boxes daily for	11	
	the facility. The reside			functioning and document findings on t	ho		
	failed to activate the			Door Alarm Check monitoring tool. Any			
		began on 11/12/15 when			wanderguard box not functioning prope		
						HIY	
		facility unsupervised and			will be corrected immediately by		
		night by staff. The dining			maintenance. All wanderguard boxes		
		to alarm due to a dead			were audited 11/19/15 by maintenance		
		Jeopardy was identified on			and are working properly.		
		and was removed 11/20/15			Resident #116: The wanderguard	:41-	
		e facility provided and			implemented on 10/11/15 has worked	NITN	
	1	ole allegation of compliance.			no other exit seeking events since		
	1	out of compliance at a lower			10/11/15. Resident assessed for	_	
	scope and severity le				placement of wanderguard on 11/19/19)	
	•	ctual harm with potential for			and Wanderguard was removed from		
		arm that is not Immediate			wheelchair and reapplied to resident		
		monitoring of systems put in			#116 □s ankle. Nursing staff was in		
	-	of employee training.			serviced by the ADON on 11/19/15		
	The findings included				regarding placement of wanderguards	•	
	_	renced to F 323: Based on			manufacturer□s guidelines. Wandergu		
	I .	aff interviews, the facility			placement has been added the MAR a		
		4 cognitively impaired			nurses will check placement every shif	t	
		#22 and Resident #116) who			starting 3-11 shift 11/19/15.		
		behaviors from exiting the			All Current residents were reassessed	on	
	facility while unsuper	vised.			11/20/15 by the ADON to identify any		
					residents who are at high risk for		
		is notified of the Immediate			wandering behavior. Residents identif		
	Jeopardy on 11/19/15	5 at 8:45 AM.			as having exit seeking behaviors have		
					new and/or updated Care plan comple	ted	
	The facility provided t	the following Credible			11/20/15 by MDS nurse. CNA Care		
	Allegation on 11/20/1	5 at 10:18 AM.			Guides have been updated and review	ed	
					with staff to ensure they are aware of		
	Problem Identified:				residents with a high risk of wandering	on	

OLIVILIV	e i eit medie/ iite a	1				<u> </u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345213	B. WING			1	20/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11//	20/2010
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 490	Continued From page	e 29	F	490			
	commutation page			100	11/20/15 by the ADON.		
	Facility Administrator	, Director of Nursing and			Newly admitted residents will be asses	sed	
	-	Nursing failed to create a			by the admitting nurses for safety risk	004	
		residents by not ensuring			within 24 hours of admission with		
		ined on unsafe wandering			appropriate inventions and care planning	ng	
		r, not having Policies and			for any resident assessed as high risk.		
		for checking door alarms per			The DON/designee will complete a 24	ĺ	
	manufacturer's recon				hour admission chart review during the		
		guards were on the resident			A.M. clinical meeting to ensure all MD		
	rather than their wheelchair. New interventions:				orders, admission assessments and at		
		Clinical Compart Novaca has			risk assessments have been completed	ן נ	
	_	Clinical Support Nurse has			correctly and timely.	ol.	
		with facility Administrator, nd Assistant Director of			Two notebooks were created by Medic Records and Ward Clerk that contains	aı	
	Nursing regarding un				photos of all residents identified as high	h	
		identification of resident			risk for wandering on 11/19/15. The	•	
		creating a safe environment,			notebooks will be located at the		
		nt assessments at the time of			receptionist desk and nurse ☐s station	ίΟ	
	admission and the tin	ne of any event of unsafe			ensure staff is able to identify any resid	lent	
	wandering or elopem	ent, notification of any			with a high risk for wandering. MR will		
	events with potential				review and update notebooks as neede		
	outcomes to Clinical				All residents currently with a wandergu	ard	
	completion of Quality				have been assessed for wanderguard		
		ement Plan to prevent			placement. All wanderguards are place	:a	
	re-occurrence of any regarding resident ca				on residents as recommended by the manufacturer as of 11/19/15.		
	Togatumy resident ca	iic and salety.			As of 11/19/15 any resident experiencial	na	
	Resident #22: Mainte	enance will check			an exit seeking event will be immediate	-	
		daily for functioning and			re-assessed and intervention put in pla		
		the Door Alarm Check			The DON/Administrator will be notified		
	_	wander guard box not			follow-up.	ſ	
		will be corrected immediately			Training was completed by the ADON of		
		vanderguard boxes were			11/19/15 with all current staff on unsafe	;	
	-	maintenance and are working			wandering or Elopement including,	ĺ	
	properly.				identification of resident wandering		
	NA-integral	all the coefficient of Latter			behavior, creating a safe environment	and	
	Maintenance will che			providing a safe environment for	:_		
		all door alarms 4 x weekly ng a meter and following			residents. Any staff not available for thi training will not be allowed to work unti		
	ioi ballery ille by usil	ig a motor and ioliowing			I coming will not be allowed to work drill	1	I

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345213	B. WING _				C 20/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON			ILLINGTON, NC 27546		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	2.30		490			
1 400			F 4	490	Annining to a second of All to south this of		
		nmendation of changing			training is complete. All newly hired		
		is 7.0 voltage or less.			employees will receive this training dur orientation.	ing	
		ument his finding on the pointoring tool. All doors			The Maintenance Director received		
		11/19/15 by maintenance			in-service training by the Administrator	on	
		all battery voltage over 7.0.			11/18/15 on the new procedure of (1)	OH	
		vander guard implemented			Maintenance will check the wandergua	rd	
	on 10/11/15 has work	- · · · · · · · · · · · · · · · · · · ·			boxes daily for functioning and docume		
	seeking events. Resident assessed for				findings on the Door Alarm Check	,,,,	
	_	guard on 11/19/15 and			monitoring tool. (2) Maintenance will		
			check the voltage of batteries and audi	ble			
	wheelchair. Wanderg				alarm on all door alarms 4 x weekly for		
	wheelchair and reapp	lied to resident #116's			battery life by using a meter and follow		
	ankle. Nursing staff w	as in serviced by the ADON			manufacturer□s recommendation of		
	on 11/19/15 regarding	g placement of			changing battery when reading is 7.0		
	wanderguards. Wand	lerguard placement has			voltage or less. Maintenance will		
		and nurses will check			document his finding on the Door Alarn		
		starting 3-11 shift 11/19/15.			Check monitoring tool. Any wandergua	rd	
	Potential Residents:				box or audible alarm not functioning		
	All Current residents				properly will be corrected immediately	and	
		N to identify any residents			documented by maintenance.		
	_	or wandering behavior.			All wanderguard boxes were audited		
	Residents identified a				11/19/15 by maintenance and are work	-	
		v and/or updated Care plan			properly. All doors alarms were audited	1	
		by MDS nurse. CNA Care			11/19/15 by maintenance and		
	•	dated and reviewed with			documented with all battery voltage ov 7.0.	er	
	-	re aware of residents with a g on 11/20/15 by the ADON.			The facility will conduct an interdiscipling	on.	
		created that contain the			weekly standards of care meeting (SO	•	
		ts identified as high risk for			to review residents at risk for safety	-)	
	'	5. The notebooks will be			incidents. Members of the		
	_	onist desk and nurse's			interdisciplinary team include but is not		
	· ·	f is able to identify any			limited to the Director of Nursing,		
	resident with a high ri				Rehabilitation, and Social Work. This		
		with a wander guard have			meeting will include input from the facil	ity	
		anderguard placement. All			psychological group and attending MD	-	
	wanderguards are pla				applicable, on current interventions and		
	recommended by the				any necessary changes to the resident		

11/19/15.

care to ensure residents are receiving

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				CIVID IVC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345213	B. WING			11/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 490	Continued From page	e 31	F	490			
		admitted residents will be			appropriate and timely interventions.		
		of wandering /exit seeking			Beginning 11/19/15 the Administrator w	vill .	I
	behaviors within 24 h				monitor the Maintenance Door Alarm		I
		esident experiencing an exit			Check sheets daily x 4 weeks; then,		I
	1	immediately re-assessed			weekly times 3 months to ensure		
	and intervention put in	•			compliance.		
	1	ill be notified for follow-up.			The DON/designee will submit the		
		leted with all current staff on			minutes of the weekly SOC to the		1
	unsafe wandering or	Elopement including,			Regional Clinical Director x 3 months for	or	1
	identification of reside	ent wandering behavior,			review.		1
creating a safe environment, providing a safe The Facility DON		The Facility DON and/or designee will		1			
	environment for resid	ents and proper placement			monitor the wanderguard placement of		1
	_	the resident and not their			identified residents weekly x 4weeks a	nd	
		ON on 11/19/15. Any staff			compare to MARs documentation on		
		training will not be allowed to			wanderguards to ensure compliance. It		1
	work until training is o				any discrepancies are found, the nurse	J	1
		ck wanderguard boxes daily			will be identified, reeducated and		1
	_	ocument finding on the Door			counseled by the DON or ADON.		
		ing tool. Any wanderguard			Compliance will be monitored daily by		
		roperly will be corrected			Director of Nursing/administrative nurs		
		enance. Maintenance			and/or facility Administrator with review		
		aining on this procedure on			daily 24 hour reports, physician telephorders, and resident incident reports to		
	11/19/15. All wanderg	guard boxes were audited			ensure that all potential adverse events		1
	properly.	ance and are working			regarding resident care and safety are	,	
	1	ck the voltage of batteries			addressed and interventions are in place	<u></u>	
		all door alarms 4 x weekly			DON will submit summary of the weekl		
	for battery life by usin				SOC with all the evidence of training,	,	
		nmendation of changing			audits, monitoring and trends to month	lv	1
		is 7.0 voltage or less.			Quality Assurance and Performance	,	
		ument his finding on the			Improvement meeting for review,		I
		onitoring tool. All doors			discussion and/or needed changes to	ſ	
	I .	11/19/15 by maintenance			ensure continued compliance until	ſ	
		all battery voltage over 7.0.			resolved.	ĺ	
	Monitoring:	·			The Administrator/Maintenance Director	r	
	The facility will condu	ct an interdisciplinary weekly			will submit a summary of all monitoring	ļ	
	standards of care me	eting regarding wandering			efforts regarding operation of Door	ĺ	
		ew any resident with unsafe			Alarms and wanderguard system,	ĺ	
	wandering and/or elo	pement seeking behavior			including work orders of completed		l

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SUND (X3)		LETED				
		345213	B. WING _				C 20/2015
	ROVIDER OR SUPPLIER	NGTON		199	REET ADDRESS, CITY, STATE, ZIP CODE 95 EAST CORNELIUS HARNETT BOULEVARD LLINGTON, NC 27546	, -::	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	the Director of Nursin Work and Dietary. The from the facility psych attending MD on currencessary changes to residents are receiving interventions. Director of Nursing an will conduct a weekly with review of any resund/or exit seeking be include member of the input from facility psy attending physician for	Members of the include but is not limited to g, Rehabilitation, Social is meeting will include input nological group and ent interventions and any of the resident care to ensure ag appropriate and timely and/or administrative nurse standards of care meeting sident with unsafe wandering ehavior. This meeting will be interdisciplinary team with chological group and or current interventions and es to the resident care to	F2	490	repairs to the monthly Quality Assuran and Performance Improvement meetir for review, discussion and/or needed changes to ensure continued compliar until resolved.	g	
F 520 SS=J	at 11:30 AM as evide staff related to their b residents at risk for e understood how to idresidents at risk for w when wanderguard b functioning; how ofter audible alarms check wanderguard sensor accuracy of alarming addition updated care assessments were venotebooks. Observati	lopement and verifying staff entify, report and monitor andering. Interview staff on oxes are to be checked for an voltage of batteries and ed on doors and how often doors would be checked for and proper placement. In eplans, care guides and erified as well as elopement ons of proper placement of anderguard system working	F 5	520			12/21/15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _		11/20/2015
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOUL LILLINGTON, NC 27546	
(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 CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
F 520	Continued From page QUARTERLY/PLANS		F 5	520	
	assurance committee nursing services; a ph	in a quality assessment and consisting of the director of hysician designated by the other members of the			
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies.			
		rds of such committee h disclosure is related to the ommittee with the			
		y the committee to identify ficiencies will not be used as			
	by: Based on observatio interviews the facility' Assurance Committee implemented procedu interventions that the October of 2014. The of failure to prevent a failure of the facility direcord show a pattern	n, record review and staff s Quality Assessment and e (QAA) failed to maintain ures and monitor these committee put into place in e deficiency was in the area eccidents. The continued uring two federal surveys of n of the facility's inability to quality Assurance Program.		Facility failed to develop and in Quality Assurance and Perform Improvement plan for Resident supervision for Resident #116 a Resident #22. Resident #116 was assessed a to be without injury. The attendand RP were notified. A wande was implemented for safety.	ance Safety and and Ind found Jing MD

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			<u> </u>	MB NO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C 11/20/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE .	11/20/2010	
				1995 EAST CORNELIUS HARNETT BO	ULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546			
(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 C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From page	e 34	F 5	520			
	Immediate Jeopardy Resident #116 left the was found by a visitor the facility. The reside failed to activate the a Immediate Jeopardy Resident #22 left the was found outside at room exit door failed battery. Immediate 3 11/19/15 at 9:45 AM at 10:07 AM when the implemented a credib The facility remains o scope and severity le deficiency, with no acmore than minimal had Jeopardy) to ensure a place and completion The findings included This tag is cross referenced review and stafailed to prevent 2 of residents (Resident # exhibited wandering by the state of the stag is constant.)	began on 10/11/15 when a facility unsupervised and in the front parking lot of ent's wanderguard bracelet alarm system on the door. began on 11/12/15 when facility unsupervised and night by staff. The dining to alarm due to a dead deopardy was identified on and was removed 11/20/15 a facility provided and allegation of compliance. The facility provided and allegation of compliance at a lower evel of D (an isolated attual harm with potential for farm that is not Immediate monitoring of systems put in of employee training. The enced to F 323: Based on affinterviews, the facility 4 cognitively impaired and Resident #116) who behaviors from exiting the		Wanderguard was placed or #116 s right ankle on 10/11. Resident assessed for place wanderguard on 11/19/15 ar wanderguard had been mov wheelchair. Wanderguard re wheelchair and reapplied to #116 s right ankle. Nursing serviced by the ADON on 11 regarding placement of wand manufacturer s guidelines. placement has been added nurses will check placement starting 3-11 shift 11/19/15. #116 has had no other exit s since 10/11/15. Resident # 22 was assessed be without injury. The attend & RP were notified and frequentiation of the starting by staff as to local implemented. Maintenance to check the alarm and batter replaced by maintenance. Feas had no further exit seeki since 11/12/15.	ment of and noted ed to emoved from resident staff was in /19/15 derguards pe Wanderguards the MAR and every shift Resident eeking event ation was was called in try was Resident # 22	er d d ds s s o n	
	_	n 11/18/15 at 11:59 AM, the tor stated he was aware of		All Current residents were re 11/20/15 by the ADON to ide residents who are at high ris	entify any	1	
	the wanderers but it he during Quality Assurate revealed QA should hand "we could have to detriment to the residenvironment and the	nad not been discussed ince (QA) meetings. He have looked at wandering fixed it before it became a ents. It has to be a safe safety of the patients."		wandering behavior. Reside as having exit seeking behaving exit seeking behaving and/or updated Care plating and/or updated Care plating and/or updated and/	ents identified viors have a an completed IA Care and reviewed aware of	1	
	During an interview o	n 11/20/15 at 9:06 AM, the		11/20/15 by the ADON.			

wandering behavior did not come up as a

All residents currently with a wanderguard

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		SURVEY PLETED
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		345213	B. WING _			11	/20/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILL	INGTON		L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From pag	ne 35	F 5	520			
	· -	ne Administrator further stated	' \	J20	have been assessed for wanderguard		
		vandering behavior will be			placement. All wanderguards are place	ed	
	reviewed in QAA.	•			on residents as recommended by the		
					manufacturer as of 11/19/15.		
	The Administrator w			Newly admitted residents will be asses	sed		
	Jeopardy on 11/19/1	I5 at 8:45 AM.			by the admitting nurses for safety risk		
					within 24 hours of admission with		
	The facility provided the following Credible Allegation on 11/20/15 at 10:18 AM.				appropriate inventions and care planni		
	Allegation on 11/20/	15 at 10:18 AWI.			for any resident assessed as high risk. The DON/designee will complete a 24		
	Problem Identified:				hour admission chart review during the	.	
	T TODICITI Identified.				A.M. clinical meeting to ensure all MD		
	Facility failed to deve	elop and implement a Quality			orders, admission assessments and at		
		ormance Improvement			risk assessments have been complete		
	(QAPI) for residents	with wandering/exit seeking			correctly and timely.		
	behaviors.						
	Interventions:				As of 11/19/15 any resident experienci		
		nent Clinical Support Nurse			an exit seeking event will be immediate		
	has completed re-tra	•			re-assessed and intervention put in pla		
		tor of Nursing and Assistant egarding F520 Quality			The DON/Administrator will be notified	IOI	
	_	ig unsafe wandering or			follow-up.		
	_	identification of resident			The Maintenance Director received		
		, creating a safe environment,			in-service training by the Administrator	on	
	_	ent assessments at the time of			11/18/15 on the new procedure of (1)		
		me of any event of unsafe			Maintenance will check the wandergua	ırd	
	wandering or elopen	nent, notification of any			boxes daily for functioning and docume	∍nt	
		I of adverse resident			findings on the Door Alarm Check		
	outcomes to Clinical				monitoring tool. (2) Maintenance will		
	completion of Qualit	-			check the voltage of batteries and aud		
		vement Plan to prevent			alarm on all door alarms 4 x weekly for		
	re-occurrence of any				battery life by using a meter and follow		
	regarding resident c	are and salety.			manufacturer s recommendation of		
	The DON or adminis	strative nurse will review the			changing battery when reading is 7.0 voltage or less. Maintenance will		
		sician's telephone orders and			document his finding on the Door Alarr	n	
		oort daily to ensure that all			Check monitoring tool.		
		rents regarding resident care			All wanderguard boxes were audited		
		essed and appropriate			11/19/15 by maintenance and are work	ing	

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CENTERS FOR MIEDICARE & MEDICAID SERVICE		VILDIOAID OLIVIOLO	,ES			OND NO. 0930-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345213			B. WING			C 11/20/2015			
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		20/2010		
TO THE OT TH	COVIDER OF OUT FEET								
UNIVERSA	AL HEALTH CARE LILLIN	IGTON			995 EAST CORNELIUS HARNETT BOULEVARD				
				LILLINGTON, NC 27546					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 520	Continued From page 36 interventions are in place started 11/19/15. Compliance will be monitored daily by Director of Nursing/administrative nurse and/or facility Administrator with review of daily 24 hour reports, physician telephone orders, and resident incident reports to ensure that all potential adverse events regarding resident care and safety are addressed and interventions are in place. Director of Nursing and/or administrative nurse will conduct a weekly standards of care meeting with review of any resident with unsafe wandering and/or exit seeking behavior. This meeting will include input from facility psychological group and attending physician for current interventions and any necessary changes to the resident care to ensure residents are receiving timely interventions.		F	properly. All doors alarms were audited 1 st maintenance and documented we battery voltage over 7.0. The Administrator will monitor the Maintenance Door Alarm Check daily x 4 weeks; then, weekly time months to ensure compliance. Two notebooks were created by WC that contains photos of all recidentified as high risk for wander 11/19/15. The notebooks will be at the receptionist desk and nurse station to ensure staff is able to it any resident with a high risk for wandering. MR will review and unotebooks as needed.					
	Potential Residents: All Current residents were reassessed on 11/20/15 by the ADON to identify any residents who are at high risk for wandering behavior. Residents identified as having exit seeking behaviors have a new and/or updated Care plan completed 11/20/15 by MDS nurse. CNA Care Guides have been updated and reviewed with staff to ensure they are aware of residents with a high risk of wandering on 11/20/15 by the ADON. Two notebooks were created that contain the pictures of all residents identified as high risk for wandering on 11/19/15. The notebooks will be located at the receptionist desk and nurse's station to ensure staff is able to identify any resident with a high risk for wandering. All residents currently with a wanderguard have been assessed for wander guard placement. All wander guards are placed on residents as recommended by the manufacturer as of				All residents currently with a wandergu have been assessed for wanderguard placement. All wanderguards are place on residents as recommended by the manufacturer as of 11/19/15. As of 11/19/15 any resident experiencing an unsafe wandering event will be immediately re-assessed and intervent put in place. The DON/Administrator w be notified for follow-up. The DON/designee will monitor wanderguard placement of the identifier residents weekly x 4weeks and compato MARs documentation on wanderguards. If any discrepancies are found, the nurse will be identified, reeducated and counseled by the DON/designee.	ion ill ed re			

11/19/15.

Training was completed by the ADON on

Facility ID: 943230

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				OIVID IVC	7. 0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						(c	
345213			B. WING			11/20/2015		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSAL HEALTH CARE LILLINGTON				19	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	UNIVERSAL HEALTH CARE LILLINGTON			L	ILLINGTON, NC 27546			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE		
F 520	Continued From page 37			520				
	As of 11/19/15 newly admitted residents will be				11/19/15 with all current staff on unsafe	٩.		
		of wandering /exit seeking			wandering or Elopement including,	•		
	behaviors within 24 h	•			identification of resident wandering			
		esident experiencing an exit			behavior, creating a safe environment	and		
	-	immediately re-assessed			providing a safe environment for	ana		
	and intervention put i				residents. Any staff not available for th	is		
	-	vill be notified for follow-up.			training will not be allowed to work unti			
		eleted with all current staff on			training is complete. All newly hired			
	unsafe wandering or				employees will receive this training dur	ing		
	identification of resident wandering behavior,				orientation.	J		
		onment, and providing a safe						
	environment for residents by the ADON on				Training was completed by the Region	al		
	11/19/15. Any staff no	ot available for this training			Clinical Director and DON with current			
	will not be allowed to	work until training is			employees on elements of F323 Providence	ding		
	complete.				a Safe Environment and Adequate			
	Maintenance will che	ck wanderguard boxes daily			Supervision for Residents on 12/14/15			
	for functioning and do	ocument finding on the Door			The training included identification of			
	Alarm Check monitor	ring tool. Any wanderguard			residents at risk, creating a safe			
		roperly will be corrected			environment, identifying and reporting			
immediately by m		tenance. All wander guard			unsafe items in the environment;			
	boxes were audited 1			interventions and providing adequate				
	are working properly.			supervision. Any staff not available for				
	Maintenance will che			this training will not be allowed to work				
	and audible alarm on			until training is complete. All newly hire				
	for battery life by using	_			employees will receive this training dur	ring		
		nmendation of changing			orientation.			
	, ,	is 7.0 voltage or less.						
	Maintenance will doc			The DON/designee will review the 24 h				
	Door Alarm Check monitoring tool. All doors				report, physician ☐s telephone orders a	and		
	alarms were audited 11/19/15 by maintenance and documented with all battery voltage over 7.0				resident			
		i all pattery voltage over 7.0			incident reports daily to ensure that all			
	Monitoring: Beginning 11/19/15 the Administrator will monitor				potential adverse events regarding	4		
					resident care and safety are addressed			
		or Alarm Check sheets daily			and appropriate interventions are in pla			
		kly times 3 months to			The facility DON/designee will bring all			
	ensure compliance.	d/or designee will monitor the			incident/accident reports, physician telephone order, nursing 24-hour report	rt		
		d/or designee will monitor the ent of identified residents			and resident medical records of any	ι,		
					resident experiencing an incident/accident	lont		
weekly x 4weeks and		i compare to MANS			resident expending an includin/accid	iGHL	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDING			C		
	345213 B. WING			11/20/2015				
NAME OF PROVIDER OR SUPPLIER			•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
	AL	NOTON.		1995 EAST CORNELIUS HARNETT BOULEVARD				
UNIVERS	AL HEALTH CARE LILL	INGTON		L	ILLINGTON, NC 27546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE	
F 520	documentation on widiscrepancies are for identified, reeducated or ADON. Director of Nursing wistandards of care mineeting x 3 months, review, discussion at ensure compliance of The facility Administ summary of all monified it at the facility QAPI Medical Director and The credible allegating at 11:30 AM as evidente use of wander guards boxe functioning; how often audible alarms check wander guard sensor accuracy of alarming addition updated Callegating assessments were winder guards and effectively. The credible allegating at 11:30 AM as evidented to their residents at risk for winderstood how to it residents at risk for when wanderguard functioning; how often audible alarms checked.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 documentation on wander guards. If any discrepancies are found, the nurse will be dentified, reeducated and counseled by the DON or ADON. Director of Nursing will submit a summary of the standards of care meeting at the monthly QAPI meeting x 3 months, then every other month for review, discussion and/or needed changes to ensure compliance until resolved. The facility Administrator will complete a summary of all monitoring efforts and will present at at the facility QAPI meeting monthly with facility Medical Director and facility QAPI committee. The credible allegation was verified on 11/20/15 at 11:30 AM as evidenced by staff interviews on the use of wander guard monitoring tools, when Wander guards boxes are to be checked for functioning; how often voltage of batteries and audible alarms checked on doors and how often wander guard sensor doors would be checked for accuracy of alarming and proper placement. In addition updated Care Plans, care guides and assessments were verified as well as elopement notebooks. Observations of proper placement of wander guards and wanderguard system working		PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE G CROSS-REFERENCED TO THE APPROPRIATE				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
345213			B. WING			C 11/20/2015	
					EET ADDRESS, CITY, STATE, ZIP CODE	111/2	20/2015
NAME OF PROVIDER OR SUPPLIER							
UNIVERSAL HEALTH CARE LILLINGTON					5 EAST CORNELIUS HARNETT BOULEVARD LINGTON, NC 27546		
(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 520	notebooks. Observations of proper placement of		F 5	The Administrator/Maintenance Directo			
						ms irk thly	