STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Resident # 3	F 583	This plan of correction constitutes a written allegation of compliance.	12/20/19

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

Electronically Signed | 12/19/2019

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F 583	Continued From page 1 Privacy Based on Observations and staff interviews and Record Review, the facility failed to have a Nephrostomy Tube urine drainage bag covered for privacy for 1 of 1 Resident and as a result the urine drainage bag was visible to the public. (Resident #3) Findings Included: Review of the Medical Record of Resident #3 indicated the Resident was admitted 02/10/2011 with cumulative diagnoses which included Calculus of kidney, other artificial openings of urinary tract, and Obstructive and reflux uropathy. The Resident ' s Minimum Data Set (MDS) dated 10/18/2019 indicated the Resident was cognitively intact. An observation was conducted on 11/20/2019 at 10:50 AM and revealed the following: While touring the facility, a urine collection bag with yellow-colored liquid was visible at bedside and viewable to the public as the Resident ' s door was open. Several observations were made on 11/20/2019 between 12:23 PM - 1:02 PM of nursing staff walking by Resident ' s room while the door remained opened and the urine collection bag was visible from the Hallway. An Interview with NA #1 on 11/21/2019 at 1:20 PM revealed that the urine collection bag should be turned around to the privacy side or the door should be closed.	F 583	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root cause: The Executive Director and Director of Nursing met on 11/22/19 and discussed the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from when Nurse #1 failed to completely assess Resident #3 and provide proper covering for Resident #3 urine collection bag. For affected residents: Immediately upon identification on 11/22/19 Resident #3 was provided with an opaque cover for his urine collection bag to abate the alleged noncompliance. For other residents with the potential to be affected: By 11/22/19 a 100% audit of residents with urine collection bags was conducted by the Director of Nursing (DON), Asst. Director of Nursing (ADON) and unit managers to determine if any other current resident with urine collection bags were without opaque covering. No other residents were determined to have urine collection bags that were without proper	

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F 583	Continued From page 2 An Interview with the Director of Nursing on 11/21/2019 at 1:36 PM revealed that privacy should have been provided to the resident by the covering urine collection bag.	F 583	covering. Facility plan to prevent re-occurrence: Starting 11/22/2019, the Director of Nursing, Assistant Director of Nursing, and/or Unit managers will complete 100% education for all licensed nursing staff and Medication Aides, to include full time, part time and as needed employee. The education will include, refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered. If any Resident with a urinary collection bag is found not to have an opaque covering, the licensed staff or Medication Aide providing care for the Resident at the time will be expected to cover the urine bag. Effective 11/22/2019, the Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will audit 100% of residents with urine collection bags. This review will be stored in the Daily Clinical Binder. Any needed re-education will occur immediately by the Director of Nursing and/or the Assistant Director of Nursing. Information related to providing privacy covers for urinary collection bags will be included in orientation for new employees and will be taught by the Assistant Director of Nursing. Monitoring: Effective 11/22/2019, the Director of Nursing, Assistant Director of Nursing, Unit Manager or a Nurse assigned by the Director of Nursing is to monitor the audits for urinary drainage bags, five days a week for four weeks, then three days a week for four additional weeks and then	

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F 583	Continued From page 3	F 583	weekly X 4 weeks to ensure proper outcomes are being met. These audits will cover both day and night shifts. The weekend Supervisor will review privacy bag audits to ensure appropriate outcomes for Saturday and Sunday for eight weeks. This monitoring will be documented on the Privacy bag audit. Effective 11/22/2019, Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. This reporting will occur monthly for three months, or until resolution occurs. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: The Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		12/20/19

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F 657	Continued From page 4 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: F657 D Based on observation, record review and staff Interviews, the facility failed to revise the Resident #2's Care Plan to reflect resident #2 was unable to use the call light to alert staff for help for 1 of 1 Resident (Resident #2) as evidence by the decline in resident #2's functional capabilities and was physically unable to press the call light. Findings Included: Review of the resident's medical record indicated Resident #2 was admitted on 4/23/2019 with diagnoses of History of Falling, Muscle weakness (generalized), Mild Cognitive impairment, Cognitive Communication Deficit and a neurological disease.	F 657	Root cause: The Executive Director and Director of Nursing met to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed; the alleged noncompliance resulted from when the Minimum Data Set (MDS) failed to update the care plan to include the most current level of care for resident #2. For affected residents: Resident #2 care plan was updated 12/12/2019 For other residents with the potential to be affected: On 12/12/2019 All residents were assessed by ADON to determine if they were able to use the call light on demand.	

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F 657	Continued From page 5 A review of Resident #2's Minimum Data Set (MDS) dated 7/23/2019 indicated the resident #2's functional status as self-sufficient once resident #2 was in wheelchair. The Quarterly MDS dated 10/18/2019 is documented as the same functional status as MDS dated 7/23/2019. A review of resident #2's care plan updated on 10/22/2019 revealed resident #2 continued to yell and scream instead of utilizing the call light system and resident #2's goal was listed in the active care plan as resident #2 will use the call light system for assistance as needed. In addition, the care plan included the intervention to keep the call light within reach of resident #2 and encourage resident #2 to press call light for assistance as needed. On 11/20/2019 at 11:03 AM an observation revealed Resident lying in bed and the call light was clipped/attached to the top of the the privacy curtain which was out of reach of resident #2. The observation also revealed resident #2 had significant limited physical mobility. An Interview with NA #3 on 11/20/2019 at 1:54 PM revealed Resident #2's call light was "almost always" clipped/attached to the top privacy curtain. An Interview on 11/21/2019 at 2:10 PM with the Director of Nursing revealed Resident #2 was unable to use the call light due to resident #2's decreased cognitive ability, significant decreased mobility, and Resident #2's care plan should have been updated to reflect resident #2's decreased cognitive ability.	F 657	The residents that were identified, their care plans were updated on12/12/2019 by the MDS nurse. Facility plan to prevent re-occurrence: Starting 12/12/2019, the Director of Nursing will complete education for all MDS staff. The education will include, updating care plan upon admission, re-admission, and any change in condition to reflect the Resident□s ability to use call light. Monitoring: Effective 12/12/2019, the Director of Nursing, Assistant Director of Nursing, Unit Manager or other licensed nurse assigned by the Director of Nursing are to review care plans on admission, re-admission, and upon change of condition, five days a week for four weeks, then three days a week for four additional weeks to ensure proper outcomes are being met. The weekend Supervisor will review care plan to ensure appropriate outcomes for Saturday and Sunday for eight weeks. We will review care plans to assure each Resident has the ability to use the call bell is accurately included on the care plan and the care card. The results of the audit will be recorded on the care plan audit tool. Effective 12/20/2019, the Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification	

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F 657	Continued From page 6	F 657	of this plan. This reporting will occur monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: The Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance.	