PRINTED: 12/13/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345213	B. WING		C 11/07/2013	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE LIL	LINGTON	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
A facility must imm consult with the resident involving to injury and has the properties injury and has the properties injury and has the properties in the status in either life clinical complication significantly (i.e., a existing form of treatment); or a deterioration in the status in either life clinical complication significantly (i.e., a existing form of treatment); or a deterioration in the status in either life clinical complication significantly (i.e., a existing form of treatment); or a deterioration in the resident from the status in either life clinical complication in the resident from the status in either life clinical complication in the resident from the status in either life clinical complication in the resident from the status in either life clinical complication in existing form of treatment); or a deterior at life in the resident from the status in either life clinical complication in existing form of treatment); or a deterior at life in the resident from the status in either life clinical complication in existing form of treatment); or a deterior at life in the resident from the status in either life clinical complication in existing form of treatment); or a deterior at life in the resident from the status in either life clinical complication in existing form of treatment); or a deterior at life clinical complication in existing form of treatment); or a deterior at life clinical complication in existing form of treatment); or a deterior at life clinical complication in existing form of treatment in existing form of treat	ediately inform the resident; sident's physician; and if esident's legal representative mily member when there is an the resident which results in potential for requiring physician ifficant change in the resident's resident which resident's resident of the resident's resident of the resident's resident of the resident's resident of the resident's of the resident of th	F 157	Resident #103 was transferred to emergency room on August 6, 2013.	11/22/13	

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

(X6) DATE

11/22/2013 **Electronically Signed**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C 11/07/2013
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	11/0//2010
				1995 EAST CORNELIUS HARNETT BOULEVARD	
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		LILLINGTON, NC 27546	
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F 157	emergency room with resident # 103) Finding Resident # 103 was at 4/30/2013 with diagnor Disease, Chronic Airy Convulsions, Hyperling The resident 's Mining 9/6/2013 indicated the was intact. The resident memory problems. Review of the nurse's revealed Resident # 27 facility to the emerger wheezing. The nurse' doctor was notified by not notified.	end out of the facility to the signs of pneumonia(logs included:	F 157	A review of all resident transfers to the emergency room from August 6, 201: November 7, 2013 was completed by Director of Nursing (DON) on 11/22/1 No other residents were found to be affected by the alleged deficient prace. All licensed nurses were in-serviced the Staff Development Coordinator (SDC)as of 11/21/13 regarding the importance of family notification of resident transfer to emergency room. A review of the 24 hour reports to be accomplished daily by DON/Designed daily audit of family notification of residents transferred to the Emergen room. For those identified as not beir notified previously notification will be completed by DON/Designess after re of 24 hour report.	3 to 3. cice. by e for cy g
F 272 SS=D	notifying the responsi 103 was being send of emergency room with During the interview of The Director of Nursin expectations of the st responsible party imm being send out of the room. The DON also not have any docume Resident # 103's resp	on 11/5/2013 at 3:20 PM, ang(DON) reported that her aff was to notify the nediately, if a resident was facility to the emergency added that the facility did intations indicating that consible party was notified sent out to the emergency	F 272	DON/Designee will report to QA committee the findings of these audti monthly x 3 months. The QA committ will determine effectiveness of plan w revisions made as deemed necessar	ee ith

Facility ID: 943230

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345213	B. WING _		1	C 1/07/2013	
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON		STREET ADDRESS, CITY, STATE, ZIP COE 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DE		
(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 ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272	a comprehensive, ac reproducible assess functional capacity. A facility must make a assessment of a resi resident assessment by the State. The as least the following: Identification and der Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior personal functioning and continence; Disease diagnosis ar Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of su the additional assess areas triggered by the Data Set (MDS); and	duct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at mographic information; patterns; ing; and structural problems; and health conditions; I status; Ind procedures; mmary information regarding ment performed on the care e completion of the Minimum	F 2	72			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION		E SURVEY PLETED
		345213	B. WING _				C / 07/2013
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		70172010
				1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From page	e 3	F 2	272			
	by: Based on observation interviews, the facility a resident with impair residents reviewed for #31). The findings ind Resident #31 was ad 3/29/10. Diagnoses in sclerosis (both eyes) Nuclear sclerosis refe hardening and yellow lens. Presbyopia is a crystalline lens of one therefore, making it do close objects. The and (MDS) completed on impaired with no corrassessment summar as a triggered care and plan. The problem are indicated "no" for use resident was assessed visual ability." The quality 13 indicated tha status was moderate indicated as "impaire regular print in newsplenses were listed. The dated 9/12/13 did not an identified problem. During an observation Resident #31 was obbed with no eye glass.	mitted into the facility on included cataract, nuclear and presbyopia (both eyes). For the arrival of the center of the eye condition, wherein, the eye condition, wherein, the eye condition, wherein, the eye condition of the eye condition, wherein, the eye condition of the eye condition of the eye condition, wherein, the eye condition, wherein, the eye condition of the eye loses its flexibility; ifficult for one to focus on anual minimum data set 5/15/13 indicated vision was ective lenses. The care area eye dated 5/15/13 listed vision for ea with a visual function ea section for vision function er of visual appliances. The eye d'at risk for worsening arterly MDS completed on the Resident #31 cognitive eye impaired. Vision was disease large print, but not expers/books." No corrective the most recent care plan indicate visual function as exerved in his room in the ses on.			Corrective action for resident #31 was accomplished by completing a new quartely MDS on 11/13/13. B100 was coded "1" based on exam by MDS and eye doctor. A review of all current residents trigger for visual impairments on last assessm will be audited to check for correct codi of need for visual appliances by MDS nurse with modifications of MDS as indidcated. MDS nurses in-serviced by Regional M Nurse regarding need for accurate cod for residents triggering for visual impairments. MDS Coordinator to do weekly audits x and monthly x 3 months of assessment to ensure accuarate coding for visually impaired residents with modications as indidcated. MDS Coordinator to reprot to QA Committee the findings of these audits monthly x 3 months. The QA Committee will determine effectiveness of plan with revisions made as deemed necessary.	ing ent ing IDS ing	
	During an observation	n on 11/6/13 at 3:47 pm					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				C 07/2013
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546			0172010
(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 272	Continued From page	÷ 4	F 2	272			
		served outside smoking acility staff with no eyes					
	that he enjoyed playir difficulty seeing the w this affected his ability the game, due to it was letter/numbers on the because he could not	se #2 Resident #31 indicated and bingo and that he had riting on the bingo card and to successfully perform at as difficult for him to see the card. He added that see the numbering clearly d his ability to win, due to he					
	when questioned regareliability stated the recapable of conveying just spoke softly and words out due to a his concluded she had be	esident was reliable and his needs to the staff; he had trouble getting his story of stroke. Nurse #2 een Resident #31's nurse for observed the resident with					
	nurse when questioned MDS assessment did utilized stated that she facility during the common 5/15/13 and the quadded that her expect section should have to	7/13 at 11:42 am, the MDS ed why the comprehensive not capture vision devices e was not employed in the apletion of the annual MDS parterly on 8/14/13. She tation was that the vision been assessed correctly to vices prescribed and a plan					
	I	7/13 at 1:41 pm, the that she had not seen le last evaluation on 7/27/10.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DNSTRUCTION		X3) DATE SURVEY COMPLETED	
			7 50.25			,	С	
		345213	B. WING			11/	07/2013	
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLIN	NGTON		1995	EET ADDRESS, CITY, STATE, ZIP CODE 5 EAST CORNELIUS HARNETT BOULEVARD LINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 279 SS=D	She stated "at the time exam, my assessment diagnoses of cataract of the eye exam the research for cataract surgery." come since the last elecome a candidate that was my expectation to annually to monitor the cataract in both eyes eye glasses were preserved in an interview on 11/regional MDS consultational record acknowled coding error on the coducted 5/15/13 which is lenses that should ha 483.20(d), 483.20(k)(COMPREHENSIVE COMPREHENSIVE COMPREHE	e of Resident #31's last eye at findings revealed and presbyopia. At the time esident was not a candidate She added "in the years to valuation, the resident would for cataract survey and it to have seen the resident e progression of the " The optometrist concluded scribed during the last visit. 7/13 at 1:51 pm, the ant after reviewing the vledged that there was a comprehensive assessment indicated "no" for corrective ve indicated "yes." 1) DEVELOP CARE PLANS e results of the assessment of care. elop a comprehensive care at that includes measurable bles to meet a resident's mental and psychosocial led in the comprehensive escribe the services that are ain or maintain the resident's rysical, mental, and		272			11/22/13	

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 /07/2013	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEV. LILLINGTON, NC 27546		11/0//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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 279	§483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on record rev facility failed to develor impaired vision for 1 reviewed for visual fur findings included: Resident #31 was ad 3/29/10. Diagnoses in sclerosis (both eyes) Nuclear sclerosis refe hardening and yellow lens. Presbyopia is a crystalline lens of one therefore, making it do close objects. The and (MDS) completed on impaired with no corrussessment summarias a triggered care and plan. The problem are indicated "no" for use resident was assessed visual ability." The que 8/14/13 indicated that status was moderate indicated as "impaire regular print in newsplenses were listed. The	exercise of rights under e right to refuse treatment is not met as evidenced few, and staff interviews, the op a plan of care for of 3 sampled residents inction (Resident #31). The mitted into the facility on included cataract, nuclear and presbyopia (both eyes). For some a gradual cloudiness, ring in the center of the eye condition, wherein, the est eye loses its flexibility; ifficult for one to focus on inual minimum data set 5/15/13 indicated vision was ective lenses. The care area of dated 5/15/13 listed vision rea with a visual function are exection for vision function of visual appliances. The ed "at risk for worsening arterly MDS completed on the Resident #31 cognitive of the propersy books." No corrective the most recent care plan indicate visual function as	F 27	Corrective action for resdient #31 accomplished by developing a placare for impaired vision on 11/13/MDS nurse. An audit of all current residents trifor visual impairments on last asseessment for a plan of care for impaired vision was completed by 11/22/13 with plan of care updated necessary. MDS nurses to be in-serviced by MDS Nurse on the importance of developing a plan of care for all restriggering for visual impairments be 11/19/13. MDS Coordinator to do weekly aurand monthly x 3 of assessments the ensure all plans of care are in placed in the plant of the plant o	iggering r MDS by d as Regional esidents by dits x 4 co ce for irments.		
	In an interview on 11	7/13 at 9:45 am					

NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE LILLINGTON STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII	TIPLE CONSTRUCTION NG	, ,	MPLETED
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE LILLINGTON (X4) ID (X5) (X6) ID (X6) ID (X6) ID (X7) ID (X8) ID (X6) ID (X8) ID (X9) I			345213	B. WING _			C 1/07/2013
F 279 Continued From page 7 accompanied by Nurse #2 Resident #31 indicated that he enjoyed playing bingo and that he had difficulty seeing the writing on the bingo card and this affected his ability to successfully perform at the game, due to it was difficult for him to see the letter/numbers on the card. He added that because he could not see the numbering clearly on the card, it affected his ability to win, due to he was seeing the numbers incorrectly. In an interview on 11/7/13 at 9:50 am Nurse #2 when questioned regarding Resident #31 reliability stated the resident was reliable and capable of conveying his needs to the staff; he			NGTON		1995 EAST CORNELIUS HARNETT BOUL	·	
accompanied by Nurse #2 Resident #31 indicated that he enjoyed playing bingo and that he had difficulty seeing the writing on the bingo card and this affected his ability to successfully perform at the game, due to it was difficult for him to see the letter/numbers on the card. He added that because he could not see the numbering clearly on the card, it affected his ability to win, due to he was seeing the numbers incorrectly. In an interview on 11/7/13 at 9:50 am Nurse #2 when questioned regarding Resident #31 reliability stated the resident was reliable and capable of conveying his needs to the staff; he	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
words out due to a history of stroke. Nurse #2 concluded she had been Resident #31's nurse for one year and had not observed the resident with eye glasses on throughout the day. In an interview on 11/7/13 at 11:42 am, the MDS nurse when questioned why there was not a care plan for vision function stated that she was not employed in the facility during the completion of the annual MDS on 5/15/13 and the quarterly on 8/14/13. She indicated "a care plan should have been completed for vision due to the resident was identified with impaired vision. As a result of impaired vision, the resident was at risk for falls and physically limited with activities of daily living." In an interview on 11/7/13 at 12:10 pm, the director of nursing accompanied by the administrator indicated that she expected there to be a care plan for vision because the resident was identified with impaired vision according to the MDS assessment and was prescribed eye glasses by the eye doctor per review of the	F 279	accompanied by Number that he enjoyed playing difficulty seeing the within affected his ability the game, due to it will letter/numbers on the because he could no on the card, it affected was seeing the number of the card, it affected was seeing the number of the card, it affected was seeing the number of the card, it affected was seeing the number of the card, it affected was seeing the number of the card, it affected was seeing the number of the card, it affected was seeing the number of the card, it affected words out due to a his concluded she had been one year and had not eye glasses on through words on the year and had not eye glasses on through words on the year and had not eye glasses on through words on the year and had not eye glasses on through words on the year and had not eye glasses on through words on the year and had not eye glasses on through words on the year and had not	se #2 Resident #31 indicated ing bingo and that he had writing on the bingo card and by to successfully perform at as difficult for him to see the exard. He added that it see the numbering clearly and his ability to win, due to he pers incorrectly. 17/13 at 9:50 am Nurse #2 arding Resident #31 esident was reliable and in his needs to the staff; he had trouble getting his story of stroke. Nurse #2 een Resident #31's nurse for it observed the resident with ghout the day. 17/13 at 11:42 am, the MDS ed why there was not a care on stated that she was not atty during the completion of 17/15/13 and the quarterly on and "a care plan should have rision due to the resident was ed vision. As a result of esident was at risk for falls it with activities of daily 17/13 at 12:10 pm, the ecompanied by the ed that she expected there to ion because the resident inpaired vision according to it and was prescribed eye	F	279		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345213	B. WING		C 11/07/2013
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 279 F 313 SS=D	optometrist indicated Resident #31 since to She stated "at the tire exam, my assessmediagnoses of cataract of the eye exam the for cataract surgery." come since the last obecome a candidate was my expectation annually to monitor to cataract in both eyes eye glasses were provided and assistive devices hearing abilities, the assist the resident in by arranging for transoffice of a profession of office of a profession.	/7/13 at 1:41 pm, the I that she had not seen the last evaluation on 7/27/10. The of Resident #31's last eye Int findings revealed It and presbyopia. At the time resident was not a candidate I She added "in the years to evaluation, the resident would for cataract survey and it to have seen the resident the progression of the I." The optometrist concluded escribed during the last visit. ENT/DEVICES TO MAINTAIN The receive proper treatment as to maintain vision and facility must, if necessary, making appointments, and sportation to and from the r specializing in the r hearing impairment or the	F 2		11/22/13
	by: Based on observation interviews, the facility coordinate follow up with impaired vision. ensure a resident pro-	ons, record review and staff y failed to arrange or vision services for a resident. The facility also failed to escribed eye glasses were ordered by the physician for 1		Corrective action for resient #31 was accomplished by obtaining a follow u visit with opthalmologist on Novembe 2013. Consult from opthalmologist st resident with 20/25 vision with no need prescription eye glasses.	p er 12, ated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		ATE SURVEY DMPLETED
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NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO		
UNIVERSAL HEALTH CARE L	II LINGTON		1995 EAST CORNELIUS HARNETT B	OULEVARD	
ONIVERSAL HEALIH CARE E	ILLINGTON		LILLINGTON, NC 27546		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
Resident #31 was 3/29/10. Diagnos sclerosis (both ey Nuclear sclerosis hardening and yelens. Presbyopia crystalline lens of therefore, making close objects. The completed on 8/1 cognitive status we was indicated as not regular print in recent care plant of visual function as During an observe Resident #31 was bed with no eye of During an observe Resident #31 was accompanied by glasses on. In an interview or accompanied by that he enjoyed provided the same of the game, due to letter/numbers or because he could on the card, it affer.	iewed for vision (Resident #31). ided: s admitted into the facility on es included cataract, nuclear res) and presbyopia (both eyes). refers to a gradual cloudiness, fllowing in the center of the eye is a condition, wherein, the is one's eye loses its flexibility; jit difficult for one to focus on e quarterly minimum data set 4/13 indicated that Resident #31 ras moderately impaired. Vision "impaired sees large print, but in newspapers/books." The most dated 9/12/13 did not indicate an identified problem. ation on 11/5/13 at 10:40 am is observed in his room in the	F 31	A chart audit of all residents vision exams was accommon central supply clerk on 11/1. Administrative nurses will be by Staff Development Coord 11/22/13 regarding the need that all residents will have a ophthalmological follow up dindicated. Director of Nursing/Designe order for residents needing with transportation aid setting visits. Medical records to complete audits for residents need for Audit will be reviewed by DO All Ophthalmology consults to DON/designee to ensure appointments are made and glasses are available for use by the physician. DON/Designee to do randor residents to ensure prescrib glasses are available for use by the physician daily x 2 woweekly x 4 weeks then mon months. DON/Designee will report to Committee findings of these monthly x 3 months with reveas deemed necessary by Q	e in-serviced dinator by d to ensure exam as ee will obtain vision exam ng up follow up e quarterly r vision exam. ON. will be given follow up d prescription e as ordered eas ordered eeks then on the QA e audits visions made	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345213	B. WING			C 11/07/2013
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEV LILLINGTON, NC 27546	•	11/0//2013
(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 CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 313	In an interview on 11/when questioned regreliability stated the recapable of conveying just spoke softly and words out due to a hiconcluded she had be one year and had not eye glasses on through In an interview on 11/activity director reveal Resident #31 had vis resident vision was fill In an interview on 11/activity assistant state "bingo activity" she placetion and the entire game. She add why he did not particis mood related. In an interview on 11/director of nursing (Dadministrator reveale clinical record she state Resident #31 refused services. The DON in resident diagnosis of resident to have been since 2010. The DON had not been evaluat last two years. In an interview on 11/2 in	arding Resident #31 esident was reliable and his needs to the staff; he had trouble getting his story of a stroke. Nurse #2 een Resident #31's nurse for observed the resident with ghout the day. 7/13 at 10:15 am, the led she was not aware that had deficits; she thought the he. 7/13 at 10:18 am, the ed that on 11/5/13 during haced a bingo card before did not participate during the heled that she was not sure pate, and assumed it was 7/13 at 12:10 pm, the ON), accompanied by the hated she did not see where he the offer of follow up vision dicated considering the cataract, she expected the he evaluated by the eye doctor he concluded that the resident he by the eye doctor in the 7/13 at 1:41 pm, the	F3	13		
	Resident #31 since th	that she had not seen ne last evaluation on 7/27/10. ne of Resident #31's last eye				

AND DI AN OF CORRECTION INDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 11/07/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1995 EAST CORNELIUS HARNETT LILLINGTON, NC 27546		11/0//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 X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 313	exam, my assessment diagnoses of cataract of the eye exam the refor cataract surgery." come since the last electore a candidate for was my expectation to annually to monitor the cataract in both eyes, that the process for he that the facility provide onsite that needed to residents were evaluated that she did not choose be seen, but the facility during the onsite visitic concluded that Reside been revaluated by he exam. In an interview on 11/ administrator when quelocation of Resident # stated she was not su	and presbyopia. At the time esident was not a candidate She added "in the years to valuation, the resident would for cataract survey and it to have seen the resident e progression of the "The optometrist indicated er evaluating residents is ed a list of residents when been seen and the ated accordingly. She added se which residents were to try provided a list of residents s. The optometrist ent #31's vision should have er one year after the last eye and the set of the staff to boom to see if the eye	F	313		