**Statement of Deficiencies and Plan of Correction**

- **Provider/Supplier/CLIA Identification Number:** 345213

**Building**: A. **Building:** _____________________________

**Wing:** _____________________________

**Date Survey Completed:** 04/16/2014

**Name of Provider or Supplier:** Universal Health Care Lillington

**Street Address, City, State, Zip Code:**
1995 East Cornelius Harnett Boulevard
Lillington, NC  27546

**Summary Statement of Deficiencies**

<table>
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<tr>
<th>ID</th>
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<th>Provider's Plan of Correction</th>
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</thead>
<tbody>
<tr>
<td>F 157</td>
<td>SS=G</td>
<td>483.10(b)(11) NOTIFY OF CHANGES</td>
<td>F 157</td>
<td></td>
<td>5/16/14</td>
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A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on observations, staff interviews and record review, the facility failed to notify the physician of a newly identified pressure ulcer.

The physician of resident # 4 was notified by Director of Nursing on April 16, 2014 of wound to inner buttock and orders...

**Laboratory Director's or Provider/Supplier Representative's Signature and Title**

**Date:** 05/09/2014

**Signature:** Electronically Signed

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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.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSAL HEALTH CARE LILLINGTON

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1995 EAST CORNELIUS HARNETT BOULEVARD
LILLINGTON, NC  27546

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 1 upon discovery until the pressure ulcer progressed to tunneling of the wound for 1 of 2 residents (Resident #4) reviewed for pressure ulcers.</td>
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<td>The findings included: Review of the facility's policy titled &quot;Standing Order for Wound Protocol&quot; dated 3/26/14 revealed in part &quot;Treatment order must include site, stage, cleansing agent, treatment, secondary dressing if used, frequency of change, and discontinue date if known, complete a pressure/non-pressure documentation form, notify physician/family, document all wounds and changes on the 24 hour report, telephone order must be written before initiating any wound orders.&quot;</td>
<td></td>
<td>F 157 received for treatment of wounds to inner buttocks and scrotum. Orders initiated on April 15, 2014.</td>
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<td></td>
<td>Resident #4 was admitted to the facility on 1/7/14 with medical diagnoses which included diabetes mellitus and hypertension.</td>
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<td>All residents have the potential to be affected by the same alleged deficient practice. An audit was completed April 18, 2014 by Director of Nursing to ensure that the physician had been notified of the current status of all wounds. No other residents were identified to be affected.</td>
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<td></td>
<td>The most recent Minimum Data Set (MDS) dated 2/17/14 revealed the resident was cognitively intact. The assessment further revealed the resident was independent with bed mobility and transfers. The same assessment further indicated the resident has rejected care less than daily. The MDS assessment indicated Resident #4 was at risk for developing pressure ulcer and had a healed Stage 2 pressure ulcer on prior assessment,</td>
<td></td>
<td>Licensed nurses will be in-serviced by Director of Nursing, Assistant Director of Nursing, or RN Supervisor by May 16, 2014 to notify attending physician of any change of condition and of any wounds resulting in decline.</td>
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<td>Review of the care plan for Resident #4 updated 2/19/14 revealed the resident was at risk for potential for skin breakdown, bruising and skin tears and pressure ulcer, excoriation related to decreased in mobility, incontinence. The goal</td>
<td></td>
<td>Any resident change of condition, new wound, or wound decline will be discussed in daily Clinical meeting Monday through Friday and reviewed by weekend supervisor Saturday and Sunday.</td>
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<td>Director of Nursing, Assistant Director of Nursing, and Weekend supervisor will monitor documentation of physician notification of and change of status, new wound, and wound decline to ensure compliance. Any instance of lacked physician notification will be corrected immediately by notifying physician and providing one on one in-service with licensed nurse.</td>
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<td>Physician notification audits will be done by the Director of Nursing, Assistant</td>
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</table>
F 157 Stated for the problem was the resident will maintain or develop clean and intact skin. The care plan indicated the following interventions: provide measures to decrease pressure/irritation to skin, Geo mattress, heel protectors, and w/c cushion as indicated, keep skin clean and dry and provide for baths per schedule and as needed, change incontinent pad as soon as possible after voiding or bowel movement and provide incontinent care after episodes, apply barrier cream or protective lotion after incontinence, assist resident to turn and reposition routinely, position with pads and cushions, pillows to prevent pressure, observe skin during personal cares and notify nurse/MD of any skin issues.

During the wound care observation on 4/14/14 that began at 2:20 pm, the Wound Care Nurse stated to Resident #4 that she could see the new area that was reported from the weekend while pointing to an open area proximal to the second opened area to the left inner buttocks. The wound bed was pink with no drainage or odor. The Wound Care Nurse cleansed the area with wound cleanser and applied saline soaked gauze followed by dry gauze and tape. During the wound observation, the resident stated he was aware of a new area of skin breakdown to the scrotum identified over the weekend but not of a new area to the buttocks. Interview with the Wound Care Nurse at this time revealed the new area was identified over the past weekend by Nurse #1. She further indicated Nurse #1 had initiated the same treatment of wet to dry dressing for the proximal wound. The Wound Care Nurse did not have the treatment record available during the dressing change or interview.

Review of the weekly interdisciplinary team

Director of Nursing, or Weekend Supervisor daily x 4 weeks then weekly x 4 weeks and then monthly x 4 months. Any identified concerns will be addressed immediately with attending physician as indicated.

The Director of Nursing or Assistant Director of Nursing will report findings from audits to QAPI Committee monthly times 6 with revisions as necessary until otherwise determined by QAPI Committee.
Continued From page 3
progress notes dated 4/9/14 documented "Wound note-Stage 3 to inner buttock on scar tissue line reopened. Cleanse daily with wound cleanser and apply wet to dry dressing daily. Monitor for signs and symptoms of infection."

Review of the April 2014 Treatment Record revealed an order to cleanse open area to left inner buttocks near the scrotum with wound cleanser and apply wet to dry dressing daily dated 4/4/14. Further review of the same treatment record revealed an order to clean area to scrotum with normal saline; apply triple antibiotic ointment and non adherent dressing dated 4/11/14.

During an interview on 4/15/14 at 2:15 pm, the Wound Care Nurse stated the area to the buttocks previously identified on 4/14/14 had tunneled into one large area overnight. The resident refused to allow surveyor to do a second observation of wound care. The Wound Care Nurse stated she did not measure the new pressure area identified, notify the physician or initiate a treatment on 4/14/14 when she identified the area because she thought the area had been addressed by Nurse #1 over the weekend. She stated she just continued the same treatment of wet to dry that was already in place. The Wound Care Nurse was unable to provide documentation of wound assessment or physician notification at this time. She further stated she normally complete documentation on wounds at the time of discovery or assessment.

On 4/15/14 at 3:10 pm in an interview, Nurse #1 stated she worked the weekend of 4/11/14-4/13/14 as the treatment nurse. She further indicated she did not see a new open area to the buttocks. Nurse #1 stated the area that she
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<td>Continued From page 4 identified and initiated treatment for was an open area on the scrotum for Resident #4. The nurse further stated she would not have written scrotum for an area that was on the buttlock. On 4/15/14 at 5:30 pm, the facility (Wound Care Nurse) was unable to provide updated documentation on the changes in the status of the wound. During an interview on 4/15/14 at 5:40 pm, the Director of Nursing indicated it was her expectation for the Wound Care Nurse to follow the protocol and assess any new areas identified, notify the physician and the family.</td>
<td>F 157</td>
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<td>F 221</td>
<td>SS=D</td>
<td></td>
<td>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS. The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility restrained a resident without a medical symptom, for a resident that had a lap buddy since October 2013. This was for 1 of 1 resident (Resident #3). The findings included:</td>
<td>F 221</td>
<td></td>
<td></td>
<td>Therapy referral for restraint reduction ordered April 16, 2014. Restraint reduction completed for Resident # 3 by Physical therapy on April 17, 2014, restraint (lap buddy) removed. All residents with restraints have the potential to be affected by the same alleged deficient practice. An audit was done by Director of Nursing on April 24, 2014. No other restraints are present in facility.</td>
<td>5/16/14</td>
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### Statement of Deficiencies and Plan of Correction

**Universe Health Care Lillington**

**Street Address:** 1995 East Cornelius Harnett Boulevard, Lillington, NC 27546

**Provider/Supplier/CLIA Identification Number:** 345213

**Date Survey Completed:** 04/16/2014

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<thead>
<tr>
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| (MDS) dated 12/13/13 revealed the resident was severely cognitively impaired. The same assessment further revealed the resident required extensive assistance with one person assistance for bed mobility and locomotion on unit. The same assessment further indicated the resident required extensive assistance with transfers with two plus person physical assistance. The section for falls indicated the resident had two or more falls since reentry. The section for functional mobility indicated the resident was not steady moving from seated to standing position and the resident was only able to stabilize with staff assistance. The MDS assessment revealed a restraint used daily in the chair. The care plan for Resident #3 updated 4/7/14 revealed the resident required assistance with Activities of Daily Living (ADL’s) related to dementia, immobility, fall risk and post right hip fracture. The goal stated for the problem was the resident will have no further decline in ADL function. The interventions for this problem included staff to provide assistance with transfer/mobility needs. The same care plan further revealed the resident was at risk for falls and fall related injury related to dementia and immobility. The interventions for this problem included lap buddy to wheelchair when out of bed, release for meals, ADL’s and activities as needed. Review of the facility "Physical Restraint Reduction Assessment "revealed " Restrainted individuals should be reviewed at least quarterly to determine whether or not they are candidates for restraint reduction, less restrictive restraining measures, or total restraint elimination." Review

Licensed Nurses will be in-serviced by May 16, 2014 by Director of Nursing, Assistant Director of Nursing, or Weekend Supervisor on the resident Right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.

Interdisciplinary Team to complete restraint assessment with initiation of a restraint then quarterly and prn for possible restraint reduction and appropriate medical symptom.

Audit for initiation of restraints to include appropriate medical symptoms as well as attempted restraint reduction quarterly by IDT to be completed monthly by Director of Nursing or Assistant Director of Nursing for 6 months. Any identified concerns will be addressed immediately with physician as indicated.

The Director of Nursing or Assistant Director of Nursing will report findings from audits to QAPI Committee monthly times 6 months with revisions as necessary until otherwise determined by QAPI Committee.
| F 221 | Continued From page 6 of the same form for Resident #3 revealed the last documented restraint reduction attempt was on 10/22/13. Review of the telephone physician order dated 10/22/13 revealed "Lap buddy to wheelchair when resident is out of bed, release for meals, ADL's, and activities and as needed." A continuous meal observation on 4/15/14 that began at 11:45 am revealed Resident #3 with the lap buddy in place to the wheelchair. The resident was fed by the wound care nurse. During an interview on 4/16/14 at 5:50 pm, the Director of Nursing (DON) was unable to provide documentation of the medical symptoms for the lap buddy restraint for Resident #3. The DON further indicated she had not attempted a restraint reduction since the last noted documented attempt dated 10/22/13. The DON stated she and other members of the interdisciplinary team were responsible for ensuring restraint reduction attempts were completed quarterly. |
| F 282 | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident’s written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the physician

Restraint reduction completed for Resident #3 by Physical therapy on April
NAME OF PROVIDER OR SUPPLIER

UNIVERSAL HEALTH CARE LILLINGTON

UNIVERSAL HEALTH CARE LILLINGTON

ADDRESS: 1995 EAST CORNELIUS HARNETT BOULEVARD
             LILLINGTON, NC  27546

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<td>orders that were documented on the care plan for the removal of lap buddy during meals for 1 of 1 resident (Resident #3) with a restraint.</td>
<td>17, 2014, restraint (lap buddy) removed.</td>
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<td>The findings included:</td>
<td>All residents who have a restraint have the potential to be affected by the same alleged deficient practice. An audit was done by Director of Nursing on April 16, 2014. No other restraints are present in facility.</td>
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<td>Resident #3 was admitted to the facility on 3/18/13 with medical diagnoses which included dementia, psychosis and depressive disorder. The most recent quarterly Minimum Data Set (MDS) dated 12/13/13 revealed the resident was severely cognitively impaired. The same assessment further revealed the resident required extensive assistance with one person assistance for locomotion on unit. The same assessment further indicated the resident required extensive assistance with transfers with two plus person physical assistance. The section for falls indicated the resident had two or more falls since reentry. The section for functional mobility indicated the resident was not steady moving from seated to standing position and the resident was only able to stabilize with staff assistance. The MDS assessment revealed a restraint used daily in the chair.</td>
<td>Nursing staff will be in-serviced by Director of Nursing, Assistant Director of Nursing or Weekend Supervisor by May 16, 2014 on reviewing care guides/care plans for restraint orders to remove restraints during meals.</td>
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<td>The care plan for Resident #3 updated 4/7/14 revealed the resident required assistance with Activities of Daily Living (ADL ' s) related to dementia, immobility, fall risk and post right hip fracture. The same care plan further revealed the resident was at risk for falls and fall related injury related to dementia and immobility. The interventions for this problem included lap buddy to wheelchair when out of bed. Release for meals, ADL ' s and activities as needed.</td>
<td>After review of physician orders and twenty four hour report the Director of Nursing, Assistant Director of Nursing or Weekend Supervisor will update care plan and care guide for all restraint orders daily.</td>
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<td>Review of the telephone physician order dated 10/22/13 revealed &quot; Lap buddy to wheelchair</td>
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<td>Care guides/ Care plans will be audited for restraint updates and observations will completed for release of restraint per physician order by Director of Nursing, Assistant Director of Nursing, or Weekend Supervisor daily times four weeks, then weekly times 4 weeks, then monthly times 4 months.</td>
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<td>The Director of Nursing or Assistant Director of Nursing will report findings from audits to QAPI Committee monthly times 6 months with revisions as necessary until otherwise determined by QAPI Committee.</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

UNIVERSAL HEALTH CARE LILLINGTON

STREET ADDRESS, CITY, STATE, ZIP CODE

1995 EAST CORNELIUS HARNETT BOULEVARD
LILLINGTON, NC  27546

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F 282 Continued From page 8
when the resident is out of bed, release for meals, ADL’s, and activities and as needed."

A continuous meal observation on 4/15/14 that began at 11:45 am and ended at 12:30 pm revealed Resident #3 with the lap buddy in place to the wheelchair. Resident #3 was fed by the Wound Care Nurse.

In an interview on 4/15/14 at 12:30 pm, the Wound Care Nurse stated she was not aware of the residents care plans or orders. She further stated she just tried to help the residents who required assistance with meals. The Wound Care Nurse further stated she did not have time to check the residents charts before she assist them with their meal.

During a continuous meal observation on 4/16/14 that began at 11:49 am and ended at 12:40 pm, Resident #3 was observed in the dining room with the lap buddy in place to the wheelchair. Resident #3 was assisted during the meal by the Dietary Manager.

In an interview on 4/16/14 at 12:40 pm, the Dietary Manager stated she was not aware of the orders for the resident to have the lap buddy removed during meals. She further stated the administrative staff normally just helped to set the resident’s trays up for them.

During an interview on 4/16/14 at 5:50 pm, the Director of Nursing (DON) stated it was her expectation for the staff to remove the lap buddy from Resident #3’s wheelchair during meals.

F 314
SS=G
483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

F 314
5/16/14
Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on observations, staff interviews and record review, the facility failed to assess a pressure ulcer upon discovery and failed to initiate a treatment for the pressure ulcer until the pressure ulcer progressed to tunneling of the wound for 1 of 2 residents (Resident #4) reviewed for pressure ulcers.

The findings included:

Review of the facility 's policy titled Standing Order for Wound Protocol " dated 3/26/14 revealed in part " Treatment order must include site, stage, cleansing agent, treatment, secondary dressing if used, frequency of change, and discontinue date if known, complete a pressure/non-pressure documentation form, notify physician/family, document all wounds and changes on the 24 hour report, telephone order must be written before initiating any wound orders. "

Resident #4 was admitted to the facility on 1/7/14 with medical diagnoses which included diabetes mellitus and hypertension.

The wound of Resident # 4 was assessed by licensed nurse on April 15, 2014 and treatment orders were received from physician and initiated on April 15, 2014.

All residents have the potential to be affected by the same alleged deficient practice. Licensed nurse and Director of Nursing completed 100% skin audit on April 17, 2014. No other unidentified wounds were found. The Director of Nursing completed an audit of all Treatment Administration Records and performed wound observations on all current wounds on April 18, 2014 to ensure all treatments were being followed per physician order. No other residents were found to be affected.

Licensed nurse assigned to treatments was reassigned to floor on April 17, 2014.

Current Wound Nurse and Weekend Supervisor were in-serviced by the DON.
The most recent Minimum Data Set (MDS) dated 2/17/14 revealed the resident was cognitively intact. The assessment further revealed the resident was independent with bed mobility and transfers. The same assessment further indicated the resident has rejected care less than daily. The MDS assessment indicated Resident #4 was at risk for developing pressure ulcer and had a healed Stage 2 pressure ulcer on prior assessment.

Review of the care plan for Resident #4 updated 2/19/14 revealed the resident was at risk for potential for skin breakdown, bruising and skin tears and pressure ulcer, excoriation related to decreased in mobility, incontinence. The goal stated for the problem was the resident will maintain or develop clean and intact skin. The care plan indicated the following interventions: provide measures to decrease pressure/irritation to skin, Geo mattress, heel protectors, and w/c cushion as indicated, keep skin clean and dry and provide for baths per schedule and as needed, change incontinent pad as soon as possible after voiding or bowel movement and provide incontinent care after episodes, apply barrier cream or protective lotion after incontinence, assist resident to turn and reposition routinely, position with pads and cushions, pillows to prevent pressure, observe skin during personal cares and notify nurse/MD of any skin issues.

Review of the weekly interdisciplinary team progress notes dated 4/9/14 documented "Wound note-Stage 3 to inner buttock on scar tissue line reopened. Cleanse daily with wound cleanser and apply wet to dry dressing daily. Monitor for signs and symptoms of infection."

F 314 Continued From page 10

F 314

on April 25, 2014 regarding wound care system to include assessing pressure ulcer upon discovery of wound, notification of MD of new orders, wound decline and verification of treatment order of wounds per TAR prior to performing treatment.

Director of Nursing or Assistant Director of Nursing will perform 3 wound observations 2 times week times 4 weeks, and then weekly times 5 months to ensure correct treatment of wounds administered. Any discrepancies found will be addressed as appropriate by Director of Nursing.

Director of Nursing, Assistant Director of Nursing, and Weekend Supervisor will check TAR daily times 4 weeks, then weekly times 4 weeks, and then monthly times 4 months and perform random observations 2 times week times 4 weeks, and then weekly times 5 months. Any identified concerns will be addressed immediately with physician as indicated.

The Director of Nursing or Assistant Director of Nursing will report findings from audits to QAPI Committee monthly times 6 months with revisions as necessary until otherwise determined by QAPI Committee.
Review of the April 2014 Treatment Record revealed an order to cleanse open area to left inner buttocks near the scrotum with wound cleanser and apply wet to dry dressing daily dated 4/4/14. Further review of the same treatment record revealed an order to clean area to scrotum with normal saline; apply triple antibiotic ointment and non adherent dressing dated 4/11/14.

During the wound care observation on 4/14/14 that began at 2:20 pm, the Wound Care Nurse stated to Resident #4 that she could see the new area that was reported from the weekend while pointing to an open area proximal to the second opened area to the left inner buttocks. The wound bed was pink with no drainage or odor. The Wound Care Nurse cleansed the area with wound cleanser and applied saline soaked gauze followed by dry gauze and tape. During the wound observation, the resident stated he was aware of a new area of skin breakdown to the scrotum identified over the weekend but not of a new area to the buttocks. Interview with the Wound Care Nurse at this time revealed the new area was identified over the past weekend by Nurse #1. She further indicated Nurse #1 had initiated the same treatment of wet to dry dressing for the proximal wound. The Wound Care Nurse did not have the treatment record available during the dressing change or interview.

During an interview on 4/15/14 at 2:15 pm, the Wound Care Nurse stated the area to the buttocks previously identified on 4/14/14 had tunneled into one large area overnight. The resident refused to allow surveyor to do a second observation of wound care. The Wound Care Nurse stated she did not measure the new...
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

345213

**Date Survey Completed:**

04/16/2014

**Name of Provider or Supplier:**

Universal Health Care Lillington

**Street Address, City, State, Zip Code:**

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<td>F 314</td>
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<td>pressure area identified, notify the physician or initiate a treatment on 4/14/14 when she identified the area because she thought the area had been addressed by Nurse #1 over the weekend. She stated she just continued the same treatment of wet to dry that was already in place. The Wound Care Nurse was unable to provide documentation of wound assessment or physician notification at this time.</td>
<td>F 314</td>
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Summary Statement of Deficiencies

(F 314) Continued From page 13
indicated the documentation needed to accurately describe the wound.

(F 323) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on record review, observations, physician and staff interviews, the facility failed to stop providing care and return at a later time, for a resident who was resistant to care which resulted in mouth injury for 1 of 2 sampled residents reviewed for accidents (Resident #2).

Findings included
Resident #2 was admitted to the facility on 7/16/2013 with diagnoses of muscle weakness, edema, joint pain-ankle, altered mental status and acute kidney failure. The current Minimum Data Set (MDS) dated 2/20/2014 indicated the resident's cognitive status was severely impaired, she was total dependent on staff for bed mobility, and she needed extensive assistance using one person with dressing and personal hygiene. The MDS did not indicate any behavioral problems. Review of the care plan dated 2/25/2014 revealed the resident was not care planned for resistance to care.

Resident #2 left lower lip bruise was assessed by Assistant Director of Nursing on April 8, 2014 and orders received from attending physician for an antibiotic which started on April 8, 2014 and seen by dentist on April 9, 2014. Care plan was updated on April 14, 2014.

All residents resistive to care have the potential to be affected by the same alleged deficient practice. Residents resistant to care were identified by reviewing MDS and 24 hour report. Licensed nurse completed 100% skin audit on identified residents resistive to care on April 14, 2014. No other residents identified as resistive to care had any bruising of unknown origin.

Nursing Assistants were in-serviced by Director of Nursing, Assistant Director of Nursing, or Staff Development
Review of the facility's staff meeting report dated 1/13/2014 revealed the staff were in-serviced as to how to care for residents who were resistive to care. The report documented "if a resident refuse care and/or resist care, stop let nurse know or get someone else to try if you notice a change in condition you must report to nurse immediately."

During a phone interview with Nurse's Aide # 4 on 4/15/2014 at 1:40 PM, She reported she was getting ready to dress the resident at around 8:00 AM on 4/8/2014. The resident was lying in bed with eyes open. The resident resisted being dressed up by swinging her hands. She wanted to finish with dressing the resident so she pushed the resident harder towards the side rails so she could dress the resident. She added the resident must have hit her mouth on the side rails when she (Nurse's Aide # 4) was trying to dress her. She stated both side rails were up during the time she was dressing the resident and the bed was next to the wall. Nurse's Aide # 4 further added she did not stop dressing the resident when she was resisting being dressed. She further added that she had been trained to stop providing care when the resident is resistive to care and notify the nurse then come back later. Nurse's Aide # 4 also reported that she did not have the reason as to why she did not tell a nurse and stop dressing the resident when the resident was resisting being dressed. She further stated the blood on the wall must have come from the resident's mouth and once she left the room the resident must have spit the blood on the wall. The bed was next to the wall. Nurse 's Aide # 4 further reported she was aware before 4/8/2014 that the resident was resistive to being dressed in the
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morning but she could not explain why she did not stop dressing the resident on 4/8/2014. The Nurse’s Aide # 4 reported that she was not aware that the resident had been injured when she left the resident’s room.

Review of a written statement by Nurse’s Aide # 1 as part of the facility investigation dated 4/8/2014 documented “was passing out tray, resident up on edge of bed can’t remember if rail was up or down. Pants were partially up. Nurse’s Aide # 2 passing by summoned to assist her (Resident # 2) to chair. Nurse’s Aide # 2 came in and was in the process of transferring Resident # 2 to chair. Nurse’s Aide # 2 noticed blood. It was bright red blood on the wall. Nurse’s Aide # 2 went to get Nurse # 1.”

Review of a written statement by Nurse # 1 as part of the facility’s investigation dated 4/10/2014 documented “Resident was laying on her right side closer to the side rail. Nurse # 1 noted blood on wall, right side rails (rail was up) and sheet. Bed was pulled back and blood was noted on floor. When Nurse # 1 entered Resident # 2’s room, the resident was laying on right side. ”

During the interview with Nurse’s Aide # 2 on 4/16/2014 at 11:00 AM, she reported that on 4/8/2014 at 8:30 AM, she was passing out trays. Resident # 2 was sitting on the side of bed. She and Nurse’s Aide # 1 were passing trays. She and Nurse’s Aide # 1 noticed blood on Resident # 2’s wall and on the bed sheets. She left the room and asked Nurse # 1 to check the resident to see where the blood was coming from. She (Nurse’s Aide #2) asked Nurse’s Aide # 4 to come to the resident’s room and showed her the blood on the wall.
### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345213

### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### NAME OF PROVIDER OR SUPPLIER

**UNIVERSAL HEALTH CARE LILLINGTON**

#### STREET ADDRESS, CITY, STATE, ZIP CODE

**1995 EAST CORNELIUS HARNETT BOULEVARD**

**LILLINGTON, NC  27546**

### MULTIPLE CONSTRUCTION

#### A. BUILDING ____________________________

#### B. WING ____________________________

#### DATE SURVEY COMPLETED

**04/16/2014**

### PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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During the phone interview with Nurse’s Aide # 5 on 4/16/2014 at 11:30 AM, She stated that she fed the resident on 4/8/2014 at 8:30 AM. She noticed stain on the wall which looked burgundy in color. She remembered it appeared like someone had tried to wipe it from the wall. The Nurse’s Aide # 5 further reported it was her first time working with the resident. The resident was quite and did not eat much at all. She did not report the stain to anyone but just went on to feed another resident.

During the interview with Nurse # 1 on 4/16/2014 at 10: 00 AM, She reported Nurse’s Aide # 1 approached her at around 8: 30 AM on 4/8/2014 to report that Resident # 2 had blood on her wall. She checked on the resident. There was no bleeding noted on the resident ’ s mouth. Nurse # 1 stated she saw the blood on the wall which was bright red in color splattered on the wall. Nurse # 1 added blood was noted on the resident's sheet on right side of bed and small clot in it. She asked her assigned nurse to check the resident as well.

During the interview with Nurse # 2 on 4/16/2014 at 10:40 AM, she reported Nurse # 1 called her around 9:00 AM on 4/8/2014 to Resident # 2's room. She observed blood on the wall. She then asked the resident to open her mouth and she did not notice blood or anything in the resident ’ s mouth

Grievance report dated 4/8/2014 documented “family member (2nd contact) voiced concern in reference to a bruise to her mom ’ s left corner lower lip. She stated “someone has hit her or something " also states “there is blood on the floor to right side of the bed sheet and wall.”
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Universal Health Care Lillington  
**Address:** 1995 East Cornelius Harnett Boulevard, Lillington, NC 27546

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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<th>TAG</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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| F 323 | Continued From page 17 | | Nurse's note written by Assistant Director of Nursing (ADON,) dated 4/8/2014 at 5:00 PM documented  
"Resident noted with discoloration to left side of bottom lip. Swelling noted upon inspection of mouth, inside of lip noted with discoloration and swelling. Area is warm to touch. Resident does not open mouth completely on command. 2nd contact (family member) present in room. Voicing concerns Re: area, states wasn't present on day before. Resident does mimic when area palpated. Informed 2nd contact would follow up and notify 1st contact (family member) of findings."

Review of the dentist report dated 4/9/2014 documented "Resident was seen for a dental examination on 4/9/2014 due to chief complaint of lower left swelling and bruising outside the lip and cheek area in the lower left region. A large bruise measuring 4.4 cm (Centimeter) X 2.5 cm was present extended below the lower left lip region on the exterior face. Inside the mouth a small laceration was noted (6 cm X 6 cm). In my professional opinion the lesion may have been the result of blunt force trauma causing the tissue to contact the edges of her teeth resulting in laceration, swelling and bruising. An odontogenic (tooth) infection would not present in this manner or travel in this pathway. Close monitoring, antibiotics therapy and a 7 day follow up evaluation is recommended."

During the interview with Resident # 2's Doctor on 4/16/2014 at 2:00 PM, he stated he saw the resident on 4/9/2014. The resident had a left lower lip bruise. He added that he could not explain how the resident got the bruise | F 323 | | | | |
Observation of the resident on 4/16/2014 at 9:30 AM revealed the resident sitting in her wheelchair in front of the nurse's station. The resident was calm and pleasant. A slight sign of bruising was noted on the left lip.

Resident #2's care plan last updated 4/16/2014 indicated the resident was "resistive with Activity of Daily Living (ADL) care and the resident becomes combative towards staff during ADL care trying to hit the staff, spits at the staff. " The goal was "have all needs anticipated and met without incident/injury through next review." The Approach for this problem was "approach with a calm and quiet demeanor, monitor and document behaviors, do not argue with resident and when resident becomes combative/resistive, leave resident safely in wheelchair or bed, and reproach when she as calmed down."

During the interview with Assistant Director of Nurse (ADON) on 4/16/2014 at 3:00 PM, she stated the family approached her on 4/8/2014 at around 5:00 PM stating there was blood on resident's mouth, wall and the bed rail. She (ADON) went to investigate and she saw the blood on the resident's wall, side rails and shirt. She (ADON) also observed a bruise on the resident mouth and began an investigation. She concluded that Nurse's Aide #4 was dressing the resident and she (Resident #2) was resistive to care and Nurse's aide #4 continued to dress the resident anyway. The side rails were up. ADON further reported Nurse's Aide #4 did not report the incident to any staff at the facility. ADON added the resident was resistive to care and got bruised due to improper repositioning technique by Nurse's Aide #4. Nurse's Aide #4 was
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suspended and 24 hour report was completed and faxed timely to the state agency. The ADON also reported her expectation of the staff was when a resident is resistive to care, the staff was to leave the room and notify the nurse then come later to the resident’s room. She added that no staff reported to her that there was blood on the resident's wall on 4/8/2014. The blood had been on the wall starting at around 8:00 AM until at 5PM when the family member reported that they saw the blood on the resident's mouth, wall and side rails.

During the interview with Director of Nursing (DON) on 4/16/2014 at 4:00 PM, She reported her expectation of the staff when a resident was resistive to care was to stop providing care and report the incident to the nurse. DON added the staff may go back to the resident’s room later to try to give care. She (DON) also added all the staff at the facility was trained that if they do not stop providing care when the resident is resistive to care, they may injure the resident which would be abuse.