PRINTED: 12/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING	 	C 11/20/2	2015
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVAR 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CC	(X5) DMPLETION DATE
F 253 SS=E	The facility must provimaintenance services sanitary, orderly, and This REQUIREMENT by: Based on observation interviews with staff at to provide maintenant secure a leaking toile Rooms (Rooms 30 and The findings included On 11/18/15 at 11:00 of rooms 30 and 28, strong urine smell. Tobserved unstable with brown substance. Resident #68 resided quarterly Minimum Direvealed he was cognounted by the cause the toilet was affaid to get on the fall. He stated he told about the toilet not be they had not told any when someone would	ide housekeeping and somecessary to maintain a comfortable interior. is not met as evidenced and resident the facility failed are services by failing to to for 2 of 2 Residents' and 28). AM the adjoining bathroom revealed that the toilet had a she base of the toilet was the a 2 inch dark yellow In room 30 and his ata Set (MDS) dated 8/14/15 intively intact. AM Resident #68 stated his	F 25	Submission of this response to the statement of deficiencies does not constitute an admission that the deficiencies exist and/or were correcited or required correction. On November 18, 2015, the flange seal were replaced on the toilet bet rooms 30 and 28. After replacement floor was bleached and cleaned to remove any remaining odor. Toilets throughout the facility were inspected by the Maintenance Direct assure they were secured and seal Other toilets were found to be defer and were repaired between 11/24/2 and 12/01/2015. On 12/14/15 the Administrator and Maintenance Director in-serviced of facility staff on the timely notification identified repairs to the facility Maintenance Director. A form entith Work Orders will be located at the nurse station, front office, and receptionist, to be available to staff complete and place in a tray located nurse station for the Maintenanc Director and/or assistant to retrieve ensure repairs are completed timely	and ween nt, the ctor to ed. ctive 015	Z21/15

BURATURY 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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 1/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	0.02.0		STREET ADDRESS, CITY, STATE, ZIP C		1/20/2015	
				1995 EAST CORNELIUS HARNETT E			
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546	OULLVAND		
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCY	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 253	Continued From page	e 1	F 2	253			
	toilet would turn over really scary when you rocking." On 11/18/15 at 11:31 #1 stated about 2 we maintenance that the leaking." She stated toilet and there was the stain around the base stated there was a howhere the toilet was I smelled so bad and so odor was still very str loose. She stated Re Assistant got him up to the state of the stat	toilet was "wobbly and she had tried to clean the wo inches of dark brown to of the toilet. She further sole 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		All toilets will be checked we months by the Maintenance ensure to toilets are in good Maintenance Director will refacility Administrator to reveand work orders completed 6 weeks; then, monthly x 22. The facility Maintenance Director/Administrator will summary of monthly monition and this summary will be perfacility monthly Quality Assemprovement Committee mereview, discussion and/or rechanges to ensure continuation.	e Director to d repair. meet with the iew the repairs d for the week x months. complete a oring efforts resented at the curance meeting for meeded		
	Assistant (NA #1) staresident very often but (11/18/15). NA #1 staresident very often being very often but (11/18/15). NA was the toilet when staresident very often but (11/18/15). Start very often but (11/18/15). NA was the toilet when staresident very often but (11/18/15). NA was the toilet when staresident very often but (11/18/15). NA was the toilet when staresident very often but (11/18/15). NA #1 staresident very oft	AM the Maintenance ne had told him that the until now. He stated that the to fill out a work order and					

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NAME OF P	ROVIDER OR SUPPLIER		_	STREET ADDRESS, CITY, STATE, ZIP CODE		72072010	
				1995 EAST CORNELIUS HARNETT BOULEV	'ARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546			
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F 253	Continued From page 2 but it got loose again and the maintenance man told her that the resident sat on the toilet too hard and that is why it got loose again. 483.15(h)(3) CLEAN BED/BATH LINENS IN		F 2	53			
E 254			F 25	54		12/21/15	
SS=B	GOOD CONDITION	BED/BATTI LINENS III	F 23) +		12/21/13	
	The facility must prov linens that are in good	ide clean bed and bath d condition.					
	by: Based on observatio and staff interview the			Damaged or stained linen in Roo Bed A, was removed on 11/18/20 replaced with unstained and unda linen on 11/18/15.	15 and		
	The findings included	:		An inventory of all linen was company 11/18/2015. All stained and dama linen was discarded from resident	aged		
		ent council minutes revealed he residents complained ins on them.		linen carts, and laundry. A linen of was placed on 11/18/2015 and re on 11/19/2015. Laundry and Housekeeping were in-serviced o	order eceived		
	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	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 in the fitted sheet. AM, 11 out of 15 fitted sheets oles and brown yellow stains		11/19/2015 by the Housekeeping Supervisor to assure residents we provided with unstained and unda linen. Nursing staff was in-service 12/15/15 by the DON to assure rewere being provided unstained/undamaged linen.	ere being amaged e on		
	in the laundry cart to resident halls. The la laundry was laundere washed between 11:0 laundry was returned	be distributed to all the aundry staff stated that the ad at another facility and was 00 PM to 5:00 AM. The back to the facility around o be distributed to all halls.		Started 11/20/15 linen has been in daily by laundry staff before being resident rooms. Nursing will mon daily prior to use in resident room remove and return any stained/ days	g sent to nitor linen ns; will		

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		345213	B. WING				20/2015
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					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON			ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IENCY MUST BE PRECEDED BY FULL PREFIX		FIX (EACH CORRECTIVE ACTION SHOULD BE		
F 254	Continued From page	÷ 3	F 2	254			
		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 Housekeeping Manager			The facility Housekeeping Supervisor/Administrator will complete summary of monthly monitoring efforts and this summary will be presented at facility monthly Quality Assurance		
	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	in a transition in which they in laundry at the facility but at the other facility laundry staff light. The Housekeeping and it was his expectation for dry staff to check the linen there were stains to have the the estains did not come out be discarded. Also if there linen it should also be not staff when providing care to check for stains and his clean sheets or linen.			Improvement Committee meeting for review, discussion and/or needed changes to ensure continued complian	ce.	
		were observed on the bed					
	(NA#3) stated she ha seen the holes in the when there were hole	AM Nursing Assistant d made Bed A and had not bed spread. She stated es in the linen or if the linen d discard the bed spread and r bed spread in good					
F 323	Director of Nursing (Director of Nursing (Director of Nursing (Director) was for real available to staff for real parts of the control of the		F3	323			12/21/15

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NAME OF D	20//050 00 01/00/150	343213	D. WING		TREET ADDRESS SITY STATE ZID SODE	11/	20/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLI	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
				L	ILLINGTON, NC 27546		
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F 323	Continued From page	o 4		200			
	Continued From pag		F	323			
SS=J	HAZARDS/SUPERV	ISION/DEVICES					
	as is possible; and ea	ure that the resident as free of accident hazards ach resident receives an and assistance devices to					
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent 2 of 4 cognitively impaired residents (Resident #22 and Resident #116) who exhibited wandering behaviors from exiting from the facility while unsupervised.				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	l:			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 the implemented a credit The facility remains cope and severity lessed to the facility remains to scope and severity lessed to the facility remains to scope and severity lessed to the facility remains to scope and severity lessed to the facility remains to scope and severity lessed to the facility remains to scope and severity lessed to the facility remains to scope and severity lessed to the facility remains to scope and severity lessed to the facility remains to scope and severity lessed to the facility remains to scope and severity lessed to the facility remains the fa	began on 10/11/15 when e facility unsupervised and r 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 ctual harm with potential for			wanderguard had been moved to wheelchair. Wanderguard removed frow wheelchair and reapplied to resident #116 sright ankle. Nursing staff was inserviced by the ADON on 11/19/15 regarding placement of wanderguards manufacturer squidelines. Wanderguplacement has been added the MAR and 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 physicials RP were notified and frequent	n per ard nd i ents	
	more than minimal ha	arm that is not Immediate monitoring of systems put in			monitoring by staff as to location was implemented. Maintenance was called	in	

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F 323	Continued From page	e 5	F 32	23			
	place and completion The findings included 1. Resident #22 was facility on 09/26/13. included Cognitive D Hypertension, Anxiet	n of employee training. I: originally admitted to the Resident #22's diagnoses		to check the alarm and batte replaced by maintenance. Fhas had no further exit seeki since 11/12/15.	Resident # 22 ng events		
	Weakness. Nursing note dated of in part: "At 9:45 AM housekeeping staff bout a war and the resident stated states and the checks were a common to the checks were checks were a common to the checks were a common to the checks w	n 04/04/15 at 4:15 PM read a member of the rought Resident #22 to the resident had seen Resident zeway door that connects are) to the assisted facility the door did not sound. The bund Resident #22 sitting returned her to the "C" hall. the was "looking for her r discomfort. Q (every) 15 initiated. Resident received mouth) for anxiety, her ecked for placement and ON (Director of Nursing), ember of the Maintenance		All Current residents were re 11/20/15 by the ADON to ide residents who are at high risk wandering behavior. Reside as having exit seeking behavious new and/or updated Care pla 11/20/15 by MDS nurse. CN Guides have been updated a with staff to ensure they are residents with a high risk of v 11/20/15 by the ADON. All residents currently with a have been assessed for wan placement. All wanderguards on residents as recommended manufacturer as of 11/19/15. 11/19/15 any resident experiunsafe wandering event will immediately re-assessed and put in place. The DON/Admin be notified for follow-up.	entify any k for ents identified viors have a an completed IA Care and reviewed aware of wandering on wanderguard derguard s are placed ed by the . As of encing an be d intervention		
	Nursing note dated of in part: "Resident brown by nurse (nurse name sitting under bridgew ambulance after setti (nurse name) had be when it sounded to some she found her sitting	n 09/15/15 at 7:05 PM read bught back in from outside e) where she had been ay (breezeway) beside ng off door alarm. Nurse en responding to alarm ee what had set it off when there. Resident was given		Newly admitted residents will by the admitting nurses for swithin 24 hours of admission appropriate inventions and c for any resident assessed as The DON/designee will comphour admission chart review A.M. clinical meeting to ensuorders, admission assessmerisk assessments have been	afety risk with are planning high risk. plete a 24 during the are all MD ents and at		

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		345213	B. WING _		11	/20/2015	
NAME OF P	ROVIDER OR SUPPLIER		· I	STREET ADDRESS, CITY, STATE, ZIP COD	E.		
				1995 EAST CORNELIUS HARNETT BOU	JLEVARD		
UNIVERSA	AL HEALTH CARE LIL	LINGTON		LILLINGTON, NC 27546			
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F 323	Continued From pa	age 6	F:	323			
	·	hours. She then sat quietly in		correctly and timely.			
		r). 7:30 PM - Reported to		correctly and timely.			
	,	ursing). 7:35 PM - Notified		The Maintenance Director red	reived		
	,	7:38 PM - Notified Dr. (name		in-service training by the Adm			
		M - Put to bed and was		11/18/15 on the new procedu			
	· ·	time. Bed alarm attached and		Maintenance will check the w			
		ent with eyes closed and		boxes daily for functioning an	•		
		nd unlabored. Q (every) 15		findings on the Door Alarm Cl			
	minute checks continuing." Note written by Staff Nurse #6.			monitoring tool. (2) Maintenar	nce will		
				check the voltage of batteries	and audible		
				alarm on all door alarms 4 x v			
		ent assessment dated on		battery life by using a meter a			
		elopement/wandering risk		manufacturer□s recommenda			
		opement risk included		changing battery when readir	-		
	interventions of free	· -		voltage or less. Maintenance			
		oom, staff aware of resident's		document his finding on the D	Joor Alarm		
	wander risk and wa	anderguard was placed."		Check monitoring tool. Any wanderguard box not fun	etioning		
	The guarterly Minin	num Data Set (MDS) dated		properly will be corrected imn			
		Resident #22 was severely		documented by maintenance			
		d and exhibited wandering		All wanderguard boxes were			
		1 to 3 days. The assessment		11/19/15 by maintenance and			
	_	esident needed extensive		properly.			
	assistance of one p	person physical assist for		All doors alarms were audited	d 11/19/15 by		
		and hygiene and limited		maintenance and documente	d with all		
	assistance of one p	person physical assist for		battery voltage over 7.0.			
	locomotion. The re	esident was coded as balance					
		le to stabilize with human		The Administrator will monitor			
		sident was assessed to		Maintenance Door Alarm Che			
	require a wheelcha	ir for mobility.		daily x 4 weeks; then, weekly			
				months to ensure compliance	; .		
		itled "Report of Resident Exit		Two patetrations	by MD ===	 	
	,	g: Missing From Facility"		Two notebooks were created			
		:40 PM read in part "B hall resident down hall to her room		WC that contains photos of a			
		vare that resident was behind		identified as high risk for wan 11/19/15. The notebooks will	-		
		tside of the facility on her		at the receptionist desk and n			
	_	the window. Resident had		station to ensure staff is able			
		dining area, door did not		any resident with a high risk f			

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F 323	Continued From pa	age 7	F.3	323			
	alarm. Alarm was	broken. Resident had gotten nd had mud on her clothes		wandering. MR will review an notebooks as needed.	nd update		
	made CNA (certifie	Resident was not hurt. Nurse d nursing assistant) aware of		The DON/designee will mon			
	put her into bed. A	NA cleaned resident up and ction taken: Resident on q		wanderguard placement of the residents weekly x 4weeks a			
		checks. A new plan of		to MARs documentation on			
care/intervention has been completed to prevent wanderguards. If any discrepation further events." found, the nurse will be identified to prevent formula for the prevent for the prevent formula for the prevent formula for the prevent formula for the prevent for the prevent formula for the prevent for the		tified,					
		on 11/12/15 at 11:42 PM read was found outside of dining		DON/designee.	y alo		
	room this pm, resid	ent was banging on door to		Training was completed by the	he ADON on		
		was assisted into wheelchair		11/19/15 with all current staf			
	_	nto building, C Hall nurse and		wandering or Elopement incl			
		N (Director of Nursing) was		identification of resident wan	-		
		also. Resident does have		behavior, creating a safe env			
		nd also personal alarm which		providing a safe environmen			
		r. No apparent injuries noted written by Staff Nurse #7.		residents. Any staff not avail training will not be allowed to	o work until		
		her history for November 12, the actual temperature was		training is complete. All newl employees will receive this to orientation.			
	78 degrees Fahren	heit and the low was 46 t. The weather history		Training was completed by the Clinical Director and DON w	-		
		ned on November 10, 2015.		employees on elements of F a Safe Environment and Ade	323 Providing		
	Review of Residen	t #22 updated care plan dated		Supervision for Residents or			
		sed the problem of the		The training included identification			
	"Resident has exit	seeking behavior. Resident		residents at risk, creating a s	safe		
	was found outside	of dining room on 11/12/15		environment, identifying and	reporting		
		oal: Resident will not leave		unsafe items in the environm			
	building unattended			interventions and providing a			
		onal secure alarm as ordered.		supervision. Any staff not a			
		of secure alarm per policy.		this training will not be allowed			
		per protocol. Redirect resident		until training is complete. All			
	· · · · · · · · · · · · · · · · · · ·	Observe frequently. Attempt		employees will receive this to	raining during		
		s PRN (as needed). Routine		orientation.			
	risk assessment. N	Meds as ordered. Contact MD					

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UNIVERSAL LIEA	LTUCARELIII	INCTON		19	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSAL HEA	LIH CARE LILL	INGTON		L	ILLINGTON, NC 27546			
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(medifacility Neuronotifice Adminimals Maints) Obsee 11/18 whee wand whee wand whee Durin (nursisted told bon Quexit the Durin MDS wand guard Obsee of resistation attack Durin Nurse reside stated check	y. Q (every) 15 ochecks initiated. MD (medicinistrator/DON) (enance in to fixed for the control of the control	I family of attempts to leave in minute checks indefinitely. I family of attempts to leave in minute checks indefinitely. I family of (responsible party) all doctor) notified. Director of Nursing) notified. I door." I de of the resident on in her room sitting up in or breakfast with the ed to the back of the I have been done in the further stated that she has seen the front area and look out the further stated that she was the hall that the resident is ute checks due to trying to I have been done in the further stated that she was the hall that the resident does he facility and a wander	F	3323	The DON/designee will review the 24 h report, physician stelephone orders a resident incident reports daily to ensure that all potential adverse events regard resident care and safety are addressed and appropriate interventions are in plath facility DON/designee will bring all incident/accident reports, physician telephone order, nursing 24-hour report and resident medical records of any resident experiencing an incident/accide to the Morning/Clinical Team Meeting. This meeting will include members of the facility inter-disciplinary Team (nursing, dietary, social services, administrator). Residents will be reviewed and medical records will be audited to ensure accurant complete documentation. If there is any discrepancy or need for follow up with the resident medical record the DON/designee will provide follow up with the licensed nurses, physically provide assessment visit with resident, and ensure accurate, complete documentation interventions are provided for that resident. The facility will conduct an interdisciplin weekly standards of care meeting (SOC to review residents at risk for safety incidents. Members of the interdisciplinary team include but is not limited to the Director of Nursing, Rehabilitation, and Social Work. This meeting will include input from the facil psychological group and attending MD, applicable, on current interventions and any necessary changes to the resident	nd e ing l ce. tt, ent ne l ate is n th cion mary C) ity if		

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	ROVIDER OR SUPPLIER	INGTON	'	STREET ADDRESS, CITY, STAT 1995 EAST CORNELIUS HAR LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE SED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 323	resident does wheel throughout the buildid During an interview of Social Worker stated herself in wheelchair only tries to exit the Tract Infection. During an interview of Assistant Director of the resident may go easily redirected. The she has not seen the building. Observation was matter resident sitting us area visiting with a fawas made of the ware resident's wheelchair olling an interview of #8 stated that she sate her wheelchair rolling PM and 10:40 PM were wrounds. During an interview of Maintenance Director of the ware stated that she sate her wheelchair rolling PM and 10:40 PM were wrounds. During an interview of Maintenance Director of the ware stated that she sate her wheelchair rolling PM and 10:40 PM were wrounds.	NA #7 further stated that the herself in wheelchair ing. on 11/18/15 at 10:18 AM, the distribution that the resident does wheel throughout the facility and facility if she has a Urinary on 11/18/15 at 10:20 AM, the Nursing (ADON) stated that to the door to look out but is the ADON further stated that the resident try to exit the deep on 11/18/15 at 2:30 PM of p in wheelchair in the foyer amily member. Observation inderguard attached to the	FS	appropriate and time The DON/designee v minutes of the week! Regional Clinical Dire review. DON will submit sum SOC with all the evid audits, monitoring an Quality Assurance ar Improvement meeting discussion and/or ne ensure continued con resolved. The Administrator/Ma will submit a summan efforts regarding ope Alarms and wanderg including work orders repairs to the monthly and Performance Impor review, discussion changes to ensure countil resolved.	will submit the ly SOC to the ector x 3 months for mary of the weekly dence of training, and trends to monthly and Performance g for review, leeded changes to impliance until alintenance Director rry of all monitoring leration of Door luard system, s of completed ly Quality Assurance provement meeting n and/or needed		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345213	B. WING		C 11/20/2015	
	ROVIDER OR SUPPLIER AL HEALTH CARE LILL	LINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 323	alarm system compinstruction. The Mastated that the dining in with the wanderg door will alarm when Maintenance Direct 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 indicat 10:00 PM on 11/1 in her room doorwathat the resident was to her wandering the stated that the nurse banging noise and the dining room door the glass door with the Nurse #7 was pwheelchair back into stated that the resider and cleaned up and Nurse #9 said she of The Administrator awere notified. During an interview Nurse #7 stated that the resider and was part of the Administrator awere notified.	any for manufacturer's intenance Director further ig room door alarm is not tied uard system, the dining exit in it is opened. The or further stated that he or on the alarm system for the or on 11/13/15 around 12:30 otified at home that Resident	F 32	3		

		(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 AL HEALTH CARE LILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEY LILLINGTON, NC 27546	VARD	11/20/2015	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	resident on her kneed door banging on the stated she yelled for another door about a resident. Nurse #7 s wheelchair was about in the mud. Nurse # resident while she we to stand. The reside and rolled back into weather outside was Nurse #7 stated said DON. During an interview of housekeeping staff # Resident #22 attempthe kitchen area on I Resident #22. Observation was mand there was 12 for out from the dining of the area where the and there was 12 for out from the dining of the area where the and there was 12 for out from the dining of the area where the and there was 12 for out from the dining of the area where the and there was 12 for out from the dining of the area where the and there was 12 for out from the dining of the area where the another was of the construction send to fall the state of the manual stat	door with a rock. Nurse #7 help and she went out 10 feet away from the stated that the resident ut 6 feet away from her stuck 7 said she checked the as outside and she was able ent was put in her wheelchair the facility. Nurse #7 said the damp and the air was brisk. I she immediately called the on 11/19/15 at 7:55 AM, #2 revealed that she saw of to go out of the door near ast week and she redirected de on 11/19/15 at 10:30 AM the Resident #22 was found to cement sidewalk that goes from exit door. Observation from site which was about 40 from exit door. facturer's instructions dated 14 read in part "Parts to 9 volt battery. Low battery siren chirps and red LED teconds intervals when the froximately 7 volts. "The to had the manufacturer's	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	' '	ATE SURVEY DMPLETED
		345213	B. WING			C 11/20/2015
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOUL LILLINGTON, NC 27546		00.10
(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 COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	When the code watch a resident's ankle, be at each door to a 4 to Failure to do so may because they will be door detects the tran manual, read in part, in a wheelchair, attactor the back of the character with the Adjust the band so the comfortable position ankle." During a telephone in AM a Technician from wander guard code we (wanderguard brace) the metal portion of a interfere with the transport of the metal portion of a interfere with the adjusted of the metal portion of a interfere with the adjusted of the metal portion of a interfere with the adjusted of the metal portion of a interfere with the adjusted of the metal portion of a interfere with the adjusted of the metal portion of a interfere with the adjusted	n, read in part, "Warning: In (wanderguard) is placed on the sure to adjust the antennae to 5 ft. range to the ankle. Is allow a resident to elope closer to the door when the smitter." Also pg. 9 of the "Note: To monitor a resident the transmitter to the seat thair as the metal on the chair that the transmitter is in a that the transmitter is in a on the resident's wrist or Interview on 11/19/15 at 10:33 In the manufacturer of the watch, stated the code watch the should not be placed on the wheelchair because it could dismitter's signal. In 1/20/15 at 9:06 AM, the the ded that it is her expectation the ector use the alarm system totions and change the istering 7 volts by using the	F	323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345213	B. WING			C 11/20/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEV LILLINGTON, NC 27546	•	11/20/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	of Daily Living, Res assistance with trar A Nursing Note date part, "Informed per building. Writer noti wheelchair outside Wheeled back into placed on right wris Staff Nurse #1. Review of a docum. Assessment - Reposeking/Wandering revealed: "7/18/15 12:45 PM resident out of build sitting in wheelchair lot. Wheeled back in indicated that the remonitoring device. included the placen on the resident. A Nursing Note date part, "Resident ale bed in wheelchair, p. Noticed resident habracelet. Placed bawas written by Staff During an interview Supervisor# 1, state elopement incident did not work that off noted on Resident a report of 7/18/15 as supervisor. During an interview Nursing Assistant #Resident # 116 elop	ident #116 required limited isfers and used a wheelchair. It is a taff seeing resident out of ced resident sitting in of building in parking lot. If acility. Wanderguard bracelet it." The note was written by the titled "Elopement it of Resident Exit and the titled "Elopement it of Resident Exit and the titled is a taff of seeing ing. Writer noticed resident are outside of building in parking into facility." The document is identified in the titled is a to the titled into th	F3	23		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345213	B. WING _		C 11/20/2015
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVA 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 323	contact Staff Nurse # #116 from the parking elopement incident re #1 was no longer em her telephone was di The resident was dis 7/20/15 and was read 7/23/15. According to the most Data Set (MDS) date Brief Interview for Me which meant Resider impaired with severe skills. In the area of the coded, with no wand area of Activities of D required extensive as used a wheelchair. A Nursing Note dated in part, "Another resi pushing resident dow stated resident was s Nurse supervisor and Nursing made aware minute checks. Resid person/family member message to return ca Will monitor. Resider note was written by S Review of a document Assessment Report of Seeking/Wandering: revealed: "10/11/15 5:00 PM" "	PM an effort was made to all who retrieved Resident golot and wrote the eport on 7/18/15. Staff Nurse ployed with the facility and sconnected. Charged to the hospital on dmitted to the facility on the recent Quarterly Minimum and 10/6/15, Resident #116's ental Status (BIMS) was 00, at #116 was cognitively ly impaired decision making behavior, Resident #116 was earing behaviors, and in the earily Living, Resident #116 sesistance with transfers and and 10/11/15 at 8:15 PM, read ident's family member was an hallway to nurse and additing outside. Registered at Assistant Director of and stated to start every 15 dent #116's responsible er was called and left all. Night nurse made aware. In the staff Nurse #2. In titled "Elopement of Resident Exit Attempting to leave facility "Another resident family dent back in stated she was	F3	23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(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			20.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	alarm did not sound, monitoring device was at the time the reside building. However, the The action taken by the resident's wherea A Nursing Note dated in part, "Resident wi On every 15 minute owritten by Staff Nurse Review of Resident # 10/14/15, read in part ordered, Wandergua secure alarm per pol facility protocol. Observed frequently." During an interview of Nurse #2 stated she on 10/11/15 when an member brought Resident #116 in her medication cart and if #116 was found sittin parking lot. Staff Nursee a wanderguard but she recalled the on the resident's when	ted the facility's security and the resident's as observed on the resident ent was found outside of the de device was not working. The facility included to check abouts every 15 minutes. If 10/12/15 at 8:07 AM, read thout attempt to leave facility. Checks." The note was	F	323	CY)		
	missing. Staff Nurse remember which stat work with the resider facility while unsuper she did know whethe exit seeking behavior. Staff Nurse	# 2 said she did not if member was assigned to it the day she exited the vised. Staff Nurse #2 said ir or not Resident #116 had r and she had not observed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C I1/20/2015	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP COI 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DE		
(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)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	came in to do the inc Resident #116 wand she did not know wh sounded when Resid During an interview of Nursing Assistant #4 work with Resident # never wandered outs Resident #116 wand her wheelchair near 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 benche not recall taking any During an interview of Assistant Director of known Resident #11 behavior and she wo was wearing a wand she had never seen Assistant Director of Resident #116's incid Supervisor, she did in Nurse #2 about the in 10/11/15. During an interview of Director of Nursing (I) to call her about eve Assistant Director of October and she was	and. She stated when she ident report staff told her ered a lot. She relayed that ether or not the door alarm lent #116 exited the facility. In 11/18/15 at 5:55 PM, revealed he was assigned to eit16 and the resident had side 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 allegedly saw Resident #116 I took her to the staff nurse in the brought residents back outside all the time. The day that the did took her to facility, but he did	F 32	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345213	B. WING		11/20/2015		
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETION		
F 323	incident of 10/11/15 The DON revealed in Resident #116 exited The DON revealed in Resident #116 exited The DON revealed in Resident #116 was a eloped from the facil said she realized Rebased on the resider revealed once staff feloped from the facil wanderguard braceled DON said after Resident was at rish responsible person a initiate fifteen minute expected supervisors her. During an interview of Maintenance Director door and side door ear a wanderguard system checked doors once open the door, set of the door. He said he bracelet, walk up to alarm. The Maintenance wanderguard braceled while he tested the bresident with a wand close to the door in cound. The Maintenance sometimes he would	tated she found out about the on Monday after the incident. To one notified her when a from the facility in October. It aff should have known a wanderer because she ity in July 2015. The DON sident #116 was a wanderer not's last assessment. She ound out Resident #116 had ity in July 2015, a set was placed on her. The dent #116's elopement in July staff to know whether or not a k for elopement, to notify the and the medical doctor and to be checks. She stated she also is to start an investigation for an 11/19/15 at 9:29 AM, the per revealed the facility's front entrance were equipped with the medical doctor and contained the door alarm and close would hold a wanderguard the door and set off the ance Director stated a set had never malfunctioned bracelet. He explained the lerguard would have to get order for the door alarm to ance Director revealed use a resident with a set to test the door alarm and	F 323				
	wheelchair because remove the wander of	residents would attempt to guard when placed on their nce Director emphasized that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345213	B. WING		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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 323	door would lock when set off the door alarm for staff to turn off the Maintenance Directo wanderguard bracele Restorative Aide. During an interview of facility Restorative Ai indicating that she te wanderguard bracele she always held the wanderguard bracele on the tester until it be she tested the wanderguard bracele on the tester until it be she tested the wanderguard bracele on the tester until it be she tested the wanderguard bracele on the tester until it be she tested the wanderguard bracele on the tester until it be she tested the wanderguard bracele would come on to income working. She revealed work, she would rete at the front door. Review of the manufication of the wander working. She revealed work, she would rete at the front door.	we a system in which the in the resident's wanderguard in. He said there was a code is alarm once it sounded. The infurther revealed individual of the weekly by a surface of the state of	F 323				
	date 5/21/15, page 7 When the code watch a resident's ankle, be at each door to a 4 to Failure to do so may because they will be door detects the tran manual, read in part, in a wheelchair, attac or the back of the cha can interfere with the	nitters, User Guide, "release read in part, "Warning: In (wanderguard) is placed on e sure to adjust the antennae of 5 ft. range to the ankle. It is allow a resident to elope closer to the door when the smitter. "Also pg. 9 of the "Note: To monitor a resident the transmitter to the seat air as the metal on the chair transmitter's signal. #4 at the transmitter is in a					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		(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 BOULE 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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	ankle." During a telephone in AM a Technician from wanderguard code w (wanderguard bracel the metal portion of a interfere with the transparent of the metal portion of a interfere with the transparent of the metal portion of a interfere with the transparent of the metal portion of a interfere with the transparent of the metal portion of the metal portion. The wastached to the lower wheelchair near the mount of the metal of the me	on the resident's wrist or Interview on 11/19/15 at 10:33 In the manufacturer of the atch, stated the code watch et) should not be placed on a wheelchair because it could ismitter's signal. In on 11/19/15 at 9:45 AM, itting in her wheelchair in the anderguard bracelet was right corner, metal portion of right wheel. In 11/19/15 at 3:27 PM, the revealed he used a	F 32				
	nurse's station with o						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345213	B. WING _		C 11/20/2015
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEV 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 CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPL	OULD BE COMPLETION
F 323	of wheelchair on a m wheel. On 11/19/15 at 2:12 I observed at the hallw Work office, sitting in residents. The reside was on the back of the brace near the right wheelchair strough administrative offices station. Resident #11 on the right side of he brace lower portion of wheel. During an interview of Staff Nurse #3 states Resident #116's hall (7:00AM-3:00PM). Signopel herself in her and down the hall. Signeyer left the building of the time Resident areas. Staff Nurse #3 was not one to be mosher relayed Resident wanderguard braceled one anymore because exit the facility. Staff not observed Reside seeking behaviors, wheelchairs of the side of th	PM Resident #116 was vay entrance near the Social wheelchair next to other int's wanderguard bracelet ie wheelchair on the metal wheel. PM, Resident #116 was her wheelchair to the lobby int 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 if wheelchair near the right on 11/19/15 at 11:52 AM, I she was assigned to on first shift he said Resident #116 could wheelchair and could go up he stated Resident #116 g by herself. She said most #116 sat in the common is revealed Resident #116 onitored for her whereabouts. It #116 used to have a bit, however, she did not have he she had not attempted to Nurse #3 revealed she had int #116 exhibiting any exit as not aware Resident #116 and was not aware the	F3	23	

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				CIVID IVC	7. U930-U39 I
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345213	B. WING			1	C 20/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
UNIVERS	AL HEALTH CARE LILLI	NGTON		1	995 EAST CORNELIUS HARNETT BOULEVARD		
OIIIV LINO	AL HEALIN OAKE LILLI	toron		L	ILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
		,			DEFICIENCY)		
F 323	Continued From page	e 21	F	323			
				0_0			
	During an interview o	n 11/19/15 at 12:09 PM,					
	_	revealed Resident #116					
		wn halls in the facility and					
		outside of the facility. She					
		sat in her wheelchair at the					
		as usually around that area					
		ference to supervision,					
	Nursing Assistant #5	stated they had a certain					
	number of residents of	on every fifteen minute					
	checks and Resident	#116 was never on the list					
	to check frequently. S	She stated she had never					
		ry to open doors. Nursing					
		en it was time for Resident #					
		toileting, she revealed, nine					
		_					
	· ·	dent #116 would be at the					
		ng Assistant #5 stated when					
		ry morning, the charge nurse					
		residents needed to be					
	-	ntly and Resident #116's					
	name never came up	. Nursing Assistant #5					
	stated she was not av	ware Resident #116 exited					
	the facility while unsu	pervised in July 2015 and					
	October 2015. She fu	irther revealed she did not					
		ebook with a list of residents					
	that were wanderers						
		no one had discussed the				ĺ	
	wandering notebook	with the nursing assistants.					
	Review of the alonem	nent notebook on 11/19/15 at				ſ	
	-						
		esident #116's exit seeking				ĺ	
	profile was in the note	ероок.				ſ	
	During on interview a	n 11/10/15 at 1:06 DM tha				ſ	
		n 11/19/15 at 1:06 PM the					
	• ·	OON) stated from what she				ĺ	
		116 was found on 10/11/15 at					
	end of the brick walky	way, in the facility parking lot				ĺ	
	on 10/11/15.						
	1		1		I .		l .

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG	(.	X3) DATE SURVEY COMPLETED
		345213	B. WING _			C 11/20/2015
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP COL 1995 EAST CORNELIUS HARNETT BO 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) MULT A. BUILDI	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 11/20/2015	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP COD 1995 EAST CORNELIUS HARNETT BOU LILLINGTON, NC 27546	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 323	Resident #116 not to behaviors and the wa on her ankle. She fur was staff would report of Nursing, the Assist to her. The Administrator staff to document eloreport and notify the The Administrator saicommunicated with Nelopements. During an interview of Facility Medical Direct the wanderers but it Nelopements and "we could have detriment to the resident in the Administrator was Jeopardy on 11/19/18. The facility provided the Allegation on 11/20/18.	and her expectation was for have any more exit seeking anderguard would be placed ther stated her expectation telopements to the Director tant Director of Nursing, then ator's expectation was for pement on the 24 hour family and medical director. In they usually dursing Assistants about the stor stated he was aware of the nad not been discussed ance (QA) meetings. He have looked at wandering fixed it before it became a dents. It has to be a safe safety of the patients." It is notified of the Immediate to at 8:45 AM.	F	323			
	member at 8:15 pm of wheelchair at the edgentrance patio and w facility. Resident #11 be without injury. Sta #116's exiting the fac RP were notified. The for resident #116 was	vas observed by a family on 10/11/15 sitting in her ge of the driveway to the front as brought back inside the 6 was assessed and found to ff was alerted to resident ility, the attending MD and e intervention implemented is placement of a ight ankle and 15 minute					

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 I1/20/2015	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CO 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DE	11/20/2010	
(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 E APPROPRIATE	(X5) COMPLETION DATE	
F 323	precautionary measure wanderguard. Residexit seeking events is 2) Resident #22 was on the sidewalk outsi 10:40 pm on 11/12/1 into the facility by numo injuries noted. The were notified. The fac (1) that resident #22' at 10:20pm and reside hallway. (2) The alarmot be working when door. (3) Resident #2 checks by staff as to precautionary measure called in to check the replaced at 12:29 am # 22 has had no furth 11/12/15. New Interventions: Resident #22: Mainterwanderguard boxes and document findings on monitoring tool. Any functioning properly by maintenance. All wanderguard by maintenance will che and audible alarm or for battery life by using manufacturer's recombattery when reading Maintenance will doc Door Alarm Check malarms were audited	location x 72 hours as are after placement of the ent #116 has had no other ince 10/11/15. As discovered on her knees de the dining room door at 5. She was assisted back ring staff and assessed with the attending physician & RP incility investigation revealed: She CNA had checked resident lent was in her w/c in m on DR door was found to staff tested by opening the 22 was placed on 15 min resident 's location as a lare. (4) Maintenance was a larm and battery was a by maintenance. Resident her exit seeking events since	F 32	23			

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 _		11	C / 20/2015
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	·	7.20.20.10
(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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	on 10/11/15 has work seeking events. Resplacement of wander noted wanderguard has wheelchair. Wander wheelchair and reappankle. Nursing staff won 11/19/15 regarding wanderguards. Wanderguards are high risk of the ADO who are at high risk of Residents identified a behaviors have a new completed 11/20/15 to Guides have been upstaff to ensure they a high risk of wandering. Two notebooks were pictures of all resident wandering on 11/19/10cated 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	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 a and nurses will check at starting 3-11 shift 11/19/15. Were reassessed on N to identify any residents for wandering behavior, as having exit seeking and/or updated Care plan by MDS nurse. CNA Care bodated and reviewed with the aware of residents with a ground of the contain the lats identified as high risk for 15. The notebooks will be onist desk and nurse's f is able to identify any isk for wandering. If with a wanderguard have ander guard placement. All acced on residents as	F3	23		
	behaviors within 24 h As of 11/19/15 any re exiting seeking event	ours of admission. esident experiencing an				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DATE COMP	SURVEY LETED
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	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 PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Training will be compunsafe wandering or identification of reside creating a safe environment for reside of wanderguards on the wheelchair by the AD not available for this the work until training is of Maintenance will cheefor functioning and do Alarm Check monitor box not functioning primmediately by maintenance will cheefor functioning primmediately by maintenance will cheef on the work in the work wander of the work wander of the work wander of the work wandering or resident wander of the work wandering and/or elocation of the work wandering and/or elocation of the work wander of the work wan	ill be notified for follow-up. leted with all current staff on Elopement including, ent wandering behavior, onment, providing a safe ents and proper placement he resident and not their ON on 11/19/15. Any staff training will not be allowed to complete. It wander guard boxes daily ocument finding on the Door ing tool. Any wanderguard roperly will be corrected enance. Maintenance aining on this procedure on guard boxes were audited ance and are working to the voltage of batteries all door alarms 4 x weekly a meter and follow of the point of changing is 7.0 voltage or less. The point of	F	323			
	the Director of Nursin	Members of the include but is not limited to g, Rehabilitation, Social is meeting will include input					

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 AL HEALTH CARE LILLIN	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546	11/20/2010	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 323	Continued From page		F 32	23		
F 490 SS=J	necessary changes to residents are receiving interventions. The credible allegation at 11:30 AM as evidents at risk for elegation at 11:30 AM as evidents at risk for elegation at 11:30 AM as evidents at risk for elegation at 11:30 AM as evidents at risk for elegation and enforce adherent intervention in the control of	ent interventions and any of the resident care to ensure 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 inced by: interview of all eing able to identify dependent and verifying staff entify, report and monitor andering. Interview staff on oxes 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 a plans, care guides and erified as well as elopement ons of proper placement of anderguard system working in a manner that assources effectively and maintain the highest mental, and psychosocial sident. The is not met as evidenced is not met as evidenced is any appropriate and staff interviews, the in failed to have available	F 49	Facility Administrator, Director of Nurs and Assistant Director of Nursing failed create a safe environment for residents not ensuring staff was properly trained unsafe wandering /exit seeking behavi	d to s by on	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345213	B. WING			1	C 20/2015
NAME OF PI	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	28	F	490			
				-30	not having Policies and Presedures in		
	•	d in an immediate jeopardy			not having Policies and Procedures in		
		mpaired residents (Resident			place for checking door alarms per		
		16) who exhibited wandering			manufacturer □s recommendations and		
	behaviors from exiting	g the facility while			not ensuring the wanderguards were o		
	unsupervised.	40/44/45			the resident rather than their wheelcha	ır.	
		began on 10/11/15 when			Resident #22 has had no exit seeking	•••	
		e facility unsupervised and			events since 11/12/15. Maintenance w	III	
	-	r in the front parking lot of			check wanderguard boxes daily for		
	-	ent's wander guard bracelet			functioning and document findings on		
		alarm system on the door.			Door Alarm Check monitoring tool. Any		
	Immediate Jeopardy			wanderguard box not functioning prop	erly		
		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		
	at 10:07 AM when the				implemented on 10/11/15 has worked	with	
		ble allegation of compliance.			no other exit seeking events since		
		ut of compliance at a lower			10/11/15. Resident assessed for	_	
	scope and severity le	•			placement of wanderguard on 11/19/1	5	
		tual 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		
		off interviews, the facility			placement has been added the MAR a		[
		4 cognitively impaired			nurses will check placement every shift	t	
	· ·	22 and Resident #116) who			starting 3-11 shift 11/19/15.		
	_	pehaviors 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		
		s notified of the Immediate			wandering behavior. Residents identif		
	Jeopardy on 11/19/15	at 8:45 AM.			as having exit seeking behaviors have		
					new and/or updated Care plan comple	ted	
	The facility provided t	<u>~</u>			11/20/15 by MDS nurse. CNA Care		
	Allegation on 11/20/1	5 at 10:18 AM.			Guides have been updated and review	red .	
					with staff to ensure they are aware of		
	Problem Identified:				residents with a high risk of wandering	on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		NOTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGION		L	ILLINGTON, NC 27546		
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TAG	REGULATORY OR	ESC IDENTIFY TING INFORMATION)	TAG		DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
F 490	Continued From page	e 29	F.	490			
	F-3				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	ocu	
		residents by not ensuring			within 24 hours of admission with		
		ined on unsafe wandering			appropriate inventions and care planning	าต	
		or, not having Policies and			for any resident assessed as high risk.	.9	
	_	for checking door alarms per			The DON/designee will complete a 24		
	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.				orders, admission assessments and at			
	New interventions:				risk assessments have been completed	t	
	Choice Management Clinical Support Nurse has				correctly and timely.		
	completed re-training	with facility Administrator,			Two notebooks were created by Medic	al	
		nd Assistant Director of			Records and Ward Clerk that contains		
	Nursing regarding un	safe wandering or			photos of all residents identified as high		
	elopement including	identification of resident			risk for wandering on 11/19/15. The		
	wandering behavior,	creating a safe environment,			notebooks will be located at the		
	completion of resider	nt assessments at the time of			receptionist desk and nurse □s station to		
	admission and the tir	ne of any event of unsafe			ensure staff is able to identify any resid	ent	
	wandering or elopem	ent, notification of any			with a high risk for wandering. MR will		
	events with potential	of adverse resident			review and update notebooks as neede	ed.	
	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	d	
	re-occurrence of any	adverse outcomes			on residents as recommended by the		
	regarding resident ca	are and safety.			manufacturer as of 11/19/15.		
					As of 11/19/15 any resident experiencing	-	
	Resident #22: Mainte				an exit seeking event will be immediate		
		daily for functioning and			re-assessed and intervention put in pla		
		n the Door Alarm Check			The DON/Administrator will be notified	tor	
		wander guard box not			follow-up.		
		will be corrected immediately			Training was completed by the ADON of		
		wanderguard boxes were			11/19/15 with all current staff on unsafe	;	
	•	maintenance and are working			wandering or Elopement including,		
	properly.				identification of resident wandering	and	
	Maintananaa will aha	ak the voltage of betteries			behavior, creating a safe environment a	anu	
		ck the voltage of batteries			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 until		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345213	B. WING			11/	20/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
I INIVEDS	AL HEALTH CARE LILLII	NGTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
ONIVERS	AL IILALIII CANL 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)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 490	Continued From page	e 30	F.	490			
	manufacturer's recon	nmendation of changing			training is complete. All newly hired		
		is 7.0 voltage or less.			employees will receive this training dur	ing	
	-	ument his finding on the			orientation.	J	
		onitoring tool. All doors			The Maintenance Director received		
	alarms were audited	11/19/15 by maintenance			in-service training by the Administrator	on	
	and documented with	all battery voltage over 7.0.			11/18/15 on the new procedure of (1)		
	Resident #116: The v	vander guard implemented			Maintenance will check the wandergua	rd	
	on 10/11/15 has work				boxes daily for functioning and docume	ent	
	seeking events. Res				findings on the Door Alarm Check		
	·	guard on 11/19/15 and			monitoring tool. (2) Maintenance will		
	noted wanderguard h				check the voltage of batteries and audi		
	wheelchair. Wanderg				alarm on all door alarms 4 x weekly for		
		olied to resident #116's			battery life by using a meter and follow		
	_	vas in serviced by the ADON			manufacturer s recommendation of		
	on 11/19/15 regarding	derguard placement has			changing battery when reading is 7.0 voltage or less. Maintenance will		
	_	R and nurses will check			document his finding on the Door Alarr	n	
		t starting 3-11 shift 11/19/15.			Check monitoring tool. Any wandergua		
	Potential Residents:	t starting of 11 shift 11/10/10.			box or audible alarm not functioning	ıu	
	All Current residents	were reassessed on			properly will be corrected immediately	and	
		N to identify any residents			documented by maintenance.		
	-	or wandering behavior.			All wanderguard boxes were audited		
	_	as having exit seeking			11/19/15 by maintenance and are work	ing	
	behaviors have a nev	v and/or updated Care plan			properly. All doors alarms were audited	j	
	completed 11/20/15 b	by MDS nurse. CNA Care			11/19/15 by maintenance and		
		dated and reviewed with			documented with all battery voltage ov	er	
	-	re aware of residents with a			7.0.		
		g on 11/20/15 by the ADON.			The facility will conduct an interdiscipling	•	
		created that contain the			weekly standards of care meeting (SO	3)	
	·	ats identified as high risk for			to review residents at risk for safety		
		15. 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 r				Rehabilitation, and Social Work. This	itv	
		y with a wander guard have anderguard placement. All			meeting will include input from the facil 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		
			1				

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391 </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		345213	B. WING				0
		345213	B. WING			11/	20/2015
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLII	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
				L	ILLINGTON, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page As of 11/19/15 newly assessed for the risk behaviors within 24 h As of 11/19/15 any re seeking event will be and intervention put in DON/Administrator w Training will be comp unsafe wandering or identification of reside creating a safe enviro environment for resid of wander guards on wheelchair by the AD not available for this t work until training is of Maintenance will chee for functioning and do Alarm Check monitor box not functioning pr immediately by maint received in-service tra 11/18/15. All wanderg 11/19/15 by maintena properly. Maintenance will chee and audible alarm on for battery life by usin manufacturer's recom	admitted residents will be of wandering /exit seeking ours of admission. sident experiencing an exit immediately re-assessed in place. The ill be notified for follow-up. leted with all current staff on Elopement including, ent wandering behavior, onment, providing a safe ents and proper placement the resident and not their ON on 11/19/15. Any staff training will not be allowed to complete. ck wanderguard boxes daily ocument finding on the Door ing tool. Any wanderguard roperly will be corrected enance. Maintenance and are working ck the voltage of batteries all door alarms 4 x weekly	TAG		CROSS-REFERENCED TO THE APPROPRIA	will for f nd fee v of one o s ce. ly	
	Maintenance will doc Door Alarm Check me alarms were audited and documented with Monitoring:	ument his finding on the pointoring tool. All doors 11/19/15 by maintenance all battery voltage over 7.0.			Improvement meeting for review, discussion and/or needed changes to ensure continued compliance until resolved. The Administrator/Maintenance Directors		
	standards of care me behavior that will revi	ct an interdisciplinary weekly eting regarding wandering ew any resident with unsafe pement seeking behavior			will submit a summary of all monitoring efforts regarding operation of Door Alarms and wanderguard system, including work orders of completed		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345213	B. WING			C 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	the Director of Nursin Work and Dietary. The from the facility psychattending MD on currencessary changes to residents are receiving interventions. Director of Nursing are will conduct a weekly with review of any resund/or exit seeking be include member of the input from facility psycattending physician for any necessary changensure residents are interventions. The credible allegation at 11:30 AM as evidents at risk for elegible understood how to identify the input from facility psycattending physician for any necessary changensure residents are interventions. The credible allegation at 11:30 AM as evidents at risk for elegible at 11:30 AM as evidents at risk for when wanderguard befunctioning; how ofter audible alarms check wanderguard sensor accuracy of alarming addition updated care assessments were venotebooks. Observati	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 g appropriate and timely and/or administrative nurse standards of care meeting sident with unsafe wandering enhavior. This meeting will be interdisciplinary team with chological group and or current interventions and less to the resident care to receiving timely	F 49	repairs to the monthly Quality Assura and Performance Improvement meet for review, discussion and/or needed changes to ensure continued complia until resolved.	ing	
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMB	ERS/MEET	F 52			12/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (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		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

CENTER	3 FOR MEDICARE &	WEDICAID SERVICES				CIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMP	SURVEY
						(С
		345213	B. WING			11/	20/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLI	NGTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
ONVERO	AL HEALTH OAKE LILLI	NOTON .		L	ILLINGTON, NC 27546		
(X4) ID	I .	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
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F 520	Continued From page	e 34	F	520			
		began on 10/11/15 when			Wanderguard was placed on Resident		
		e facility unsupervised and			#116 s right ankle on 10/11/15.		
		r in the front parking lot of			Resident assessed for placement of		
	-	ent's wanderguard bracelet			wanderguard on 11/19/15 and noted		
	failed to activate the	alarm system on the door.			wanderguard had been moved to		
	Immediate Jeopardy	began on 11/12/15 when			wheelchair. Wanderguard removed from	mc	
		facility unsupervised and			wheelchair and reapplied to resident		
		night by staff. The dining			#116□s right ankle. Nursing staff was	n	
		to alarm due to a dead			serviced by the ADON on 11/19/15		
	battery. Immediate			regarding placement of wanderguards	-		
	11/19/15 at 9:45 AM			manufacturer □s guidelines. Wandergu			
		e facility provided and ole allegation of compliance.			placement has been added the MAR a nurses will check placement every shift		
	-	out of compliance at a lower			starting 3-11 shift 11/19/15. Resident	·	
	scope and severity le				#116 has had no other exit seeking ev	ents	
		ctual harm with potential for			since 10/11/15.	J. 100	
		arm that is not Immediate			Resident # 22 was assessed and foun	d to	
		monitoring of systems put in			be without injury. The attending physic	ian	
	place and completion	of employee training.			& RP were notified and frequent		
	The findings included	i :			monitoring by staff as to location was		
	_	renced to F 323: Based on			implemented. Maintenance was called	l in	
		aff interviews, the facility			to check the alarm and battery was		
		4 cognitively impaired			replaced by maintenance. Resident #		
	-	#22 and Resident #116) who			has had no further exit seeking events		
		behaviors from exiting the			since 11/12/15.		
	facility while unsuper	visea.			All Current residents were reassessed	on	
	During an interview o	on 11/18/15 at 11:59 AM, the			11/20/15 by the ADON to identify any	OII	
	_	ctor stated he was aware of			residents who are at high risk for		
	-	had not been discussed			wandering behavior. Residents identif	ied	
		ance (QA) meetings. He			as having exit seeking behaviors have		
		nave looked at wandering			new and/or updated Care plan comple		
		fixed it before it became a			11/20/15 by MDS nurse. CNA Care		
		lents. It has to be a safe			Guides have been updated and review	/ed	
	environment and the	safety of the patients."			with staff to ensure they are aware of		
					residents with a high risk of wandering	on	
		on 11/20/15 at 9:06 AM, the			11/20/15 by the ADON.		
		ed that residents with				_	
	wandering behavior of	did not come up as a			All residents currently with a wandergu	ard	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 11/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/20/2010	
				1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
F 520	Continued From pag		F 520			
	concern in QAA. The	e Administrator further stated		have been assessed for wanderguard	1	
	that residents with wa	andering behavior will be		placement. All wanderguards are place	ced	
	reviewed in QAA.			on residents as recommended by the		
				manufacturer as of 11/19/15.		
		as notified of the Immediate		Newly admitted residents will be asse		
	Jeopardy on 11/19/1	5 at 8:45 AM.		by the admitting nurses for safety risk		
	T. 6 99			within 24 hours of admission with		
		the following Credible		appropriate inventions and care plann	-	
	Allegation on 11/20/1	5 at 10:18 AM.		for any resident assessed as high risk The DON/designee will complete a 24		
	Problem Identified:			hour admission chart review during th		
	i iobiciii identiiled.			A.M. clinical meeting to ensure all MD		
	Facility failed to deve	elop and implement a Quality		orders, admission assessments and a		
		ormance Improvement		risk assessments have been complete		
		with wandering/exit seeking		correctly and timely.		
	behaviors.					
	Interventions:			As of 11/19/15 any resident experience	cing	
		ent Clinical Support Nurse		an exit seeking event will be immedia	tely	
	has completed re-tra			re-assessed and intervention put in pl		
		or of Nursing and Assistant		The DON/Administrator will be notified	d for	
		egarding F520 Quality		follow-up.		
		g unsafe wandering or				
		identification of resident		The Maintenance Director received		
		creating a safe environment, nt assessments at the time of		in-service training by the Administrator 11/18/15 on the new procedure of (1)	I OII	
		ne of any event of unsafe		Maintenance will check the wandergu	ard	
		nent, notification of any		boxes daily for functioning and docum		
	events with potential			findings on the Door Alarm Check	icit	
	outcomes to Clinical			monitoring tool. (2) Maintenance will		
	completion of Quality			check the voltage of batteries and aud	dible	
		ement Plan to prevent		alarm on all door alarms 4 x weekly fo		
	re-occurrence of any			battery life by using a meter and follow		
	regarding resident ca			manufacturer □s recommendation of		
	-	-		changing battery when reading is 7.0		
	The DON or adminis	trative nurse will review the		voltage or less. Maintenance will		
		cian's telephone orders and		document his finding on the Door Alar	m	
		ort daily to ensure that all		Check monitoring tool.		
		ents regarding resident care		All wanderguard boxes were audited		
	and safety are addre	ssed and appropriate		11/19/15 by maintenance and are wor	rking	

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				CIVID IVC	7. 0930-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
						(C		
		345213	B. WING			11/	20/2015		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
UNIVERSA	AL HEALTH CARE LILLIN	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD				
				L	LILLINGTON, 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 520	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			520	properly.	· In.			
					All doors alarms were audited 11/19/15 maintenance and documented with all battery voltage over 7.0.	о бу			
					The Administrator will monitor the Maintenance Door Alarm Check sheets daily x 4 weeks; then, weekly times 3	3			
					months to ensure compliance. Two notebooks were created by MR ar	nd			
					WC that contains photos of all resident	S			
	with review of any resident with unsafe wandering and/or exit seeking behavior. This meeting will				identified as high risk for wandering on 11/19/15. The notebooks will be located				
	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.				at the receptionist desk and nurse□s station to ensure staff is able to identify	ı			
					any resident with a high risk for	,			
					wandering. MR will review and update notebooks as needed.				
	Potential Residents: All Current residents			All residents currently with a wandergu have been assessed for wanderguard	ard				
11/20/15 by the ADON to identify any who are at high risk for wandering be					placement. All wanderguards are place	ed			
		_			on residents as recommended by the				
	Residents identified as having exit seeking behaviors have a new and/or updated Care plan				manufacturer as of 11/19/15. As of 11/19/15 any resident experiencing an				
	I .	by MDS nurse. CNA Care			unsafe wandering event will be				
		odated and reviewed with			immediately re-assessed and intervent				
	staff to ensure they are aware of residents with a high risk of wandering on 11/20/15 by the ADON.				put in place. The DON/Administrator w be notified for follow-up.	III			
		created that contain the			So nounce to tonout ap.				
	·	nts identified as high risk for			The DON/designee will monitor				
		15. The notebooks will be onist desk and nurse's			wanderguard placement of the identifice residents weekly x 4weeks and compa				
	•	f is able to identify any			to MARs documentation on	i C			
	resident with a high ri				wanderguards. If any discrepancies are	Э			
All residents currently with a wanderguard have				found, the nurse will be identified,					
	been assessed for wander guard placement. All				reeducated and counseled by the				
	wander guards are placed on residents as recommended by the manufacturer as of				DON/designee.				
	11/19/15.	manadatarar ad or			Training was completed by the ADON of	on			

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CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	7. 0930-0391	
STATEMENT OF DEFICIENCIES (X 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 PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				19	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	UNIVERSAL HEALTH CARE LILLINGTON				ILLINGTON, NC 27546			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		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 520	Continued From page	a 37		520				
1 020				320	44/40/45 :11 .11			
	As of 11/19/15 newly admitted residents will be				11/19/15 with all current staff on unsafe	}		
		of wandering /exit seeking			wandering or Elopement including,			
	behaviors within 24 h				identification of resident wandering	d		
	-	sident experiencing an exit			behavior, creating a safe environment	and		
	_	immediately re-assessed			providing a safe environment for	•		
	and intervention put i	ill be notified for follow-up.			residents. Any staff not available for the training will not be allowed to work unti			
		-			training will not be allowed to work und training is complete. All newly hired	·		
	Training will be completed with all current staff on unsafe wandering or Elopement including,				employees will receive this training dur	ina		
	identification of resident wandering behavior,				orientation.	"'9		
	creating a safe environment, and providing a safe				0.10.11.41.0.11			
	environment for residents by the ADON on				Training was completed by the Region	al		
	11/19/15. Any staff not available for this training				Clinical Director and DON with current			
	will not be allowed to work until training is complete.				employees on elements of F323 Providence	ding		
					a Safe Environment and Adequate	J		
	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	ing tool. Any wanderguard			residents at risk, creating a safe			
	box not functioning properly will be corrected				environment, identifying and reporting			
	immediately by maint	enance. All wander guard			unsafe items in the environment;			
are working properly.		11/19/15 by maintenance and			interventions and providing adequate			
					supervision. Any staff not available for			
	Maintenance will check the voltage of				this training will not be allowed to work			
and audible alarm on all door alarms 4 x weekly for battery life by using a meter and follow		_			until training is complete. All newly hire			
				employees will receive this training dur	ing			
	manufacturer's recommendation of changing				orientation.			
	, ,	is 7.0 voltage or less.						
	Maintenance will document his finding on the				The DON/designee will review the 24 h			
	Door Alarm Check monitoring tool. All doors				report, physician ☐s telephone orders a	na		
	alarms were audited 11/19/15 by maintenance and documented with all battery voltage over 7.0				resident			
	I .	i ali battery voltage over 7.0			incident reports daily to ensure that all			
	Monitoring:				potential adverse events regarding	1		
	Beginning 11/19/15 the Administrator will monitor				resident care and safety are addressed and appropriate interventions are in pla			
		the Maintenance Door Alarm Check sheets daily x 4 weeks; then, weekly times 3 months to			The facility DON/designee will bring all			
	ensure compliance.	kiy unicə ə monus to			incident/accident reports, physician			
		d/or designee will monitor the			telephone order, nursing 24-hour report	t		
	1	ent of identified residents			and resident medical records of any	ι,		
	. wanuciuala biaceiii	511 51 14511111154 1531451113	1					

weekly x 4weeks and compare to MARs

resident experiencing an incident/accident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDING			C		
		345213	B. WING			11/20/2015		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	AL UEALTH 04BE LUL	WOTON.		1995 EAST CORNELIUS HARNETT BOULEVARD				
UNIVERS	AL HEALTH CARE LILL	INGTON		L	ILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 520	documentation on with discrepancies are for identified, reeducated or ADON. Director of Nursing with standards of care mineeting x 3 months, review, discussion at ensure compliance of the facility Administ summary of all monified at the facility QAP Medical Director and The credible allegating at 11:30 AM as evidente use of wander guards boxed functioning; how often audible alarms check wander guard sensor accuracy of alarming addition updated Catassessments were with notebooks. Observational wander guards and effectively. The credible allegating at 11:30 AM as evidential at 11:30 A	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 effectively. The credible allegation was verified on 11/20/15 at 11:30 AM as evidenced by: interview of all staff related to their being able to identify residents at risk for elopement and verifying staff understood how to identify, report and monitor residents at risk for wandering. Interview staff on when wanderguard boxes are to be checked for functioning; how often voltage of batteries and audible alarms checked on doors and how often wanderguard sensor doors would be checked for functioning; how often voltage of batteries and audible alarms checked on doors and how often wanderguard sensor doors would be checked for		520	to the Morning/Clinical Team Meeting. This meeting will include members of the facility inter-disciplinary Team (nursing, dietary, social services, administrator). Residents will be reviewed and medical records will be audited to ensure accurand complete documentation. If there any discrepancy or need for follow up in the resident medical record the DON/designee will provide follow up with the licensed nurses, physically provide assessment visit with resident, and ensure accurate, complete documental and interventions are provided for that resident. The facility will conduct an interdiscipling weekly standards of care meeting (SOO to review residents at risk for safety incidents. Members of the interdisciplinary team include but is not limited to the Director of Nursing, Rehabilitation, and Social Work. This meeting will include input from the facil psychological group and attending MD, applicable, on current interventions and any necessary changes to the resident care to ensure residents are receiving appropriate and timely interventions. DON will submit summary of the weekl SOC with all the evidence of training, 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.	I ate s n th ion ary C)	E COMPLETION DATE E te in on ary) Y if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245242	P WING			С		
345213			B. WING _			11/2	20/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE			
UNIVERSA	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BO	OULEVARD			
ONIVERO	AL HEALTH OAKE EILEN	TOTON		LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 520	1.3.		F 5		nce Directo	or.		
	Continued From page 39 notebooks. Observations of proper placement of wanderguards and wanderguard system working effectively.			The Administrator/Maintenar will submit a summary of all efforts regarding operation of and wanderguard system, in orders of completed repairs. Quality Assurance and Perform Improvement meeting for rediscussion and/or needed of ensure continued compliance resolved. The DON/designee will subminutes of the weekly SOC Regional Clinical Director x serview.	peration of Door Alarms system, including work d repairs to the monthly and Performance ting for review, needed changes to compliance until			