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

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		, ,	(X3) DATE SURVEY COMPLETED	
	345213	B. WING _			C 07/24/2015	
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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
(INJURY/DECLINE/R A facility must immed consult with the reside known, notify the residence or an interested family accident involving the injury and has the positive physical, mental, or publications are intervention; a significantly (i.e., a new existing form of treatment); or a decist the resident from the §483.12(a). The facility must also and, if known, the resor interested family mechange in room or roospecified in §483.15(resident rights under regulations as specifications. The facility must record the address and phore legal representative of this REQUIREMENT by: Based on record revisite the resident record revisite reviews the facility.	isately inform the resident; ent's physician; and if dent's legal representative y member when there is an resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a y, mental, or psychosocial eatening conditions or y; a need to alter treatment ent due to adverse commence a new form of ion to transfer or discharge facility as specified in promptly notify the resident ident's legal representative ember when there is a mmate assignment as e)(2); or a change in Federal or State law or end in paragraph (b)(1) of and periodically update the number of the resident's ir interested family member. The is not met as evidenced ew and staff and family failed to assure the	F	Preparation and/or execution of correction does not constitu	ute	8/21/15	
· · ·			admission or agreement by th	ne provider of	(X6) DATE	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LEACH DEFICIENCY REGULATORY OR LEACH DEFICIENCY (INJURY/DECLINE/R A facility must immedican consult with the reside known, notify the resion or an interested family accident involving the injury and has the potential intervention; a significantly accident involving the injury and has the potential physical, mental, or produced the deterioration in health status in either life thractinical complications; significantly (i.e., a new existing form of treatm consequences, or to a treatment); or a decise the resident from the §483.12(a). The facility must also and, if known, the resor interested family mandange in room or root specified in §483.15(resident rights under regulations as specifications as specificating section. The facility must record the address and phore legal representative of the section. This REQUIREMENT by: Based on record revisite the facility responsible party was section.	AL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to assure the responsible party was notified regarding a change	ROVIDER OR SUPPLIER AL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). 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This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to assure the	ROUBER OR SUPPLIER AL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, resident in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment due to adverse consequences, or to commence a new form of treatment of 483.15(e)(2), or a change in resident from the facility as specified in §483.12(a). 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This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility falled to assure the responsible party was notified regarding a change	A BULDING 345213 BUNDAG STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 3.10(b)(11) NOTIFY OF CHANGES (INJURYY)DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical mental or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision for transfer or discharge the resident from the facility as specified in \$483.15(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in \$483.16(a)(2); or a change in room or roommate assignment as specified in pargraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member of the resident's legal representative or interested family member of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to assure the responsible party was notified regarding a change	

Electronically Signed Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

08/07/2015

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OIVID INC	<u>7. 0936-039 i</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
						(c
		345213	B. WING			07/	24/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIMINEDO	AL UEALTU CADE LILLI	NCTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		L	ILLINGTON, NC 27546		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	e 1	F	157			
		Resident # 1) of two sampled		,	the truth of the facts alleged or		
		ilies were interviewed. The			conclusions set forth in the statement	of	
	findings included:	mes were interviewed. The			deficiencies. The plan of correction is	,,	
	_	£ 1 's closed record revealed			prepared and/or executed solely becau	ise	
		at the facility from his most			it is required by the provisions of feder		
		ate of 2/13/15 until 7/13/15			and state law.		
	upon which date he v	vas discharged home. The					
	-	esident had multiple diagnoses which included			1. Corrective action accomplished for		
	but were not limited t			those residents found to have been			
I	Mellitus Type 2; Gout	t; Neuropathy, Congestive			affected by the alleged deficient praction	ce:	
	Heart Failure, Chroni			Resident #1 was discharged home with	า		
		, and Lung Cancer. The			his wife on 7/13/15.		
	resident was also do				2. How corrective action will be		
	T	a and mild venous stasis			accomplished for those residents having	ıg	
	changes in his lower				potential to be affected by the same		
	Review of interdisciple	linary notes revealed lated to the resident 's			alleged deficient practice:		
		ecifically on 7/9/15 at 12:07			 a. On 7/24/15 appointment scheduler audited all appointments scheduled for 	•	
		nted that the resident was "			the following two weeks to confirm all		
		3. " On 7/12/15 at 3:25 AM			residents' responsible parties were		
		nented that the resident " is			notified of appointment. All responsible	<u> </u>	
	alert and oriented to				parties were notified.		
		poor decisions. Able to make			b. DON/ADON/Unit Manager/Nursing		
		st rely on staff to anticipate			Supervisor will review 24 hour nursing		
	some of his needs i.e	e. changes of cloths "			reports from 6/23/15 to present to iden	tify	
	Review of the record	revealed the resident had a			all residents with a change of condition	ı by	
	family member who v	vas identified on his record			8/21/15. Notification of all responsible		
	to be his responsible				parties by licensed nurse of any identif	ied	
		nt ' s record revealed a			change of condition not notified		
	-	ne order, dated 7/12/15, that			previously.		
		o be made for the resident to			3. Measures put into place to ensure the	nat	
	,	ing physician concerning his			the alleged deficient practice will not		
		of the resident 's nursing			recur:	:c	
	-	linary notes from the date of			a. Appointment scheduler/nurse to not	-	
	7/7/15 through 7/13/1				responsible party of appointments at le		
		ne resident had a foot			two weeks prior to scheduled appointm or as soon as practicable. Appointmen		
	provided to the reside	that wound care was being			scheduler to keep log of resident		
	1 *	that the resident had a foot			appointment date, name of responsible	<u>د</u>	
	was nouncu	and recident had a loot	1		- Spromanom dato, name of responsible	•	ı I

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	E SURVEY IPLETED
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		345213	B. WING		. ا	7/24/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	124/2015
NAME OF T	NOVIDEN ON OUT FEIEN			1995 EAST CORNELIUS HARNETT BO		
UNIVERSA	AL HEALTH CARE LII	LINGTON			DULEVARD	
				LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 157	Continued From p	age 2	F 1	57		
	Record review review a wound clinic on necrotic toe ulcer of consulting physicial insulin dependent necrosis at the dol Multiple maggots of another one inside physician further of moderate "tunnel maggots had debrighysician was interested and the state of the state	cheduled for a consult. ealed the resident was seen at 7/13/15 and identified to have a with a maggot in it. The wound an documented, "This is an diabetic patient with some real aspect of third right toe. Were found in his shoes and the toe ulcer. "The consulting ocumented that there was " ing of the ulcer and that the ided the ulcer. The wound rviewed by phone on 7/24/15 at und physician stated that on and multiple maggots on the documented to the removed a couple from his e were maggots on his clothes		party and date notified of sci appointment. b. All nurses will be educate DON/ADON/administrative r protocol for resident's chang and notification of responsib nurse not receiving education will not be allowed to work u received the education. All the facility will receive education orientation. c. Nurses will notify MD/DON Manager of all residents' changer of all responsible paresident with a change of co	d by the nurses on the period condition ale party. Any on by 8/21/15 ntil they have new nurses to ation during N/ADON/Unit ange of tation of arty for any indition by	
	the resident 's resident on 7/23/15 at 11:4 family member staresident home on plan for him to be family member stafacility the resident stated she was as and shortly thereat transport van. The the resident was a facility, the resident doctor because he family member stathat he knew his to had gout and that of his toe to the gothat this was the fithere was a problem.	mily member, who was listed as ponsible party, was interviewed 5 AM by phone. The resident 's ted she arrived to take the 7/13/15 because there was a discharged that date. The ted when she arrived at the twas gone. The family member ked to have a seat in the lobby fiter the resident arrived in the family member stated that as ssisted from the van into the at told her that he had been to a se had maggots in his toe. The ted that the resident told her be was swollen but that he also he had attributed the swelling but. The family member stated are knowledge that she had sem with his toe or about there the ulcer. The family member		DON/ADON/Unit Manager. A discrepancies noted at that the reviewed with employee with intervention as deemed necestable. E. Responsible party will be nurse of resident's change of and document notification in medical record. E. DON/ADON/Unit Manager Supervisor will review daily (weekends) all residents with condition, notification of respand documentation. If not confollow-up will be done immediated in the facility plans to effectiveness of the corrective DON/ADON will submit sum to monthly Quality Assurance Performance Improvement in months then quarterly theres.	time will be a appropriate essary by the essary by the essary by the notified by of condition resident's f/Nursing (including a change of consible party empleted, diately and unseled. Evaluate the experience of audits e and meeting x3	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345213	B. WING				24/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
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			+				
F 157	Continued From page	e 3	F	157			
	· -	staff had not informed her		.07	Revisions to this plan will be determine	d	
		with the resident 's toe or			by the QA Committee.	u	
	that he had maggots.				by the Q/Committee.		
		lucted with the following staff					
		: NA (Nurse Aide) # 1 was					
		15 at 1:05 PM; Nurse # 2 was					
	interviewed on 7/24/1	5 at 12 noon; Nurse # 1 was					
	interviewed on 7/24/1	5 at 9:50 AM; and Nurse # 3					
	was interviewed on 7	/23/15 at 3:10 PM. The					
		revealed that on 7/12/15 the					
	_	n drainage around his toes					
		crawled out from between					
		gan to clean them. NA # 1					
		diately told both Nurse # 1					
		nterviews with Nurse # 1 and					
		sistance had been obtained rted the maggots to them.					
	-	with Nurse # 2, the nurse					
		ne also saw " dead bugs "					
		d. Nurse # 2 stated Nurse #					
		assigned to the resident that					
		Nurse # 3 called the family					
	after the order was of	_					
	arrangements for the	resident to be seen at the					
	wound clinic. Nurse	# 3 stated during her					
	interview that she tho	ought Nurse # 2 called the					
		e # 2 was the one who cared					
		ot and was designated as					
	supervisor on that da						
	Interview with the Dir	<u> </u>					
		./15 at 8:10 AM revealed					
	I	ormed the family member					
		f the resident 's toes when					
	00	rered between his toes on e staff members stated they					
	had been made awar						
	condition on 7/12/15						
F 226	483.13(c) DEVELOP	-		226			8/21/15
1 220	+00.10(0 <i>)</i> DL V LLOF	THAN FIAIFIAI		0			0/2 1/ 10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		E SURVEY MPLETED
		345213	B. WING		0.	C 7/24/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEV	•	
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	Continued From page	e 4	F 22	26		
SS=D	ABUSE/NEGLECT, E	TC POLICIES				
	policies and procedur	t, and abuse of residents				
	by: Based on record revinterview and resident to implement their ne completed investigati (Resident # 1) of three The findings included Review of the facility revealed that the polifailure to provide goo to avoid physical harrillness. "The policy of would investigate neg findings into a report, gathered from the resinterviews revealed than investigation into the staff members to nee details of the medical as follows. Review of Resident # the resident resided a recent readmission dupon which date he we resident had multiple but were not limited to	e sampled residents. : 's policy on neglect cy identified neglect as the " ds and services necessary m, mental anguish, or mental directed that the facility staff glect and formulate their The following information sident's medical record and ne facility failed to complete the development of Resident		1. Corrective action accomplished those residents found to have been affected by the alleged deficient processed that the Resident #1 was discharged horn his wife on 7/13/15. Administrator retrained on the Abuse and Negle on July 23, 2015 by the Regional of Operations. Investigation of all wound started on July 23, 2015 by and Administrator and was comply 7/28/15. 2. How corrective action will be accomplished for those residents potential to be affected by the said deficient practice: All incidents for the past 60 days reviewed on 7/28/15 for complete thoroughness by the DON/ADON Manager. All incidents investigatic complete and thorough. 3. Measures put into place to ensithe alleged deficient practice will recur: a. Nurses educated to report all in with outcomes requiring investigatincluding but not limited to falls we resident altercations, allegations and neglect, elopements and identifications.	en practice: ne with r was pect Policy Director eged by DON leted by having me were on and l/Unit ons were sure that not ith injury, of abuse	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			;
		345213	B. WING				24/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
11NIN/ED0	A	NOTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 226	Continued From page	e 5	F	226			
	Heart Failure, Chroni				of new pressure ulcers to DON/ADON	in	
		, and Lung Cancer. The			person or by phone and document on 2		
	resident was also dod	-			hour report and on facility incident repo		
	I .	a and mild venous stasis			began on 7/29/15. DON/ADON will rep		
	1 -	extremities. Interview with			all incidents with outcomes requiring		
	_	Nursing) and administrator			investigation to Administrator in person	or	
		M regarding the resident 's			by phone. Any nurse not receiving		
	I .	al status revealed that upon			education by 8/21/15 will not be allowe	d to	
	discharge the resider	nt was optimistic about his			work until they have received education	n.	
	future and hoped to li	ve at home for an extended			b. DON/ADON/Unit Manager/Nursing		
	'	as considered stable in			Supervisor will review nurses 24 hour		
	relation to his Lung C				report daily for all incidents. Administra	tor	
		nt 's most recent MDS			will review facility incident reports		
	, ,	assessment, dated 7/8/15,			Monday-Friday to ensure investigation	S	
		's abilities and status were			are completed as needed.		
		g way: The resident was core of 15 for his BIMS (Brief			c. DON/ADON/SW to initiate investigat immediately. All investigations to be	ion	
	_	Status) indicating he did not			completed thoroughly and accurately		
	I .	ment at the time of the			within 5 days of incident.		
		cting staff care during the			d. DON to maintain log of all incident		
	_	as being independent with			dates, date investigation was initiated a	and	
	bed mobility, transfer				date of completion of investigation with		
		tance with dressing; as			outcome.		
	_	assistance for personal			4. How the facility plans to evaluate the	و (
	hygiene needs, and a	as needing physical help with			effectiveness of the corrective action:		
	part of his bathing.				DON/ADON will submit summary of		
	Review of the resider	nt 's care plan, last reviewed			immediate notification of incident to		
	on 5/18/15, revealed	the resident was identified to			monthly Quality Assurance and		
	be at risk of skin brea				Performance Improvement meeting x3		
		abetes, Gout, decreased			months then quarterly thereafter.		
		s left hand and because he			Revisions to this plan will be determine	:d	
	_	The care plan included			by the QA Committee.		
	· -	which included but were not					
		g: Skin Inspections routinely;					
	treatment as ordered						
	preventative skin care						
	Review of interdiscipl						
		ated to the resident 's					
	cognitive abilities. Sp	ecifically on 7/9/15 at 12:07				ļ	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345213	B. WING				24/2015
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	24/2013
					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546		
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F 226	Continued From page	a 6	_	226			
. 220		ited that the resident was "	'	220			
		3. " On 7/12/15 at 3:25 AM					
		ented that the resident " is					
	alert and oriented to						
		poor decisions. Able to make					
		st rely on staff to anticipate					
		c. changes of cloths "					
		nt 's record revealed a					
	physician 's telephor	ne order, dated 7/12/15, that					
		be made for the resident to					
	be seen by a consulti	ng physician concerning his					
	foot wound. Review	of the resident 's nursing					
	notes and interdiscipl	inary notes from the date of					
	7/7/15 through 7/13/1						
		ne resident had a foot					
		or that wound care was					
		resident. Review of the					
		July treatment records					
		ntation that the resident had					
	-	e. Review of the resident 's					
	·	inspection report " revealed					
		mented that the resident 's n 6/12/15, 6/16/15, 6/19/15,					
		7/7/15. These entries were					
		t nurses. On one of the					
	_	se noted the skin was intact,					
	6/12/15, the resident						
		rist documented that the					
	1 .	ing ulceration to his right					
		nild erythema surrounding				ĺ	
	the area and some di	•				ſ	
		" will treat per protocol. "				ſ	
		ng physician 's progress				ĺ	
		the resident 's primary				ĺ	
	-	sident on 6/19/15 and made				ĺ	
		at the resident had a skin				ĺ	
	wound or lesion. Inte	erview with the DON on				ĺ	
	7/24/15 at 8:10 AM re	evealed the podiatrist 's				ĺ	
		eatment had never been				ľ	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONS	STRUCTION	(X3) DATE COMP	SURVEY PLETED
		345213	B. WING _				C / 24/2015
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 011	24/2013
				1995 E	AST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LIL	LINGION		LILLIN	IGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa	age 7	F	226			
		podiatrist or initiated by the					
		The DON stated she called on					
		ed the protocol. Review of the					
		hat the podiatrist noted on sident had an "ulceration					
		dorsal toe " and that the					
		should evaluate and treat the					
		oval from the primary physician.					
		sician was interviewed on					
		and stated he saw the					
		5. The physician stated that he					
	routinely took a res	ident 's socks off and looked					
	at their feet and wo	ould have noted in his last					
	progress report if the	ne resident had a toe ulcer					
		ed treatment. The physician					
		ne podiatrist notation of 6/12/15					
		eration was developing. The					
		stated that with the diagnoses					
		ency and Diabetes that the					
		e had some erythema and					
		ch were noted by the podiatrist,					
		nding physician he had not					
	which needed treat	uring his exam on 6/19/15					
		/15 wound consultation report					
		Ilting physician noted Resident					
		toe necrotic ulcer with a					
	_	e within the ulcer. The wound					
		n documented, " This is an					
		diabetic patient with some					
		sal aspect of third right toe.					
	Multiple maggots w	ere found in his shoes and					
		the toe ulcer. " The consulting					
		ocumented that there was "					
		ng of the ulcer and that the					
	maggots had debri						
		an was interviewed by phone					
		5 AM. The wound physician					
	stated that on 7/13	/15 he had found multiple					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	· ,	TE SURVEY MPLETED	
		345213	B. WING			C 7/ 24/2015	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		0.12.120.10	
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 226	couple from his ulcer maggots on his cloth physician stated the physician stated he was maggots but from his advanced in their state wound physician state them to be three or for physician stated that expert opinion gather verify the stage of the The resident's family the resident's respons on 7/23/15 at 11:45 Amember voiced concresident's feet were the facility staff may care. The family mer been able to tell her obtained the toe ulce there. The family mer knowledge there was within his ulcer prior family member stated on the morning of 7/2 was supposed to be The family member stated on the facility. The was asked to have a thereafter the resident van. The family mem resident was assisted facility, the resident the family member stated that he knew his toe	lent. He stated he removed a and that there were es and in his right shoe. The maggots were big. The was not an expert on sobservation they appeared ge of development. The red that he would estimate our days old. The wound no test had been done or red on that date to further e maggots. In y member, who was listed as ansible party, was interviewed and by phone. The family erns that the Diabetic not being assessed and felt have been negligent in his anber stated that no one had	F 22	26			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	TE SURVEY MPLETED	
		345213	B. WING			C 7/ 24/2015	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 226	that the resident also had been found in his Aide) prior to 7/13/15 things climbed out of cared for him. The fa after the resident tolo went to the resident 'belongings and that s # 1. The family mem # 1 how the resident condition it was found the nurse that the resident tondition it was found the nurse that the resident way in a twenty four member stated that the maggots had been he wore and that the staff check his feet end to the thought it was Friday corresponded to 7/10 hurting. He stated he on to go outside and at his toes before he stated he knew his to that he couldn't see stated he thought go and pain. The reside checked his toe that that the NA left the resident was interested that a nurse, whom he could not it dressed his toe. The thought this same nu and then changed it stated he went to the	The family member stated told her that the maggots is toe by a facility NA (Nurse and that a " whole bunch of his toe " when the NA had mily member stated that her about the issue, she is room to collect his she stopped to talk to Nurse ober stated she asked Nurse shoot got to be in the did that day, and was told by sident's foot could get that hour period. The family he nurse further stated that the found in his house shoes resident would not let the very day.	F 22	26			

D WING	C /24/2015
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE LILLINGTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546 D PROVIDER'S PLAN OF CORRECTION	
()	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 Continued From page 10 were crawling in his shoe when they took the shoe off at the wound clinic. Review of the resident 's records revealed he last received a shower on the evening shift of 7/10/15. NA#2, who was assigned to provide his shower assistance on that date, was interviewed on 7/23/15 at 2:55 PM. NA#2 stated that on 7/10/15 the resident was not ready for his shower when she approached the resident on multiple times during the first part of her shift. NA#2 stated that ensident appeared irritated that she kept approaching him and offering. NA#2 stated that when the resident became ready for his shower that he did almost all of the shower by himself. NA#2 stated the resident became ready for his shower chair but could stand independently to reach parts of his body which he needed to access to clean and that he stretched to bathe the lower part of his body which he needed to access to clean and that he stretched to bathe the lower part of his body while sitting in the chair. NA#2 stated the only assistance she provided him was with washing his back. NA#2 was asked if the resident washed between his toes and stated she didn' trecall because she really didn' t watch closely given the resident 's independence in his care. Following the shower, NA#2 stated the resident dried and dressed himself independently. According to staffing records, NA#1 was the dayshift NA assigned to care for Resident #1 on Saturday (7/11/15) and Sunday (7/12/15). NA#1 was interviewed on 7/23/16 at 1.05 PM. The NA stated that Resident #1 was usually up when she arrived to work. NA#1 stated that it had been Sunday, 7/11/15, on which the resident was first identified to have a problem with his loe. NA#1 stated that the resident had turned on his call light for assistance on that date and when she	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 55.25	_		، ا	
		345213	B. WING				24/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	24/2013
					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON			LILLINGTON, NC 27546		
(VA) ID	CHMMADV C	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From pag	e 11	F	226			
		e asked the resident if she		220			
		e could better inform the					
		or to getting her. NA # 1					
		ent was agreeable and when					
		t that it appeared " gunky "					
		4th toe; " like green stuff					
		when you sleep sometimes.					
		got a cleansing wipe in					
	order to clean betwe	en his toes before getting the					
	nurse. The NA stated	d as she was moving the					
		between his toes that " a					
		ame out from between his					
		d that she was referring to					
		tated "them." The NA					
	_	ck on her stomach but did					
	not want to upset the	and went to get Nurse # 1					
		nd Nurse # 2 (the nurse					
		nents for that day). NA # 1					
	_	administrative staff member					
		or to the day on which she					
	was speaking to the						
		esponded, " not until today. "					
		e Director of Nursing had					
	called her to come to	the facility, informed her she					
	needed to write a sta	tement and speak to the					
	surveyor.						
		iewed by phone on 7/24/15					
		2 stated that NA # 1 had					
		# 1 to come and look at					
		on Sunday, 7/12/15. Nurse #					
		Nurse # 1 entered the room					
		rse # 2 stated when they					
		It the resident had his shoe Nurse # 2 stated she placed					
	•	resident 's foot while he was					
		she did not see anything					
		She looked between his toes					
		a crusted area on his third					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING				C /24/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	PRESS, CITY, STATE, ZIP CODE	1 011	24/2015	
TO UNE OF TH	TO VIDER OR OUT FIER				CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LIL	LINGTON						
				LILLINGTO	ON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 226	Continued From pa	age 12	F	226				
	toe which the nurse	e described as clean, intact,						
		Nurse # 2 stated she helped						
		e resident 's feet. Nurse # 2						
		did not appear to be in pain						
		hall nurse to call the physician.						
		ne hall nurse called the						
		ined an order to have the						
		the next day at the wound						
		ated that there were two or						
		gs on the bed but they were						
		e resident. The hall nurse						
	stated she saw no more than the two dead ones.							
		nat after washing the resident '						
		d the towel from underneath						
		t and she placed the two dead						
		owel. The nurse stated she						
	_	ne towel by throwing it away in						
	•	in the dirty laundry room.						
	_	he did not know if the resident '						
	s bed linens were	changed. Nurse # 2 stated she						
		if he had noticed anything						
		oes on that day and he had						
	told her he had not	Nurse # 2 stated she did not						
	look in his shoes o	n that date. Nurse # 2						
	described the resid	lent as cooperative. Nurse # 2						
	was questioned by	the surveyor if administrative						
	staff members had	talked to her prior to the date						
	of the survey abou	t what happened. Nurse # 2						
	stated she thought	" yesterday " (7/23/15) was						
	the first day they ha	ad tried to call and speak to her						
	about the resident	and what had transpired. The						
	nurse stated that the	ne Director of Nursing had						
	called her and left							
	Nurse # 1, who ma	naged the unit on which						
	Resident # 1 reside	ed, was interviewed on 7/24/15						
		# 1 stated that on Sunday,						
		d come to get both Nurse # 2						
		e time. Nurse # 1 stated that						
	NA#1 appeared u	pset and she talked to her a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7. BOLDING		С		
		345213	B. WING				24/2015
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVERS	AL HEALTH CARE LILL	INGTON		1	995 EAST CORNELIUS HARNETT BOULEVARD		
O.M. C. L. C.	712 112 121 1 97 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2			L	LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)		(X5) COMPLETION DATE
F 226	Nurse # 1 stated when 2 had already started Nurse # 1 stated that is foot and did not set stated the resident. This skin was flaky, but drainage. Nurse # 1 maggot on the bed. The resident if he has rolled over his toe as resident did not known had looked in the rethat she had placed resident and his feet shoes. Nurse # 1 stated Resident # 1 when she arrived at around 5 PM when swas questioned by the tothe resident about been checking his fed did not ask the resident and informed the Administrator ab 7/12/15. Review of staffing slassigned as Reside for the dates of 7/11 was interviewed on stated that on Sunda supervisor (Nurse # all of Nurse # 3 's restated that Nurse # 2 date and asked her ulcer. Nurse # 3 stated that Stated that Stated that Stated that Stated that Stated that Stated the ulcer. Nurse # 3 stated that Stated the ulcer. Nurse # 3 stated that Stated the stated that Stated the ulcer. Nurse # 3 stated that Stated the ulcer. Nurse # 3 stated the stated that Stated the ulcer. Nurse # 3 stated the ulcer.	ge 13 entering the resident 's room. en she entered that Nurse # d to soak the resident 's foot. It she looked at the resident ' en maggots on it. Nurse # 1 s toe was pale-reddish and ut there was no open area or stated she saw only one Nurse # 1 stated she asked d bumped it or someone had nd Nurse # 1 was asked if she sident 's shoes and stated all her attention on the t and had not looked in his ated the resident usually wore rould spend the majority of his rearing the slippers. Nurse # 1 typically would be outside 7 AM and would be outside 7 AM and would be outside she left for the day. Nurse # 1 the surveyor if she had talked t whether the nurses had eet, and Nurse # 1 stated she tent. Nurse # 1 stated she tent. Nurse # 1 stated she the Director of Nursing and out the maggots on Sunday, neets revealed Nurse # 3 was nt # 1 's dayshift hall nurse /5 and 7/12/15. Nurse # 3 7/23/15 at 3:10 PM. Nurse # 3 ay, 7/12/15, the nurse 2) was doing wound care for esidents that day. Nurse # 3 2 came and got her on that to look at Resident # 1 's toe red Nurse # 2 kept saying his ulcer. Nurse # 3 stated that	F	226			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345213	B. WING _	B. WING		C)7/24/2015	
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP COE 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DE	772-72010	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226	and that there was a Nurse # 2 instructed Nurse # 3 stated she order for the resident clinic. Nurse # 3 stated of the resident 's foo nothing more in relative wing his foot and to be seen at the wordescribed the reside he would allow for his they needed to be of the Director of Nursi incident but that the the care that day and of what had transpire. As noted above the physician was interview stated that the reside medical conditions worsen quickly. The Diabetes, Gout, Mild as some examples of he did not see the midentified and therefor the maggots which hound. The DON (Director of were interviewed on stated that she talke and would provide dinto the matter. The that the resident was 7/10/15 and there we on that date. The DO three statements; on	e resident's toes to show her "bug." Nurse # 3 stated her to call the physician and e called and obtained an t to be seen by the wound ed that Nurse # 1 took care of that day and that she did cion to foot care other than calling to get an order for him und clinic. Nurse # 3 nt as "sweet" and stated s feet to be checked when hecked. Nurse # 3 stated that ng had asked her about the supervisor was the one doing d she had limited knowledge ed.	F 2:	26			

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				24/2015	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
				199	95 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERS	AL HEALTH CARE LILI	LINGTON		LIL	LINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC 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 226	1:05 PM, NA # 1 inf 7/23/15 was the first requested to give at about the incident. In ofurther document investigation into the provided other than On 7/23/15 at 5 PM inspection report was noted above the resistent revealed five documented that the "during weekly skinoted above one of this entry on the daton which the podiate resident had a would was questioned registent had a sees and whether she had about the findings of assessments. The latest that the about the findings of assessments. The latest that the while investigating that the while investigating that the while investigating that the white investigating that the what had transpired and 7/13/15 and while investigating that the pool of the would have to look. The DON and admit 7/24/15 at 8:10 AM stated that on Sundant into the building and int	with NA # 1 on 7/23/15 at formed the surveyor that at date she had been statement and questioned During the survey, there was station of a completed e potential negligent care the three statements. I the resident 's skin as reviewed with the DON. As view of this skin inspection different nurses had e resident 's skin was "intact in assessments. Also as the nurses had documented the of 6/12/15; the same date with the DON larding whether she had e about the discrepancy in her sment versus the podiatrist ad talked to the other nurses of their weekly skin DON stated she had not nurses yet who had been resident. The DON was the incident. The DON was the incident. The DON was the maggots were not fully esident when they were	F	2226				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 07/24/2015
	ROVIDER OR SUPPLIER	NGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVAR LILLINGTON, NC 27546		0772-472-013
(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 APPROPRIA DEFICIENCY)	5.475
F 226 F 309 SS=D	and made arrangeme seen at the wound cli administrator and DO resident was sent out clinic and upon his ar had been discharged and DON stated they resident or his family and were not aware t issue had begun on 7 and DON stated they wound physician to g the resident and his c stage the maggots had found. 483.25 PROVIDE CA HIGHEST WELL BEIL Each resident must reprovide the necessary or maintain the higher mental, and psychosol	ents for the resident to be nic the next morning. The N stated that by 7/13/15 the very early to the wound rival back to the facility he home. The Administrator had not talked to the member about the situation hat the resident thought the 1/10/15. The administrator also had not talked to the ather information related to are or tried to identify what ad been in when initially RE/SERVICES FOR NG	F 226		8/21/15
	by: Based on record revifamily interviews for consumpled residents the necessary care of asstreating a Diabetic resimaggots within it. The findings included Review of Resident #	is not met as evidenced ew, and staff, resident, and one (Resident # 1) out of five e facility failed to provide the sessing skin changes and sident 's ulcer found to have : 1's closed record revealed at the facility from his most		Corrective action accomplished for those residents found to have been affected by the alleged deficient practic Resident #1 was discharged home with his wife on 7/13/15. How corrective action will be accomplished for those residents havin potential to be affected by the same alleged deficient practice:	1

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	<u>7. 0936-0391</u>
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			07/	24/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGION		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 APPROPRI DEFICIENCY)		COMPLETION DATE
F 309	Continued From page	e 17	F	309			
		ate of 2/13/15 until 7/13/15			a. Skin assessments of all residents w	as	
		vas discharged home. The			completed by nurses with documentati	_	
	· ·	diagnoses which included			on Skin Assessment Form on 7/24/15.	011	
		o the following: Diabetes			Attending physician and responsible pa	artv	
		; Neuropathy, Congestive			were notified of residents found to have	-	
	Heart Failure, Chroni				any skin breakdown.		
	Disease, Depression,			b. All nurses will be educated on			
	-	resident was also documented as having			completing skin assessments and		
	problems with edema	a and mild venous stasis			documentation. Any nurse not receivin	g	
	changes in his lower	extremities.			education by 8/21/15 will not be allowed	d to	
	Review of the resider	nt 's most recent MDS			work until they have been educated. A	II	
	(Minimum Data Set) a	assessment, dated 7/8/15,			new nurses to the facility will receive		
		's abilities and status were			education during orientation.		
	_	g way: The resident was			c. All nursing assistants will be retrained		
	_	ore of 15 for his BIMS (Brief			by DON/ADON regarding identification		
		Status) indicating he did not			skin issues and timely reporting of any		
		ment at the time of the			skin issues identified while providing ca		
	_	cting staff care during the			to residents. Any nursing assistant who		
		as being independent with			not able to attend the required training		
		s, and locomotion; as			8/21/15 will not be allowed to work unt		
	_	tance with dressing; as			retraining is completed. All new nursing assistants to the facility will receive	9	
		assistance for personal as needing physical help with			education during orientation.		
	part of his bathing.	as needing physical neip with			3. Measures put into place to ensure the	nat	
	Review of interdiscipl	linary notes revealed			the alleged deficient practice will not	iai	
		ated to the resident 's			recur:		
		ecifically on 7/9/15 at 12:07			a. Nurses will complete skin assessme	nts	
		nted that the resident was "			and documentation on all residents		
		3. " On 7/12/15 at 3:25 AM			weekly.		
		nented that the resident " is			b. DON/ADON/Unit Manager will audit		
	alert and oriented to				weekly skin assessments and		
		poor decisions. Able to make			documentation to ensure completion.	Any	
	needs known but mus	st rely on staff to anticipate			nurse that does not complete the	-	
		e. changes of cloths "			assigned assessment and documentate	ion	
	Review of the reside	ent 's nursing notes and			timely will be counseled.		
	interdisciplinary notes	s from the date of 7/7/15			c. Ambassador Rounds will be comple	ted	
	_	hrough 7/13/15 revealed no documentation that			by designated staff including departme	nt	
		ot wound, its condition, or			managers Monday-Friday and		
	that wound care was	being provided to the			manager-on-duty Saturday-Sunday to		

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				OIVID IN	<u>J. 0930-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY PLETED
							С
		345213	B. WING			07/	/24/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LIMINEDO	AL HEALTH CARELILL	NCTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		L	ILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 309	Continued From page	e 18	F	309			
		he resident ' s June and July			identify hygiene or environmental area	s	
		vealed no documentation			that may impact a resident. Any areas		
	that the resident had	a wound of any nature.			identified will be addressed immediate		
		nt 's June and July "skin			with appropriate staff and reported to t	•	
	inspection report " re	evealed that nurses had			Administrator for follow-up with		
		mented that the resident 's skin was " intact			appropriate actions as deemed		
	" on 6/12/15, 6/16/15			necessary.			
	and 7/7/15. These er			4. How the facility plans to evaluate the	Э		
	different nurses. On o			effectiveness of the corrective action:			
		was intact, 6/12/15, the			a. DON/ADON will randomly complete		
		en by a podiatrist. The			skin assessments on 6 residents each		
	podiatrist documente developing ulceration			week to verify the accuracy of the nurs assessment. Any discrepancies noted			
	. •	urrounding the area and			that time will be reviewed with employe		
	-	d. The podiatrist also noted			with appropriate intervention as deeme		
		ol. " Review of the attending			necessary by the DON and physician t		
		s reports revealed that the			be notified for further orders as needed		
		hysician saw the resident on			b. DON/ADON will submit summary of		
	6/19/15 and made no	documentation that the			audits and the Administrator will submi	t	
	resident had a skin w	ound or lesion. Interview			summary of Ambassador Rounds to		
		4/15 at 8:10 AM revealed the			monthly Quality Assurance and		
	1 *	for wound treatment had			Performance Improvement meeting x3	1	
		from the podiatrist or			months then quarterly thereafter.	_	
		y on 6/12/15. The DON			Revisions to this plan will be determine	∌d	
		7/23/15 and obtained the			by the QA Committee.		
	1 *	he protocol revealed that the //12/15 that the resident had					
	·	loping to R # 4 dorsal toe "					
		are nurse should evaluate					
		th the approval from the					
		ne attending physician was					
		15 at 8:45 AM and stated he					
	saw the resident on 6	6/19/15. The physician stated					
		a resident 's socks off and					
		nd would have noted in his					
		f the resident had a toe ulcer					
	which he felt needed						
		podiatrist notation of 6/12/15					
	which noted an ulcer	ation was developing. The					

OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345213	B. WING		C 07/24/2015	
	INGTON		1995 EAST CORNELIUS HARNETT BOULEVAR		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCE)	D BE COMPLETION	
attending physician of venous insufficier resident could have color changes which but that as the attenseen any wound du which needed treatr there was no docum record noting specif resident 's right 4th to have skin change continued to docum no notation about th Review of the reside physician 's telephorarrangements were be seen by a consufoot wound. The resident 's respon 7/23/15 at 11:45 member stated that morning of 7/13/15 supposed to be disc family member state resident that she for the facility. The fam asked to have a sea thereafter the resident was assiste facility, the resident doctor because he is	stated that with the diagnoses ney and Diabetes that the had some erythema and newere noted by the podiatrist, ding physician he had not ring his exam on 6/19/15 ment. Following 6/12/15, mentation in the resident 's ically an assessment of the toe which had been identified as. As noted above the nurses ent "skin intact" but made the 4th toe within the record. The ent of the within the record. The ent of the made for the resident to a send or order, dated 7/12/15, that to be made for the resident to a send or order, who was listed as consible party, was interviewed and by phone. The family she went to the facility on the decause the resident was charged home that day. The end when she arrived to get the and the resident was not at in the lobby and shortly the arrived in the transport mober stated that as the end from the van into the told her that he had been to a mad maggots in his toe. The	F 30	, , , , , , , , , , , , , , , , , , ,		
facility, the resident doctor because he had family member state that he knew his toe had gout and that he of his toe to the gou	told her that he had been to a had maggots in his toe. The ed that the resident told her was swollen but that he also had attributed the swelling t. The family member stated				
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER) Continued From page attending physician of venous insufficier resident could have color changes which but that as the attenseen any wound du which needed treatr there was no docum record noting specif resident's right 4th to have skin change continued to docum no notation about the Review of the resident have were be seen by a consufoot wound. The resident's respon 7/23/15 at 11:45 member stated that morning of 7/13/15 supposed to be disc family member state resident that she for the facility. The fam asked to have a sea thereafter the resident was assisted facility, the resident doctor because he family member stated that he knew his too had gout and that he of his toe to the gout that the resident als	AL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 attending physician stated that with the diagnoses of venous insufficiency and Diabetes that the resident could have had some erythema and color changes which were noted by the podiatrist, but that as the attending physician he had not seen any wound during his exam on 6/19/15 which needed treatment. Following 6/12/15, there was no documentation in the resident 's record noting specifically an assessment of the resident 's right 4th toe which had been identified to have skin changes. As noted above the nurses continued to document "skin intact" but made no notation about the 4th toe within the record. Review of the resident 's record revealed a physician 's telephone order, dated 7/12/15, that arrangements were to be made for the resident to be seen by a consulting physician concerning his	ROVIDER OR SUPPLIER AL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 attending physician stated that with the diagnoses of venous insufficiency and Diabetes that the resident could have had some erythema and color changes which were noted by the podiatrist, but that as the attending physician he had not seen any wound during his exam on 6/19/15 which needed treatment. Following 6/12/15, there was no documentation in the resident 's record noting specifically an assessment of the resident 's right 4th toe which had been identified to have skin changes. As noted above the nurses continued to document "skin intact" but made no notation about the 4th toe within the record. Review of the resident 's record revealed a physician 's telephone order, dated 7/12/15, that arrangements were to be made for the resident to be seen by a consulting physician concerning his foot wound. The resident 's family member, who was listed as the resident 's responsible party, was interviewed on 7/23/15 at 11:45 AM by phone. The family member stated that she went to the facility on the morning of 7/13/15 because the resident was supposed to be discharged home that day. The family member stated when she arrived to get the resident that she found the resident was not at the facility. The family member stated she was asked to have a seat in the lobby and shortly thereafter the resident told her that he had been to a doctor because he had maggots in his toe. The family member stated that the resident told her that he had been to a doctor because he had maggots in his toe. The family member stated that the resident told her that he had been to the gout. The family member stated that the resident told her that he had ben to a doctor because he had maggots in his toe. The family member stated that the resident told her that the maggots	ROVIDER OR SUPPLIER AL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (RECHARDLY OR LSC IDENTIFYING INFORMATION) Continued From page 19 attending physician stated that with the diagnoses of venous insufficiency and Diabetes that the resident could have had some erythema and color changes which were noted by the podiatrist, but that as the attending physician had not seen any wound during his exam on 6/19/15 which needed treatment. Following 6/12/15, there was no documentation in the resident's record noting specifically an assessment of the resident' sight 4th toe which had been identified to have skin changes. As noted above the nurses continued to document "skin intact" but made no notation about the 4th toe within the record. Review of the resident's record revealed a physician's 1s telephone order, dated 7/12/15, that arrangements were to be made for the resident to be seen by a consulting physician concerning his foot wound. The resident's family member, who was listed as the resident's responsible party, was interviewed on 7/23/15 at 11-45 AM by phone. The family member stated when she arrived to get the resident that she found the resident was supposed to be discharged home that day. The family member stated when she arrived to get the resident that she found the resident was supposed to be discharged home that day. The family member stated when she arrived to get the resident was assisted from the van into the facility, the resident arrived in the transport van. The family member stated that as the esident tool her that he had been to a doctor because he had maggots in his toe. The family member stated that the resident told her that he had been to a doctor because he had maggots in his toe. The family member stated that the resident told her that the nesident told her that the nesident told her that the maggots	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345213	B. WING		07/24/2015
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEY. 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
F 309	things climbed out of cared for him. The fa after the resident told went to the resident told went to the resident? # 1. The family mem # 1 how the resident condition it was foun the nurse that the resway in a twenty four The resident was into 7/23/15 directly follow family member. The thought it was Friday corresponded to 7/10 hurting. He stated he on to go outside and at his toes before he stated he knew his to that he couldn't sees tated he thought go and pain. The reside checked his toe that that the NA left the restated that a nurse, whom he could not is dressed his toe. The thought this same nuand then changed it stated he went to the 7/13/15, and it was fewere crawling in his shoe off at the wound Interviews were condicility staff at the fol Aide) # 1 was interviently w	and that a "whole bunch of his toe " when the NA had mily member stated that ther about the issue, she is soom to collect his she stopped to talk to Nurse aber stated she asked Nurse is foot got to be in the did that day, and was told by sident is foot could get that hour period. The erviewed also via phone on wing the interview with the resident stated that he is, which would have but how a should be was about to put his shoes his NA (nurse aide) looked put them on. The resident be was swollen and hurt but the it that well. The resident but was causing the swelling and stated that when his NA things crawled out of it and born screaming. The resident whom he could describe but dentify by name, came and resident stated that he are checked on it Saturday Sunday. The resident then a wound clinic on Monday, bound that a lot of black things shoe when they took the diclinic. Bucted with the following lowing times: NA (Nurse ewed on 7/23/15 at 1:05 PM; iewed on 7/24/15 at 12 noon;	F 30	9	
		iewed on 7/24/15 at 12 110011,			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345213	B. WING		07/24/2015		
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION		
F 309	PM. According to stimembers roles were resident 's dayshift 7/12/15; Nurse # 2 v and was doing wour managed the unit or and Nurse # 3 was t assigned to care for 7/12/15. Information follows: The interview with N 7/12/15 the resident and had requested t that before she obtaresident 's permissic could better inform to bserved greenish of and 4th toes and states with a cleansing lot of maggots crawl resident 's toes whe and she got sick to bresident, and left the which the NA later p NA wrote, "a pile of she cleaned betwee # 1 stated she imme and Nurse # 2. The # 2 revealed their as because the NA report During the interview stated that she also bugs "on the reside washed and dried the saw no further evide or his bed. Nurse # resident 's toe appear.	pe 21 Interviewed on 7/23/15 at 3:10 Interviewed on 7/11/15 and Interviewe aide on 7/11/15 and Invas the dayshift supervisor Ind care on 7/12/15; Nurse # 1 In which the resident resided; Interviewe is as In which the resident resided; Interviewe is as In a writer of the pain In a see a nurse. NA # 1 stated Interviewe is as In a writer of the pain In the resident on the pain In a writer of the pain In a writer of the pain In a written statement In a written statement In a written statement In a written statement In the resident 's last toes. NA Interviews with Nurse # 1 Interviews with Nurse # 2, the nurse Interviews with Nurse # 3 Interviews	F 309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345213	B. WING				24/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	2-1/2010	
					995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILL	INGTON			ILLINGTON, NC 27546			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 309	Continued From pag	ge 22	F	309				
	to call the physician.	. Nurse # 2 stated there was						
		resident 's feet while she						
	provided care and th	nat she had thrown the towel						
	away in a sealed tra	sh bag within the dirty utility						
	room and had place	d the dead bugs within it.						
		e did not know if the resident '						
		nanged. Nurse # 2 also stated						
		esident if he had noticed						
	anything wrong with							
	look in the resident 's shoes. Nurse # 1 stated Nurse # 2 had already started soaking the							
	resident's feet when she entered the room and							
	she did not see mag							
	_	stated she did not see an						
		described the resident 's toe						
		flakey. Nurse # 1 stated she						
		n on the resident 's feet and						
	did not look in his sh	noes. Nurse # 1 stated the						
	resident routinely wo	ore fuzzy slippers and sat						
		on of the day. Nurse # 3						
		ed into the room on 7/12/15						
	-	resident 's toes because						
		upervisor and was the nurse						
		If the care. Nurse # 3 stated						
	l	ad the resident 's toes on						
		that the resident had bugs in he physician. Nurse # 3						
		g when the resident 's toes						
		e called the physician and						
		or the resident to be seen at						
		next day. Nurse # 3 stated						
		all the treatment to the				ĺ		
	resident on 7/12/15							
	knowledge about wh	nat treatment was done for						
	the resident and the	refore thought Nurse # 2						
	would document the	care and services provided.						
	Review of the reside	ent 's 7/13/15 wound consult						
		nt 's 3rd toe was necrotic				ĺ		
	when it was assesse	ed the following day by the						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 07/24/2015	
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOUL LILLINGTON, NC 27546	•	0172-42010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	the ulcer. The wound documented, "This diabetic patient with aspect of third right found in his shoes a ulcer." The consult documented that the tunneling of the ulcer. The wound physicia on 7/24/15 at 10:15 stated that on 7/13/maggots on the resi his clothes and his scouple from his ulcer maggots were big. In not an expert on ma observation they ap stage of developme stated that he would four days old. The would four days old. The would four days old. The word that date to further wound that date to further would four days old. The word that date to further would four days old. The word that date to further would four days old. The word that date to further would four days old. The word that date to further wor	d there was a maggot still in d consulting physician is an insulin dependent some necrosis at the dorsal toe. Multiple maggots were nd another one inside the toe ing physician further ere was "moderate" and that the maggots had in was interviewed by phone AM. The wound physician 15 he had found multiple dent. He stated they were in shoe. He stated he removed a rr. The physician stated the The physician stated he was ggots but from his peared advanced in their nt. The wound physician estimate them to be three or round physician stated that no or expert opinion gathered on rerify the stage of the	F 30	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345213	B. WING		07/24/2015		
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE LILLINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARE LILLINGTON, NC 27546	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 309 F 514 SS=D	her expectation that I changed when the mathematical that everything had be not aware why that had been done. 483.75(I)(1) RES	revealed it would have been inens would have been aggots were identified and een washed, but she was ad not transpired or what	F 30		8/21/15		
	resident in accordance standards and practice accurately documents systematically organic. The clinical record mainformation to identify resident's assessment services provided; the	ust contain sufficient the resident; a record of the ats; the plan of care and					
	by: Based on record rev facility failed to assur complete and accurat five sampled resident Review of the facility revealed it directed th " redness, induration, The wound care polic should " chart finding decline vs stability/im Review of Resident #	is not met as evidenced iew and staff interviews the e medical records were te for one (Resident # 1) of s. The findings included: 's policy on wound care nat staff were to observe for and purulent drainage " by also noted that the nurses as for comparison, indicate provement in wound. " 1 's closed record revealed at the facility from his most		Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Resident #1 was discharged home whis wife on 7/13/15. How corrective action will be accomplished for those residents have potential to be affected by the same alleged deficient practice: Audit of medical records by DON/ADON/Unit Manager of all resididentified with wounds completed by	tice: ith ving		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'	IDENTIFICATION NUMBER.		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		A. BOILDI	NG _			2	
	345213	B. WING			l	24/2015	
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSAL HEALTH CARE LILLING	TON	1995 EAST CORNELIUS HARNETT BOULEVARD					
UNIVERSAL HEALTH CARE LILLING	ION		L	ILLINGTON, NC 27546			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
prior to the date of 7/12/physician 's telephone of directed the staff to make resident to be seen by a regarding his foot wound. Review of the 7/13/15 wherevealed the consulting physician document in the second insuling physician for the second insuling physician further document in the second in the second in the second in the second interviews were conduct at the following times: Not interviewed on 7/23/15 and interviewed on 7/24/15 and interviewed on 7/24/15 and interviewed on 7/24/15 and interviewed on 7/23 interviewed with NA # 1 reviewed in the second interviewed in 7/23 interviewed in NA # 1 reviewed in Table 19/13/15/16/16/16/16/16/16/16/16/16/16/16/16/16/	e of 2/13/15 until 7/13/15 c discharged home. The agnoses which included the following: Diabetes deuropathy, Congestive dirway Obstructive and Lung Cancer. The mented as having and mild venous stasis tremities. Is June and July 2015 cords revealed no resident had any skin was receiving treatment and the acrangements for the ulcer. The wound cumented, "This is an acrangement and that the he ulcer." The consulting the ulcer and that the he ulcer and that the he ulcer. The was at 1:05 PM; Nurse # 2 was at 1:05 PM; Nurse # 2 was at 12 noon; Nurse # 1 was at 9:50 AM; and Nurse # 3	F	514	8/14/15 to ensure accurate documentation, complete and up-to-darcare plans, nursing assistant care guide treatment sheets and shower sheets. 3. Measures put into place to ensure the alleged deficient practice will not recur: a. All nurses to be educated on medicarecord documentation including timeliness, accuracy and expectations DON/ADON. Any nurse not educated be 8/21/15 will not be allowed to work untithey have been educated. b. Any nurse not documenting accurate in the medical record will be counseled c. Nurses to enter all newly identified wounds into the Wound Communication Book to be reviewed by DON/ADON/Unit Manager Monday-Friday. d. Accuracy of documentation will be reviewed in the weekly Wound Meeting by DON/ADON/Unit Manager. e. All new and readmission charts to be reviewed in clinical meeting Monday-Friday for accuracy of wound documentation. f. Licensed nurse completing weekly wound rounds with wound care physicial. How the facility plans to evaluate the effectiveness of the corrective action: a. DON/ADON/Unit Manager to audit 5 charts daily Monday-Friday for 2 weeks 10 charts weekly for 2 weeks, then 5 charts weekly thereafter for accurate medical record documentation. b. DON/ADON/Unit manager will subm summary of audits to monthly Quality Assurance and Performance Improvement meeting x3 months then	es, at by y l ely n nit s e		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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345213	B. WING _		07/24/2	2015	
		STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
		1995 EAST CORNELIUS HARNETT B	OULEVARD		
LINGTON		LILLINGTON, NC 27546			
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) OMPLETION DATE	
drainage around his toes. NA	F 5	quarterly thereafter. Revisio			
ne interview that a lot of out from between his toes when in them. NA # 1 stated she had oth Nurse # 1 and Nurse # 2. In Nurse # 1 and # 2 revealed in been obtained because the aggots to them. During the se # 2, the nurse acknowledged " dead bugs " on the resident ' had washed and dried the dishe saw no further evidence afferent descriptions of the regiven by the nurses during se # 2 described the resident on his third toe which was en during the interview. Nurse resident as having a toe which and flakey but she stated she in area. Nurse # 3 stated that nursing supervisor for the date of thought Nurse # 2 had at the resident 's toes and the state of the state of the foot wound, its condition, or as being provided to the fifthe resident had a wound of word the nursing notes and the resident had a wound of word the nursing notes and the resident had a wound of word the nursing notes and the resident had a wound of word the nursing notes and the resident had a wound of word the nursing notes and the revealed no documentation and a problem with maggots		will be determined by the Q	A Committee.		
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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		- 1	C 07/24/2015		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		72-7/2010	
				1995 EAST CORNELIUS HARNETT BOULEVA	RD		
UNIVERSAL HEALTH CARE LILLINGTON				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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE		