	-	ID HUMAN SERVICES			FORI	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	-		OMB NO	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	COM	E SURVEY PLETED
		345213	B. WING			C / 16/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOULEVARD		
ONIVERO				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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	i	F 00			
		vas conducted 11/13/17 Imediate Jeopardy was				
	(J) CFR 483.12 at tag F (J)	223 at a scope and severity 225 at a scope and severity 226 at a scope and severity				
	The tags F223, F225 Substandard Quality	of Care.				
	resident #1 and was i extended survey was The state of deficience					
F 157 SS=E	NOTIFY OF CHANG	ROOM, ETC)	F 15	7		12/28/17
	(g)(14) Notification of	Changes.				
	consult with the resid	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-				
		ving the resident which as the potential for requiring n;				
	(B) A significant chan mental, or psychosoc	ge in the resident's physical, ial status (that is, a				
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE 12/11/2017

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	deterioration in health status in either life-thr clinical complications (C) A need to alter trea a need to discontinue treatment due to adve commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provious physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the This REQUIREMENT by: Based on record revi physician interviews, physician when insuli	a, mental, or psychosocial reatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment I0(e)(6); or ent rights under Federal or ns as specified in paragraph eccord and periodically mailing and email) and resident representative(s). is not met as evidenced ew, staff, resident and the facility failed to notify the	F	157	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this pla correction does not constitute an	n of	

Facility ID: 943230

If continuation sheet Page 2 of 99

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	· · /		COMPLETED			
					с			
		345213	B. WING		11/16/2017			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BOULEVARD				
UNIVERS				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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLET			
F 157	Continued From page	e 2	F 15	7				
	reviewed (Residents			admission or agreement by the p	provider of			
		. ,		the truth of the facts alleged or th				
	Findings included:			correctness of the conclusions se				
				on the statement of deficiencies.	-			
		realed Resident #1 was		of correction is prepared and sub				
	admitted to the facility			solely because of requirement un and federal law, and to demonstr				
	and Coronary Artery	uded Diabetes, Hypertension		good faith attempts by the provid				
		1's signed physician orders		improve the quality of life of each				
		iated and dated 5/13/2017						
	for 12 units of insulin	to be administered		F157E				
		cted between the skin and		ROOT CAUSE				
		at 8:30 AM and 4:30 PM.		This alleged noncompliance was				
		ued monthly and signed by		from the Center's Licensed staff				
	the physician.	um Data Set (MDS) dated		signing medication on the electro				
		Resident #1 was cognitively		health records immediately after medication is administered, and				
		nited assistance of 1 person		facility lack of awareness of requ				
		aily living (ADLs). The MDS		related to notification to Physicia				
		t received insulin injections		medication administered out of ti	me frame			
	daily.			as specified in the center s medi				
	Review of Resident #			administration Policy and Procee	lures.			
		ne resident was at risk for		IMMEDIATE ACTION	4 7			
		lycemia (low blood sugar ar levels). The interventions		On 12/08/2017 Resident #1, #6, attending physician(s) were notif				
		nedications and insulin to be		incidents of late administered ins				
	administered as orde			that happen in the last 30 day by				
	Record review of the	Medication Administration		Assistant Director of Nursing. No				
	Record (MAR) for Re	sident #1 from 10/19/2017		orders received from this notifica				
	through 11/14/2017 r	evealed 11 documented late		IDENTIFICATION OF OTHERS				
		for the resident's 8:30 AM		100% audit of all current residen				
	insulin dose and 7 do			insulin orders completed on 12/0				
		for the 4:30 PM insulin dose.		by Director of Nursing, and/or As				
		e window of administration		Director of Nursing to identify any resident with the documented tim				
	opportunity.			administration beyond the 60 min				
		dication administration		window in the last 30 days, and				
		ducted with Resident #1 on		whether Physician was notified o				
	11/15/2017 at 8:55 Al	M. The resident was		The audit revealed 29 other resid				

Facility ID: 943230

If continuation sheet Page 3 of 99

		MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SU COMPLE		
			A. BUILDING	<u> </u>			
		345213	B. WING		C	20047	
	ROVIDER OR SUPPLIER	040210		STREET ADDRESS, CITY, STATE, ZI		5/2017	
	KOWDER OR SOLT EIER			1995 EAST CORNELIUS HARNET			
UNIVERS	AL HEALTH CARE LILLIN	NGTON		LILLINGTON, NC 27546	I DOULLVARD		
0(0)15				PROVIDER'S PLAN		(2/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 157	Continued From page	23	F 15	57			
		bed. Nurse #5 prepared		identified with insulin ord	lers with		
		resident's insulin. Nurse #5		documented times of ad			
	exited the room after	the medication was		beyond 60 minutes, atte	nding physician		
	administered. During			for each resident notified			
		d her insulin was to be		by the Director of Nursin	•		
		AM and 4:30 PM. She		received from this notific	ation.		
	reported there were ti			SYSTEMIC CHANGES			
	administration was lat			Effective 12/28/2017, an	-		
	-	e nurses had an hour past		all insulin orders will be a within 60 minutes of adn			
		administer it before they e resident indicated there		opportunity window. Lice			
		reral hours late. The resident		document the administra			
	reported her 4:30 PM			afterward in resident's re	•		
	-	8:30 PM by Nurse #2 the		that insulin administratio			
		terview. The resident stated		outside the 60 minutes v	vindow of		
	she felt fine and was	aware when she had issues		administration opportuni	ty, resident		
	-	, but felt the insulin should		attending Physician will			
	be administered as or			immediately. The notifica			
		ducted with Nurse #5 on		documented in resident's			
	11/15/2017 at 9:17 Al			Effective 12/28/2017, an	-		
		her regular assignment and		If a Licensed nurse delay			
	-	with her care. Nurse #5 imes she administered the		in Electronic Medication Record (eMAR) immedia			
	-	ulin late but tried to be very		administration of insulin	-		
	-	. Nurse #5 indicated most		60 minutes of administra			
		nistered within the hour of		window, the Licensed nu			
	•	were mornings she just		document administration			
		e to other situations. Nurse #		immediately after is able			
	-	otify the physician when the		nurses notes indicating t	he accurate time		
	insulin was administe			of administration that wil	•		
		ducted with Nurse #2 on		stamped time on eMARs			
		AM. Nurse #2 confirmed he		physician will not be noti			
		orked with Resident #1 on		administration took place			
		2 indicated the resident's administered at around 8:30		minutes window of admi	nisuation		
	PM. The nurse stated			opportunity. Effective 12/28/2017, th			
		dministration. Nurse #2		administrative team, whi	-		
		administered the insulin late		Director of Nursing, Assi			
	because he was busy			Nursing, and/or Staff De			

Facility ID: 943230

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT		CONSTRUCTION	(X3) DATE	D. 0938-03 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· /	PLETED	
			_			с		
		345213	B. WING			11/	16/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	E		
		NCTON		1995 EAST CORNELIUS HARNETT BOULEVARD				
UNIVERS	AL HEALTH CARE LILLI	NGTON		LIL	LINGTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 157	Continued From page	e 4	F 1	57				
-		se # 2 indicated there were		01	Coordinator will initiate a process for			
		to get the resident's insulin			reviewing clinical documentation for th	ne		
		ious reasons. Nurse #2			last 24 hours, 24 hour report sheets,			
		document the reason when it			incident reports for the last 24 hours a	ind		
		e and he did not notify the			Physician orders written in the last 24			
		further indicated if the			hours to ensure any needed notification	on of		
		gns or symptoms of blood			changes to the physician, and/or			
		ld notify the physician.			responsible party was done in a timely			
	physician on 11/16/2	nducted with Resident #1's			manner. This systemic process will tal			
		e was very familiar with			place daily (Monday through Friday). / identified issues will be addressed	Ally		
	Resident #1 and her			promptly and appropriate actions will I	be			
		ed he reviewed her blood			implemented by the DHS, ADHS, SD0			
		n he made his facility visits			and/or Unit coordinators. This process			
	to ensure there were	no concerns or issues with			be incorporated in a daily clinical roun	ds.		
	her diabetic manager				Any negative findings will be document			
		aware of any scheduled			on the daily clinical checklist form an			
		ate. The physician stated			maintained in the daily clinical meeting	9		
	there was an hour of				binder.			
		e expected the insulin to be			Effective 12/28/2017, week end			
		e. The physician indicated the difference of the difference of the well-being of the difference of the			Registered Nurse supervisor and/or designated licensed nurse will review			
		ected to be notified if the			clinical documentation for the last 24			
		ered beyond the hour of			hours, 24 hour report sheets, incident			
	opportunity.	, .			reports for the last 24 hours and Phys			
		nducted with the Director of			orders written in the last 24 hours to			
		/16/2017 at 3:32 PM. The			ensure any needed notification of cha	-		
		xpectation was the physician			to the physician, and/or responsible pa	arty		
		ed insulin was administered			was done in a timely manner. This			
	late.				systemic process will take place every			
	2 Record review rev	vealed Resident #6 was			Saturday & Sunday. Any identified iss will be addressed promptly and	ues		
	admitted to the facilit				appropriate actions will be implemented	ed		
		uded Diabetes, Hypertension			by the DHS, ADHS, SDC and/or			
	-	alysis on one side of the			Registered Nurse supervisor. This			
	body).				process will be incorporated in daily			
		#6's signed physician orders			clinical rounds. Any negative findings			
		November 2017 revealed			be documented on the daily checklist			
	an order for 15 units				form and maintained in the daily clinic			

Event ID: 5GBQ11

Facility ID: 943230

If continuation sheet Page 5 of 99

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		B	· · ·	PLETED
					С	
		345213	B. WING		11/	16/2017
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BOUL	EVARD	
UNIVERS		NGTON		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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 157	Continued From page	e 5	F 15	57		
		cted between the skin and		meeting binder.		
		at 9:00 AM and 5:00 PM.		Director of Nursing (DHS), Ass	stant	
		6's Annual Minimum Data		Director of Nursing (ADHS) and		
	Set (MDS) dated 9/25	5/2017 revealed the resident		Development Coordinator (SDC		
		itively impaired and required		complete 100% education for a	Il licensed	
	the extensive assista	nce of 2 persons for all		nurses and Medication aides, to	o include	
	activities of daily living			full time, part time and as need		
		t received insulin injections		The emphasis of this education		
	daily.			the importance of notifying Phy		
		6's care plan updated		timely manner for any medication		
		the resident was at risk for		specifically insulin administered		
		gars related to Diabetes.		the 60 minute window of opport	•	
	The interventions for	lin to be administered as		the documentation requirement when the insulin is administered		
	ordered.	in to be administered as		60 minutes window. This educa		
		Medication Administration		completed by 12/28/2017. Any		
		sident #6 from 10/19/2017		Nurse or Medication Aide not e		
		evealed 7 documented late		12/28/2017 will not be allowed	•	
	U U	for the resident's 9:00 AM		until educated. This education		
	insulin dose and 7 do			added on new hires orientation	process	
	administration times f	for the 5:00 PM insulin dose.		for all new licensed nurses and	-	
	The documented time	es for administration were		Medication Aides effective 12/2	8/2017.	
	beyond the 60 minute	e window of administration		MONITORING PROCESS:		
	opportunity.			Effective 12/28/2017, Director of		
		ducted with Nurse #6 on		Assistant Director of Nursing, a		
		AM. Nurse #6 indicated she		Development Coordinator, will		
		t #6 regularly. Nurse #6		compliance with notification of o	•	
		would wheel around the		Physician by conducting clinica		
		nair and the insulin is given		daily (M-F), review the daily clir		
		nt not being available at the scheduled to be given. The		meeting checklist to ensure cor and proper follow through, and		
	nurse indicated there			review all insulin administered i		
		of the hour window of		24 hours and/or from the previo		
		ster medications. The nurse		meeting to ensure that proper		
		cument the reason the		documentation are in place to i	nclude	
		and did not notify the		notification to resident's physici		
	physician.			issues identified during this mo		
		ducted with Resident #6's		process will be addressed pron	-	
	physician on 11/16/20			Findings from this meeting will		1

Facility ID: 943230

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY	
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
	0.15040			С	
	345213			11/16/201	
ROVIDER OR SUPPLIER				(4.5.5	
AL HEALTH CARE LILLIN	NGTON			IARD	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		OULD BE COMPL	
Continued From page	<u> </u>	F 15	7		
physician reported here Resident #6 and his rephysician also reporter resident's blood sugathis facility visits to ensorre or issues with diabetic physician indicated here was an here administration and here administration and here administered on times insulin was scheduled resident and he experimentiation is a scheduled resident and here was an here insulin was administer opportunity. An interview was con Nursing (DON) on 112 DON indicated the experimentiation is a scheduled late. 3. Record review reveating admitted to the facility diagnoses which inclus Review of Resident # for November 2017 re of insulin to be adminin (injected between the day at 9:00 AM and 9 Review of Resident # Data Set (MDS) dated resident was severely required the extensive persons for all activities	e was very familiar with medication regimen. The ed he reviewed the rs and labs when he made sure there were no concerns c management. The e was unaware of any ses given late. The physician nour of opportunity for the e expected the insulin to be . The physician indicated the d for the well-being of the cted to be notified if the red beyond the hour of ducted with the Director of /16/2017 at 3:32 PM. The spectation was the physician ed insulin was administered ealed Resident #7 was y on 11/2/2017 with uded Diabetes and Gout. 7's signed physician orders evealed an order for 10 units istered subcutaneously e skin and muscle) twice a 0:00 PM. 7's Admission Minimum d 11/9/2017 revealed the y cognitively impaired and e assistance of 1 to 2 es of daily living (ADLs). The	F 15	 documented on a daily clinical reand filed in a clinical meeting bind Director of Nursing office. Director Nursing and/or Assistant Director Nursing will review the completion clinical report, and daily clinical of forms daily Monday to Friday for weeks, weekly for two more weet monthly for three months or until of compliance is maintained. Effective 12/28/2017, Director of will report findings of this monitor process to the facility Quality Assistant Performance Improvement Committee for any additional mo or modification of this plan month three months, or until a pattern o compliance is maintained. The Q committee can modify this plan to the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 12/28/2017, the center Director and the Director of Nursibe ultimately responsible to ensuring plementation of this plan of compliance to the facility remains plan of compliance to the facility responsible to ensuring plementation of this plan of compliance to the facility remains the plan of compliance to the facility responsible to ensuring plementation of this plan of compliance to the facility remains plan of compliance to the planet of this plane	der in the pr of of n of daily hecklist two ks, then a pattern Nursing ing surance nitoring hy for f API p ensure Executive ing will re rection	
	AL HEALTH CARE LILLI SUMMARY ST (EACH DEFICIENC REGULATORY OR I SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page physician reported he Resident #6 and his r physician also reporte resident's blood suga his facility visits to en or issues with diabeti physician indicated he scheduled insulin dos stated there was an h administration and he administered on time insulin was scheduled resident and he expe insulin was administe opportunity. An interview was con Nursing (DON) on 11 DON indicated the expe insulin dis scheduled resident and he expe insulin was administe opportunity. An interview was con Nursing (DON) on 11 DON indicated the expe insulin to be admin late. 3. Record review reve admitted to the facility diagnoses which inclu Review of Resident # for November 2017 re of insulin to be admin (injected between the day at 9:00 AM and 9 Review of Resident # Data Set (MDS) date resident was severely required the extensiv persons for all activiti MDS indicated the re	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345213 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 6 physician reported he was very familiar with Resident #6 and his medication regimen. The physician also reported he reviewed the resident's blood sugars and labs when he made his facility visits to ensure there were no concerns or issues with diabetic management. The physician indicated he was unaware of any scheduled insulin doses given late. The physician stated there was an hour of opportunity for the administration and he expected the insulin to be administration and he expected the insulin to be administered on time. The physician indicated the insulin was scheduled for the well-being of the resident and he expected to be notified if the insulin was administered beyond the hour of opportunity. An interview was conducted with the Director of Nursing (DON) on 11/16/2017 at 3:32 PM. The DON indicated the expectation was the physician be notified if scheduled insulin was administered	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI CORRECTION IDENTIFICATION NUMBER: A. BUILDING AL B. WING	PFDEFICIENCIES (X1) PROVIDERSUPPLIER/LIA (X2) MULTIPLE CONSTRUCTION AL HEALTH CARE LILLINGTON 345213 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES D PROVIDERS OR NUMPLY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WOR LSC IDENTIFYING INFORMATION) D FROVIDERS OT NUMPLY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WOR LSC IDENTIFYING INFORMATION) D FROVIDERS OT NUMPLY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION NUMPLER D FROVIDERS OT NUMPLY OR LSC IDENTIFYING INFORMATION) Continued From page 6 F 157 Continued From page 6 F 157 documented on a daily clinical regort, and daily clinical regort and daily clinical reg	

If continuation sheet Page 7 of 99

	S FOR MEDICARE &					IO. 0938-039			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED			
	oonneonon		A. BUILDING	i					
		245042	B. WING			С			
		345213	B. WING			1/16/2017			
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD					
	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOULEVARD					
				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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE			
F 157	Continued From page	o 7	F 15	7					
1 107			FID	1					
	The interventions for								
	ordered.	ilin to be administered as							
		Medication Administration							
		esident #7 from 11/9/2017							
	· · ·	evealed 7 documented late							
	•	for the resident's 9:00 AM							
	insulin dose and 4 do								
		for the 9:00 PM insulin dose.							
		es for administration were							
		e window of administration							
	opportunity.								
		ducted with Nurse #6 on							
		AM. Nurse #6 indicated she							
		t #7 regularly. The nurse							
	indicated there were								
	administered outside	of the hour window of							
	opportunity to admini	ster medications. The nurse							
		she was busy and could not							
	get to everything on t	time. The nurse stated she							
	did not document the	reason the insulin was							
	given late and she di	d not notify the physician.							
		ducted with Resident #7's							
	physician on 11/16/2								
		e was very familiar with							
		medication regimen. The							
	physician also report								
		ars and labs when he made							
	-	sure there were no concerns							
	or issues with diabeti								
		e was unaware of any							
		ses given late. The physician							
		nour of opportunity for the							
		e expected the insulin to be							
		. The physician indicated the							
		d for the well-being of the							
	resident and expecte	d to be notified if the insulin							
1		yond the hour of opportunity.							

Facility ID: 943230

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		ND HUMAN SERVICES			PRINTED: 01/02/201 FORM APPROVE
TATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345213	B. WING		C 11/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•
	AL HEALTH CARE LILLI	NGTON	1995 EAST CORNELIUS HARNETT		TT BOULEVARD
UNIVERSI	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 157	Continued From page	e 8	F	157	
	Nursing (DON) on 11 DON indicated the ex	/16/2017 at 3:32 PM. The spectation was the physician ed insulin was administered			
F 223 SS=J	FREE FROM ABUSE SECLUSION CFR(s): 483.12(a)(1)		F	223	12/28/17
	and exploitation as d includes but is not lin corporal punishment,	, involuntary seclusion and nical restraint not required to			
	abuse, corporal punis seclusion;	r must- , mental, sexual, or physical shment, or involuntary Γ is not met as evidenced			
	Based on observation interviews and record protect residents from abuse resulting in a b	on, resident interview, staff d review the facility failed to n staff to resident physical pruise to the resident's arm sidents (Resident #1).		F223 ROOT CAUSE This alleged noncomplia the Center s former Dire misinterpretation of regu	ector of Nursing #1
	Resident #1 by the w on the shower seat ir resulting in a bruise t removed on 11/16/20	rse Aide (NA) #1 grabbed rrists and sat her down hard n the resident's bathroom, o her right wrist. The IJ was 017 when the facility's allegation was verified. The		requirements related to residents during allegati or neglect investigation, of how to conduct the de of allegation of abuse of former DON stated the understood is that she c	protection of ion of abuse and misunderstanding etail investigation r neglect. The way she

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY	
ND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED	
		345213	B. WING		C 11/16/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOULEVA LILLINGTON, NC 27546	RD	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE	
F 223	Continued From page	e 9	F 22	23		
	 F 223 Continued From page 9 potential for more than minimal harm that IJ) to allow the facility to monitor and impl its plan of correction for abuse. Findings included: Resident #1 was admitted to the facility o 5/12/2017 with diagnoses to include diabo hypertension, and contracture of left hance Review of a quarterly Minimum Data Set assessment for Resident #1, dated 9/22/2 revealed the resident had intact cognition required extensive assistance with toiletir dressing, personal hygiene and bathing. not steady, but able to transfer herself wit assistance between bed and wheelchair. weight was 115 pounds. 			saw the bruise, she assumed that resulted from uses of blood thinne Because of the medication resider taking she did not consider the bru be potentially caused by an allege perpetrator (Nurse Aide #1). Resid however alleged that Nurse Aide # grabbed her while in the bathroom caused a bruise on her arm 10/26 The DON stated, she felt she prote the resident as she removed the a perpetrator from the hall where res #1 resided during the investigation This is contrary to center s abuse Prohibition process which requires alleged perpetrator to be suspende pending investigation. IMMEDIATE ACTION TAKEN	rs. it is ise to d ent #1 1 and /2017. ected lleged sident period. for the	
	11:05 AM with Reside her body was sick bu stated a couple of we of the date, she had a soiled herself at abou in her wheelchair and bathroom, and turned for someone to come indicated a NA, who I and was not her nigh and turned off the cal someone didn't come put her call light back what time it was from her night stand that fa Resident #1 stated sh and was very still bec any mess on the floor and the bathroom sm	ent #1. Resident #1 stated it her mind was not. She eeks ago, she was not sure a bowel movement (BM) and ut 6:00 AM. The resident got d took herself to the d on the bathroom call light e and help clean her up. She had curly hair and was stout, t NA, came in about 6:15 AM Il light and told her if e to help her after a while, to c on. The resident could see a the big numbered clock on		On 11/14/2017 at approximately 9: Director of Rehabilitation at the ce followed by the facility Director of S services interviewed resident #1. Resident #1 voiced that on 10/26/2 approximately between 6:00 AM a AM, she had an episode of loose s she wheeled herself to the bathroot turn the bathroom call bell on. Nur- Aide #2 responded to the call bell the resident she will notify her assi Nurse Aide (Nurse Aide #1), and if assigned aide is not back to care f she asked resident #1 to turn the back on (no time lapse specified). morning of 10/26/2017, during initi round, noted resident #1 to be soil Nurse Aide #3 communicated to N Aide #1 about resident#1 being so asked for Nurse Aide #1 to clean t	nter Social 2017 and 7:00 stool, om and sing and told gned the or her, light On the al ed. urse iled and	

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	COMPLETED	
			A. BOILDING		с	
		345213	B. WING		11/16/20	017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		NGTON		1995 EAST CORNELIUS HARNETT BOUL	EVARD	
UNIVERS	AL HEALTH CARE LILLI	NGION		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CON	(X5) MPLETIC DATE
F 223	Continued From page	e 10	F 22	23		
		the bathroom and said how	1 22	resident#1 before leaving on 10	0/26/2017	
		sitting here waiting, and the		Nurse Aide #1 provided care to		
		an hour." NA #3 told her she		Resident#1 and gave her a sho		
		#1. NA #1 came in and was		10/26/2017.		
		ying that the other NA				
		her up. The Resident stated		Resident #1 added that Nurse		
	-	#1 grabbed her by the arm		pushed her and grabbed her or		
		to sit here," moved her over		which caused a bruise. Reside	-	
		y hard on the shower seat,		added that she reported this all	-	
		er hard. Resident #1 said cared and she knew the NA		Nurse Aide #3 on 10/26/17, Nu on 10/30/2017, and Director of		
		ent #1 said she finally said to		on 10/30/2017. Interview with N	•	
		ive to treat me like a dog."		#4 by the Center Executive Dir		
	-	s over the Resident asked		conducted on 10/31/2017 revea		
		nd the NA wouldn't tell her,		reported the Allegation made b		
	and never apolized to	o her. Resident #1 stated		#1 to the Center Human Resou	-	
	she gave me a bruise	e right here, and pointed to		Director on 10/30/2017. Intervie	ew with	
		and indicated the bruise was		Nurse Aide #3, and Nurse Aide	# 4 did not	
		er fingers. The bruise was		report this allegation to their dir	rect	
	not visible on this dat			supervisor and the center s Exe		
		uise had gone away by now.		Director per facility Abuse Proh		
		oom after NA #1 had left and		policies and procedures revised		
		IA #3 what the name of NA		2017. Director of Human Resc		
	#1 was, but NA #3 sa	ald she didn't know.		reported the Allegation to Direc		
	Becard review reveal	led the facility filed a 24 Hour		Nursing #1 on 10/30/2017 and		
		led the facility filed a 24-Hour tate Agency on 10/31/2017		executive Director via written s on 10/30/2017 that was read by		
		id neglect. The alleged		Center Executive Director on 1		
		sident stated that Aide		On 10/31/2017 and 11/3/2017,		
		throom." This report was		hour report and a 5 day report		
	signed by the Directo			to the Department of Health an		
		-		Services respectively, related to		
		aled the facility filed a		#1 s allegation of abuse made		
		rt to the State Agency on		10/26/2017. These reports we		
		t abuse and neglect. The		completed and submitted by th		
		as: "Resident stated that		Director of Nursing #1. Five da		
	-	e bathroom and was rough		completed on 11/3/2017 indica		
		er wrist. Education teaching		investigation that was not detai		
	I given and aide was re	emoved from Hall. (The NA	1	enough. On 11/15/2017 anothe	er 5 dav	

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		MEDICAID SERVICES				OMB NC	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDING	G			
		345213	B. WING			C	
		345213	B. WING	0.7		11/	16/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLI	NGTON			95 EAST CORNELIUS HARNETT BOULEVARD		
					LLINGTON, NC 27546		1
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 223	Continued From page	e 11	F 22	23			
		#1, was a different aide.			report was completed after detail		
		bruise upon investigation."			investigation conducted by the Center		
		ed by the Director of Nursing.			Executive Director, Director of Social		
		,			Services and/or Director of Nursing #1.		
	Review of statement	by NA #1 included with the			5		
		rt revealed she was in the			The investigation conducted 11/13/201	7	
	middle of her last rou	nd when NA #2 told her			by the Center Executive Director, Direc	tor	
	Resident #1 needed	her. NA #1 said she was			of Social services, Director of		
	getting another reside	ent ready for an appointment			Rehabilitation Center and MDS nurse b	у	
	and told NA #2 she c	ould not go back down to			interviewing 100% of all current alert ar	nd	
		ecause her resident needed			oriented resident s in the facility to		
		the hall to get breakfast for			determine if any other resident voiced a		
		n finished doing her resident			allegation of abuse or neglect that invol		
		When she finished with her			the alleged perpetrator (Nurse Aide #1)		
		he "actually forgot about			No other residents alleged abuse and/c	or	
		re" because she had found a			neglect that involve the alleged		
		that needed to be corrected			perpetrator. Likewise, the Director of		
		t. NA #1 gave report to the			Human Resources conducted interview		
	oncoming NA #3, and	1's call light and NA #1 had			with current employee who were on duated on 10/26/2017 between the 6AM and 7.	•	
		-					
	-	ident #1's room. When NA arting NA #3 came up to her			to determine if any staff on duty witness any abuse and/or neglect towards	550	
	-	dent #1 was in a mess and			Resident #1 specifically from Alleged		
		r in the bathroom with the			Perpetrator (Nurse Aide #1). No other		
		got towels and wash cloths			staff witness any abuse and/or neglect.		
		the hall, and cleaned up the			Resident s #1 allegation of abuse voice		
		been prevented if NA #2			on 10/26/2017 was unsubstantiated bas		
		Resident #1 on the toilet. NA			on findings of investigation conducted.		
		own Resident #1 "because			Nurse Aide #1 did not care for Resident	t	
	she was crying terrib	le." After calming the			#1 at the time of investigation. It is the		
	Resident, she asked	what happened and the			Center practice to suspend the Alleged		
		d put on the call light and NA			Perpetrator at the time of investigation.		
		light and told her she was					
		NA #2 had told the resident			IDENTIFICATION OF OTHERS		
		me then turn on your light			100% audit of all residents clinical		
		e resident a shower and			documentation within the last 30 days v	vas	
		around 7:30 AM on that			completed by the Director of Nursing,		
		was signed on 11/1/2017 by			Assistant Director of Nursing and/or Nu Supervisor to determine if there is any	rse	
	NA #1.						

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVE	8-039 EY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED		
					С		
		345213	B. WING		11/16/20	17	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BO	OULEVARD		
				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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMP IE APPROPRIATE D	(X5) PLETIO DATE	
F 223	Continued From page	e 12	F 22	3			
				documentation in any reside			
		5 PM, an interview was		records that indicate allegati			
		1, who requested only to be		neglect, and/or misappropria			
		DON present. NA #1 stated		resident s properties, if any,			
		called was between 6:00 and		whether a 24 hours and 5 da	-		
		told her that Resident #1 ce, and so she went in and		investigation reports were conception reported to the state agency			
		had been giving a bath to		officials as required by regul			
		I so it was a little while		Elder Justice Act. The audit			
	before she was able			other documented allegation			
		stated she went to Resident		and/or neglect documented			
	#1's room before she	had given report to day		medical records. This audit	was		
	shift, and the Resider			completed on 11/15/17. Find	lings of this		
		ed the Resident up to the		audit is documented on clin			
		Resident grabbed hold of it		audit tool located at the faci	lity		
		IA then gave her a shower		compliance binder.			
		e stated the Resident was		On 11/15/2017 100% inter			
		med her down, told her not ly, about her being left in the		On 11/15/2017, 100% interv completed by the Director of			
	bathroom. When ask			Services, Director of Rehabi			
		17, that she forgot to go back		Services, Dietary Manager,			
		NA #1 just shrugged her		office manager and/or Medic			
		wasn't that long for the		clerk for all current alert and			
	resident to wait and t			residents in the facility to ide			
		ked about her written		resident with allegation of Al			
		17 that she had given report		and or Misappropriation of p			
	to day shift before sh	-		Four other residents, Reside			
		aid it wasn't that long, and		Resident #3, Resident #4 ar			
	answered in that mar	er. Further questions were		voiced allegation of abuse, r misappropriation of resident	-		
				Alleged perpetrators suspen			
	A review of the stater	ment by NA #2 included with		investigation by the facility E			
		eport revealed that NA #2		director, 24 hour report subr			
		r Resident #1 who was		11/14/2017, thorough invest			
	-	om. The NA turned off the		initiated, resident attending	-		
	-	ident she needed to get		Responsible Party notified o			
		er cleaned up. NA #2 walked		allegation. Resident #2, #3,			
	directly to NA #1 and her. NA #1 looked do	told her Resident #1 needed		be informed of the findings a taken when the investigation			

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETED
					С
		345213	B. WING		11/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE
	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNET	F BOULEVARD
UNIVERS	AL HEALTH CARE LILLI			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 C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETI D THE APPROPRIATE DATE
F 223	Continued From page	e 13	F 2	23	
		ck down there, I already		by the Center Executive I	Director and/or
	been down there and	I'm not going back." NA #2		Director of Social Service	
	said she was doing s	-			
	went into another res	t back to her hall and NA #1		SYSTEMIC CHANGES Effective 12/28/2017, inte	anviews for alert
		informed of a complaint		and oriented residents wi	
		#1, who had received all her		by the Director of Social	
	•	#1 and not the resident.		of Recreational Services	
				designated staff member	at least once
	On 11/13/2017 at 5:3	8 PM, a phone interview was		every quarter to identify a	
		2. NA #2 stated she was		Abuse, Neglect and or M	
		all, and went to the 600 hall		properties. This interview	-
		n call light. Resident #1 was om, sitting in her wheelchair		incorporated to social ser assessment schedule an	
	-	Il light. The NA smelled BM,		on psychosocial assessr	
	-	ke some time to clean her		voiced allegation of abus	-
		said she needed help to be		misappropriation of reside	
	cleaned up. NA #2 st	tated she told the Resident		will be reported to the Ce	nter Executive
		a gown and stuff, and then		Director promptly. Allege	
		o the room NA #1 was in.		will be suspended pendir	
		t Resident #1 needed her.		by the facility, and reported	-
		s not going back in that		the regulatory requirement	nts.
		get linens and proceeded NA #2 stated that Resident		Effective 12/28/2017, the	center nursing
		ack on at shift change, and		administrative team, which	J. J
		back to her room, but saw 2		Nurse supervisors, and/o	
		door, and they answered the		process for reviewing clin	
	call light. Later, NA #	2 was told by NA #3 that NA		documentation for the las	st 24 hours,
	-	tten in an altercation about it		completed skin assessme	
		teered to go back in and give		reports for the last 24 hou	
		r. NA #2 stated that bad		Physician orders written i	
	-	ercation lingered for a few		hours to ensure that any	-
)17, Nurse #1 told NA #2 a nade against her for a		abuse, neglect, misappro resident s properties and	•
		stated she waited after her		unknown sources reporte	-
		rrive, because she felt like		investigated thoroughly, a	
		d because she had not even		perpetrator is suspended	-
	-	and had not pushed the		investigation, and reporte	
	resident in the bathro	-		Executive Director per ce	

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					OMB N	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	· · · ·	E SURVEY IPLETED
					С	
		345213	B. WING		1 [,]	1/16/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
	AL HEALTH CARE LILLIN	IGTON		1995 EAST CORNELIUS HARNE	ETT BOULEVARD	
01117 2110,				LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 223	Continued From page	2 14	F 22	23		
		DON told NA #2 there was		policy.		
	-	had pushed Resident #1 in		ponoj.		
	-	en cut the light off. NA #2		Effective 12/28/2017, T	he Executive	
	requested the DON m	nove her to another hall to		Director, Director of He		
		and Nurse #1, and the DON		and/or Director of Socia		
		part of the facility. NA #2		complete 24-hour and s		
		ow if she had neglected the		investigation reports, th		
		ow if this incident was a		then reviewed by the E		
	dignity issue or some	thing else.		before submitted to the	U	
	$O_{\rm P}$ 11/14/2017 at 9:2	1 AM on intensions was		other officials as require and/or Elder Justice Ac		
		4 AM, an interview was 3. NA #3 stated Resident #1		be incorporated in a da	•	
		nd could propel herself to		meeting. Any negative	-	
		heelchair. She has been		documented on the da		
	incontinent at times a	nd when she had soiled		meeting form and mair		
	herself, she could not	clean herself up from that.		stand up meeting binde	-	
	NA #3 stated on the n	norning of 10/26/2017, she				
	and NA #1 were cond	ucting walking rounds on		Effective 12/28/2017, w	veek end	
		neant they were going door		Registered Nurse supe		
		ent's room for report. At		designated licensed nu		
		A #1 stated the Resident		clinical documentation		
		and she had been busy so		hours, completed skin a		
		the light and told NA #1 that		incident reports for the		
		ded her. After NA #1 had		Physician orders written		
	•	was standing with NA #5 all light went on. NA #3		hours to ensure that an abuse, neglect, misapp		
		's bathroom, and Resident		resident s properties ar	-	
		ad left her like that, and NA		unknown sources repor	-	
		saw BM on her gown and		investigated thoroughly		
		athroom smelled like BM,		perpetrator is suspende	•	
		nd upset. NA #3 told the		investigation and report		
		et it taken care of. NA #3		facility Executive Direct	•	
		old NA #1 she couldn't leave		process will take place		
		Resident #1. NA #1 raised		and Sunday. Any negat		
		as some loud altercation		documented on the we	-	
		then NA #1 said she would		report form and mainta	-	
	go down and give the did not think what cou	Resident a shower. NA #3		clinical meeting binder.		

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					CONSTRUCTION		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY
				···		с	
		345213	B. WING				_ 16/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 1/	10/2011
				19	95 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERS	AL HEALTH CARE LILLI	NGTON		LII	LLINGTON, 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 223	Continued From page	- 15	F 2	22			
1 220		#3 stated she got linens and		23	involving abuse neglect exploitation	or	
		someone else. NA #3 stated			involving abuse, neglect, exploitation mistreatment, including injuries of		
		had talked to Resident #1,			unknown source and misappropriation	n of	
		#1 was mad and mean and			resident property, are reported		
	rough with her and ha	ad grabbed her hard, and			immediately, but not later than 2 hours	5	
		r. The Resident asked the			after the allegation is made, if the eve		
		IA #3 told her she didn't			that cause the allegation involve abus		
		did not show NA #3 the			result in serious bodily injury, or not la		
		nd thought the Resident e on 10/31/2017 after she			than 24 hours if the events that cause allegation do not involve abuse and do		
	had talked to the DO				result in serious bodily injury. This rep		
		••			will be done in person, or via phone by		
	On 11/13/2017 at 1:4	7 PM, an interview was			facility staff on duty to the employee's		
	conducted with NA #4	4. NA #4 stated Resident #1			direct supervisor and the administrato		
		d, and could tell you about			the facility.		
		remembered who NA #4					
		d Resident #1 needed help			Effective 12/28/2017 The facility		
		ssing. Resident #1 could			Administrator, Director of Health servi	ces,	
		let, but when she had an nce accident, she needed			Director of social services and/or designated licensed nurse will report a	511	
	help with being clean	-			alleged violations involving abuse,		
		her bruise on her right inner			neglect, exploitation or mistreatment,		
		her she had been pushed			including injuries of unknown source a	and	
		ind manhandled, and was so			misappropriation of resident property		
		d didn't want to be at the			immediately, but not later than 2 hours		
	facility.				after the allegation is made, if the eve		
		ent dated 10/30/2017, written			that cause the allegation involve abus		
		rce Manager (HR) was			result in serious bodily injury, or not la than 24 hours if the events that cause		
		Manager reported she was urse's Station when she was			allegation do not involve abuse and de		
		t Resident #1 was scared to			result in serious bodily injury. The rep		
		d the NA saw bruises on			will be made to State Survey Agency		
	Resident #1's arm.				adult protective in accordance with St		
					law through established procedures.		
		ducted on 11/13/2017 at			Facility Executive Director, Director of		
	4:04 PM, with the HR	-			Nursing (DON), and/or Director of Soc		
	-	was at the 500/600 Hall			Services will complete 100% re-educa	ation	
	-	NA #4 called her over and			on the facility s abuse/neglect policy		
	loid her that Residen	t #1 was scared to stay at			including notification, protection, and		

Facility ID: 943230

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUR	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLET	ED
		345213	B. WING		С	
	ROVIDER OR SUPPLIER	545215		STREET ADDRESS, CITY, STATE, ZIP	CODE 11/16/2	2017
				1995 EAST CORNELIUS HARNETT		
UNIVERSA		NGTON		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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE CO THE APPROPRIATE	(X5) OMPLETIC DATE
F 223	Continued From page	<u>> 16</u>	F 22	2		
		A #1 had been really mean	1 22	investigation protocols. Th	is education will	
	,	bruise. NA #4 saw the		be provided for all employ		
	bruise on her arm, like			full time, part time and as		
	grabbed her.			This education will be com		
				12/28/2017. Any employed	e not educated	
		12 PM, an interview was		by 12/28/2017 will not be		
		irector of Nursing (DON).		until educated. This educa		
	,	repeated many times, that		added on new hires orient		
	she first heard of the	sident #1 came to the		for all new employees effe 12/28/2017, and will also I		
		she was looking for the		semi-annually.		
		tesident #1 that she could		Seria annually.		
		1 showed her arm with the		MONITORING PROCESS	6	
		t #1 told her the NA had		Effective 12/28/2017, Dire		
	grabbed and pushed	her in the shower, and was		Assistant Director of Nursi	ing, and/or Staff	
		ed to her, but the DON didn't		Development Coordinator		
	-	tated she determined there		compliance with abuse po		
		se the bruise was just a		procedures, resident s pro		
		Resident's wrist, and it wasn't		thorough investigation, inju-		
	-	The DON indicated that if a ident #1's wrist, it would		unknown sources and res by conducting clinical mee		
	-	bruise, because especially		This meeting will allow all		
	on Caucasians, you c			abuse the team to review	_	
	-	grabbed. The DON stated		accidents occurred from th		
	the bruise must have	come from Resident's #1's		meeting to ensure any inju		
	medication, as she wa	as on Plavix (a blood		investigated and reported		
	thinner), and aspirin.			policy. The nursing admin		
	On 11/14/2017 at 14.4			will also review completion		
		00 AM, an interview was W. The SW stated the DON		assessments from prior da any documented injury of	-	
		t #1 to her on 10/31/2017,		was followed through per		
	-	the Resident's bruise. The		issues identified during thi		
	SW stated the bruise	was a little less than quarter		process will be addressed	-	
	-	t wrist. The DON stated she		Findings from this meeting		
		SW talked to the DON on		documented on a daily cli		
		ON reported a NA had put		and filed in clinical meetin		
		athroom, and another NA		proper follow ups are done		
	said Resident #1 coul	id take nerself to the		monitoring process will tak	ke place dally	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) D/	NO. 0938-03 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CC	OMPLETED
						С
		345213	B. WING			11/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BO	ULEVARD	
		NOTON		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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 223	Continued From page	e 17	F 22	23		
		ho did what, so she just		weeks, then monthly x 3 mor	oths or until	
	removed the NA from	· ·		the pattern of compliance is r		
		to mean that the bruise				
		to the bathroom, and since		Effective 12/28/2017, Directo	r of Nursing	
		Resident to the bathroom,		will report findings of this mo		
	abuse didn't happen.	The SW reported that		process to the facility Quality	Assurance	
	Resident #1 was aler	t and oriented.		and Performance Improveme	ent	
				Committee for any additional		
		7 PM the facility was notified		or modification of this plan m		
		vided the following credible		months, or until the pattern o		
	allegation of compliar	nce on 11/16/2017.		is maintained. The QAPI com		
	DATE 44/45/0047			modify this plan to ensure the	-	
	DATE: 11/15/2017			remains in substantial compl	ance.	
	DEFFICIENCY CITE	LEAD TO THE ALLEGED		RESPONSIBLE PARTY		
		pliance resulted from the		Effective 12/28/2017, the cer	ter Executive	
	Center's former Direc			Director and the Director of N		
		egulatory requirements		be ultimately responsible to e	0	
		of residents during allegation		implementation of this plan o		
	of abuse and or negle			for this alleged noncompliance		
		how to conduct the detail		the facility remains in substan		
	investigation of allega	ation of abuse or neglect.		compliance.		
	"The former DON sta	ted the way she understood				
	is that she can only d	ocument what resident				
		ur and a 5-day report, she				
	added that when she	-				
		ted from uses of blood				
		f the medication resident is				
		nsider the bruise to be				
		an alleged perpetrator ident #1 however alleged				
		abbed her while in the				
	bathroom and caused					
	10/26/2017. The DOM					
	protected the residen					
	-	om the hall where resident				
		investigation period. This is				
	-	buse Prohibition process				
	which requires for the	e alleged perpetrator to be				

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	B	· · · ·	PLETED
						С
		345213	B. WING		1	1/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				1995 EAST CORNELIUS HARNETT BO	ULEVARD	
UNIVERS	AL HEALTH CARE LILLI	NGTON		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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 223	Continued From page	o 19	Го			
F 223			F 22	23		
	suspended pending i					
		1 is no longer employed at 1/15/2017. New Director of				
		oversee clinical services				
	effective 11/15/2017.					
		ation from the Management				
		any that manages the				
		he Center Executive Director				
		ursing #1 on 11/14/2017 on				
	the center's Abuse P	rohibition and Investigation				
	policies and procedu	res, and emphasized the				
		ting resident(s), to include				
		ed perpetrator during the				
		investigating thoroughly all				
		r neglect as well as injuries				
		determine etiology, and mely manner per state				
		nts. This education was also				
		Director of Nursing on				
	11/15/2017 by the Di	5				
		proximately 9:00PM Director				
		e center followed by the				
		cial services interviewed				
	resident #1. Resider	nt #1 voiced that on				
	10/26/2017 approxim	ately between 6:00 AM and				
		episode of loose stool, she				
		e bathroom and turn the				
		. Nursing Aide #2 responded				
		Id the resident she will notify				
	-	Aide (Nurse Aide #1), and if				
		not back to care for her, she o turn the light back on (no				
	time lapse specified).	C				
		itial round, noted resident #1				
	-	Aide #3 communicated to				
		resident#1 being soiled and				
		#1 to clean the resident#1				
	before leaving on 10					
	before leaving on 10/	26/2017. Nurse Aide #1				

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	O. 0938-039	
and plan o	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		345213	B. WING		1.	C 1/16/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I I	1/10/2017	
UNIVERS	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	EVARD		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 223	shower on 10/26/201 Resident #1 added th and grabbed her on th bruise. Resident #1 ad allegation to Nurse Ai Aide #4 on 10/30/2017. Int by the Center Execut 11/13/2017 revealed made by Resident #1 Resources Director on Nurse Aide #3, and N this allegation to their center's Executive Di Prohibition policies an 2017. Director of Hur Allegation to Director 10/30/2017 and to the written statement on the Center Executive On 10/31/2017 and 1 and a 5 day report we of Health and Human related to resident #1 on 10/26/2017. Thes and submitted by the #1. Five days report of indicated an investiga enough. On 11/15/20 completed after detai the Center Executive Director The investigation con Center Executive Director MDS nurse by intervite	7. hat Nurse Aide#1 pushed her he arm, which caused a dded that she reported this de #3 on 10/26/17, Nurse 7, and Director of Nursing terview with Nurse Aide #4 ive Director conducted on she reported the Allegation to the Center Human n 10/30/2017. Interview with lurse Aide # 4 did not report direct supervisor and the rector per facility Abuse and procedures revised June man Resources reported the of Nursing #1 on e executive Director via 10/30/2017 that was read by Director on 10/31/2017. 1/3/2017, the 24 hour report ere sent to the Department of Services respectively, 's allegation of abuse made e reports were completed former Director of Nursing completed on 11/3/2017 ation that was not detailed 17 another 5 day report was I investigation conducted by Director, Director of Social cor of Nursing #1. ducted 11/13/2017 by the ector, Director of Social Rehabilitation Center and ewing 100% of all current ident's in the facility to	F 223				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345213	B. WING				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			1995 EAST CORNELIUS HARNETT BOULEVARD		
				L	LILLINGTON, 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From page alleged perpetrator (N residents alleged abu involve the alleged per Director of Human Re interviews with curren duty on 10/26/2017 bo determine if any staff abuse and/or neglect specifically from Alleg #1). No other staff wit neglect. Resident's #7 on 10/26/2017 was ur findings of investigation #1 did not care for Re investigation. It is the the Alleged Perpetrator investigation of any al Neglect. THE PROCEDURES ACCEPTABLE CRED THE ALLEGED IMME 100% audit of all resid within the last 30 days Director of Nursing, A and/or Nurse Supervia any documentation in records that indicate a and/or misappropriation	2 20 Aurse Aide #1). No other se and/or neglect that repetrator. Likewise, the sources conducted t employee who were on etween the 6AM and 7AM to on duty witnessed any towards Resident #1 ed Perpetrator (Nurse Aide ness any abuse and/or allegation of abuse voiced hsubstantiated based on on conducted. Nurse Aide sident #1 at the time of Center practice to suspend or at the time of leged Abuse and/or FOR IMPLEMENTING THE IBLE ALLEGATION FOR EDIATE JEOPARDY. dents' clinical documentation is was completed by the ssistant Director of Nursing sor to determine if there is any resident's medical allegation of abuse, neglect, on of resident's properties, if er a 24 hours and 5 days		223	DEFICIENCY)	IATE	DATE
	reported to the state a required by regulation The audit revealed no allegation of abuse, a in resident's medical r	agency and other officials as and/or Elder Justice Act. o other documented nd/or neglect documented records. This audit was 7. Findings of this audit is cal records audit tool"					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	LETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	IGTON		LI	ILLINGTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 223	Continued From page		F 2	23			
	by the Director of Soc Rehabilitation Service Business office mana clerk for all current all the facility to identify a allegation of Abuse, N Misappropriation of pur residents, Resident#2 and Resident #5 voice neglect and/or misapp properties. Alleged per pending investigation director, 24 hour repor thorough investigation Physician and Respon allegation. Resident # informed of the finding the investigation is co	ger and/or Medical Records lert and oriented residents in any other resident with Neglect and or					
	oriented residents will Director of Social Ser Recreational Services member at least once any allegation of Abus Misappropriation of pup process will be incorp quarterly assessment on "psychosocial asse allegation of abuse, n misappropriation of re reported to the Cente promptly. Alleged per	vices, Director of s and/or designated staff e every quarter to identify se, Neglect and or roperties. This interview borated to social services s schedule and documented essment tool". Any voiced leglect and/or esident's properties will be r Executive Director petrators will be suspended by the facility, and reported					

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	Continued From page	22	F	223			
	supervisors, and/or Si reviewing clinical docu hours, completed skin reports for the last 24 orders written in the la any allegation of abus of resident's propertie sources reported/docu thoroughly, alleged pe pending investigation, Executive Director pe Effective 11/15/2017, investigation reports a by the Executive Director state agency and other regulation and/or Elde process will take place Friday). Any identified promptly and appropri implemented by the E ADON, and/or Nurse will be incorporated in Any negative findings "daily stand up meetir the daily stand up meetir the daily stand up meetir the daily stand up meetir hours, completed skin reports for the last 24 orders written in the la any allegation of abus of resident's propertie	which includes DON, Nurse DC, initiated a process for umentation for the last 24 h assessments, incident hours, and Physician ast 24 hours to ensure that se, neglect, misappropriation as and/or injuries of unknown umented is investigated erpetrator is suspended , and reported to the facility r center's abuse policy. 24-hour and 5-days are completed and reviewed ctor before submitted to the er officials as required by er Justice Act. This systemic e daily (Monday through d issues will be addressed iate actions will be executive Director, DON, Supervisor. This process n a daily sand up meeting. will be documented on the ng form" and maintained in eting binder. week end Registered Nurse signated licensed nurse will entation for the last 24 n assessments, incident					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		LE CONSTRUCTION		E SURVEY PLETED
		345213	B. WING				/16/2017
NAME OF PF	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLIN	IGTON			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 PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	pending investigation Executive Director. The take place every Satur negative findings will I "week end supervisor maintained in the daily Effective 11/15/2017, supervisor and/or desireview clinical docume hours, completed skin reports for the last 24 orders written in the last any allegation of abus of resident's propertie sources reported/document thoroughly, alleged per pending investigation Executive Director. The take place every Satur negative findings will I "week end supervisor maintained in the daily Effective 11/15/2017, involving abuse, negles mistreatment, includin source and misapprop are reported immedia hours after the allegat that cause the allegat in serious bodily injury if the events that cause involve abuse and do injury, to the administr other officials (includin	erpetrator is suspended and reported to the facility his systemic process will urday and Sunday. Any be documented on the report form" and y clinical meeting binder. week end Registered Nurse signated licensed nurse will entation for the last 24 n assessments, incident hours, and Physician ast 24 hours to ensure that se, neglect, misappropriation es and/or injuries of unknown umented is investigated erpetrator is suspended and reported to the facility his systemic process will urday and Sunday. Any be documented on the report form" and y clinical meeting binder. All alleged violations		223			
	law provides for jurisd	diction in long-term care ce with State law through					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION		SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMF	PLETED
		345213	B. WING				C
	ROVIDER OR SUPPLIER	545215	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	/16/2017
					1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERS	AL HEALTH CARE LILLIN	NGTON	LILLINGTON, NC 27546		LILLINGTON, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective Facility Executive Dire (DON), and/or Directo complete 100% re-ed abuse/neglect policy is protection, and invest education will be prov- include full time, part This education will be prov- include full time, part This education will be prov- education will also be orientation process for effective 11/15/2017, semi-annually. THE MONITORING F THAT THE CREDIBL EFFECTIVE AND RE IMMEDIATE JEOPAF Effective 11/15/2017, Assistant Director of I Development Coordin compliance with abus resident's protection, injuries of unknown so neglect by conducting This meeting will allow team to review the into occurred from the prior	es. Report the results of all administrator or his or her ative and to other officials in e law, including to the State in 5 working days of the eged violation is verified e action must be taken. ector, Director of Nursing or of Social Services will lucation on the facility's including notification, tigation protocols. This vided for all employee, to time and as needed staff. e completed by 11/15/2017. ucated by 11/15/2017 will k until educated. This added on new hires or all new employees and will also be provided PROCEDURE TO ENSURE E ALLEGATION IS MOVE THE ALLEGED RDY Director of Nursing, Nursing, and/or Staff hator, will monitor se policies and procedures, thorough investigation, ources and resident's g clinical meeting daily (M-F). w all allegation of abuse the	F	223			

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	-					FORM	D: 01/02/2018
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345213	B. WING		_		C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON		1995 EAST CORNELIUS HA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	BEAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	in will also review con assessments from pri documented injury of followed through per p during this monitoring promptly. Findings fro documented on a dail filed in clinical meeting ups are done. This mo- place daily (M-F) for 2 weeks, then monthly 2 pattern of compliance Effective 11/15/2017, report findings of this facility Quality Assura Improvement Commit monitoring or modifica months, or until the pa maintained. The QAP plan to ensure the fac compliance. TITLE OF THE PERS IMPLEMENTING THE Effective 11/15/17, the and the Director of He ultimately responsible of credible allegation immediate jeopardy. Compliance Date: 11/ The Credible Allegatio 11/16/2017 by the foll 1. The survey team current resident's meo- records audit tool", wi	e nursing administrative team inpletion of skin or day and ensure any unknown source was policy. Any issues identified process will be addressed om this meeting will be dy clinical report form and g binder after proper follow onitoring process will take 2weeks, weekly x 2 more x 3 months or until the e is maintained. Director of Nursing will monitoring process to the nce and Performance the for any additional attern of compliance is d committee can modify this cility remains in substantial SON RESPONSIBLE FOR E CREDIBLE ALLEGATION e center Executive Director ealth services will be e to ensure implementation to remove this alleged	F 223	3			

Facility ID: 943230

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345213	B. WING				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			995 EAST CORNELIUS HARNETT BOULEVARD .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
F 223 F 224 SS=D	of abuse, neglect, mis properties and /or inju 2. The survey team incidents within the la completed to identify i injuries. 3. The survey team provided by staff and team conducted staff staff. The staff intervi in-service regarding a reporting, and recogn staff burnout. 4. The survey team and oriented residents education they had re abuse to. PROHIBIT MISTREATMENT/NE CFR(s): 483.12(b)(1)- §483.12 The resident abuse, neglect, misap property, and exploita subpart. This includes freedom from corpora seclusion and any phy not required to treat th 483.12(b) The facility implement written pol	sappropriation of resident's rreviewed the audit of all st 30 days which was any unknown source of reviewed the in-service signed by staff. The survey interviews with 16 on-duty ewed confirmed the recent buse identification, izing signs and symptoms of interviewed 41 current alert s. The residents confirmed aceived on whom to report GLECT/MISAPPROPRIATN (3) has the right to be free from propriation of resident tion as defined in this a but is not limited to I punishment, involuntary ysical or chemical restraint he resident's symptoms. must develop and icies and procedures that: event abuse, neglect, and the and misappropriation of es and procedures to		223			12/28/17

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	3			
		345213	B. WING			C 1/16/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC			
UNIVERS	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DULEVARD	EVARD	
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
F 224	Continued From page	e 27	F 22	4			
	§483.95, This REQUIREMENT by: Based on observatio interviews and record protect resident from resident in the bathro for 1 of 1 sampled res Findings included: Resident #1 was adm 5/12/2017 with diagne hypertension, and con Review of a quarterly assessment for Resident required extensive as dressing, personal hy not steady, but able to assistance between b weight was 115 pound	nitted to the facility on oses to include diabetes, ntracture of left hand. Minimum Data Set (MDS) dent #1, dated 9/22/2017 had intact cognition. She ssistance with toileting, rgiene and bathing. She was o transfer herself with limited bed and wheelchair. Her		F224D ROOT CAUSE This alleged noncompliance the Nursing aide #1 failure to facility abuse prohibition poll procedures and lack of unde what constituted neglect or v resident s dignity. When inte the former Director of Nursir #1 indicated she did not thin constituted neglect or violati s dignity. Nurse aide numbe longer employed at the cent Director of Nursing #1 is no employed at the Center effe 11/15/2017 following this evo Director of Nursing employe clinical services effective 11.	o follow the icy and erstanding on violation of erviewed by ng, nurse aide k her acts on of resident r #1 is no er. Likewise longer ctive ent. New d to oversee /15/2017.		
	11:05 AM with Reside couple of weeks ago, date, she had a bowe herself at about 6:00 wheelchair and took f turned on the bathroo come and help clean who was not her nigh AM and turned off the someone didn't come	ent #1. Resident #1 stated a she was not sure of the el movement (BM) and soiled AM. The resident got in her nerself to the bathroom, and om call light for someone to her up. She indicated a NA, t NA, came in about 6:15 e call light and told her if to help her after a while, to on. The resident could see		Director of Rehabilitation at followed by the facility Direct services interviewed resider Resident #1 voiced that on 7 approximately between 6:00 AM, she had an episode of I she wheeled herself to the b turn the bathroom call bell o Aide #2 responded to the ca the resident she will notify he Nurse Aide (Nurse Aide #1),	the center tor of Social 1t #1. 10/26/2017 0 AM and 7:00 0 ose stool, 0 athroom and n. Nursing 11 bell and told er assigned		

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		MEDICAID SERVICES				0. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
						С
		345213	B. WING		11/	16/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
		NCTON		1995 EAST CORNELIUS HARNETT BO	ULEVARD	
UNIVERS	AL HEALTH CARE LILLI	NGTON		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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 224	Continued From page	28	F 22	24		
1 227					field) On the	
		ne waited for a long time, ause she didn't want to get		back on (no time lapse speci morning of 10/26/2017, durin	•	
		r. She stated she was cold		round, noted resident #1 to b		
		elled bad, and she was		Resident # 1 alleged that she		
		ent #1 stated that NA #3, the		the bathroom for about an ho		
		the bathroom and asked		aide #1, she added she was		
	-	en waiting, and the Resident		by this event. Nurse Aide #3		
	-	NA #3 told her she was		communicated to Nurse Aide		
	going to get NA #1. I	NA #1 came in and was real		resident#1 being soiled and a	asked for	
	mad and kept saying	that the other NA should		Nurse Aide #1 to clean the re	esident#1	
	have cleaned her up.	Resident #1 said she was		before leaving on 10/26/2017		
		en NA #1 gave her a shower		#1 provided care to Resident	#1 and gave	
	and cleaned her up. NA's name, and the N	Resident #1 asked for the NA wouldn't tell her.		her a shower on 10/26/2017.		
				IMMEDIATE ACTION		
	Review of statement	by NA #1 included with the		On the morning of 10/26/201	7, during	
	5-Working Day Repo	rt revealed she was in the		initial round, noted resident #		
		nd when NA #2 told her		soiled. Nurse Aide #3 comm	unicated to	
		her. NA #1 said she was		Nurse Aide #1 about residen	•	
		ent ready for an appointment		soiled and asked for Nurse A		
		ould not go back down to		clean the resident#1 before l	•	
		ecause her resident needed		10/26/2017. Nurse Aide #1 p		
		the hall to get breakfast for		to Resident#1 and gave her a	a shower on	
		n finished doing her resident		10/26/2017.		
	-	When she finished with her		Bosidont On 10/21/2017	11/2/2017	
		he "actually forgot about re" because she had found a		Resident On 10/31/2017 and the 24 hour report and a 5 da		
		that needed to be corrected		sent to the Department of He	• •	
	-	t. NA #1 gave report to the		Human Services respectively		
	oncoming NA #3, and	- ·		resident #1 s allegation of ne		
	-	1's call light and NA #1 had		on 10/26/2017. These report		
		ident #1's room. When NA		completed and submitted by		
	-	arting NA #3 came up to her		Director of Nursing #1. Five of		
	-	dent #1 was in a mess and		completed on 11/3/2017 indic	• •	
	had feces all over he	r in the bathroom with the		investigation that was not de		
	door closed. NA #1 g	ot towels and wash cloths		and did not include the allega	ation of	
		the hall, and cleaned up the		neglect. On 11/13/2017 anot		
		been prevented if NA #2		and 5 day report was comple		
	would have just put F	Resident #1 on the toilet. NA	1	detail investigation conducted	dhutha	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G		/PLETED
				<u> </u>		С
		345213	B. WING		1	1/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		1/10/2011
				1995 EAST CORNELIUS HARNET		
UNIVERS	AL HEALTH CARE LILLI	NGTON		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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page	o 20				
1 224	1.5	e 29 own Resident #1 "because	F 22		n Director of	
		le." After calming the		Center Executive Directo		
		what happened and the		Social Services and/or D #1.	irector or nursing	
		d put on the call light and NA		<i>π</i> .		
		light and told her she was		IDENTIFICATION OF OT	THERS	
		NA #2 had told the resident				
		me then turn on your light		The investigation conduc	ted 11/14/2017	
		e resident a shower and		by the Center Executive		
		around 7:30 AM on that		of Social services, Direct		
		was signed on 11/1/2017 by		Rehabilitation Center and	•	
	NA #1.			interviewing 100% of all		
	Op 11/13/2017 at 4.3	5 PM, an interview was		oriented residents in the determine if any other re	•	
		1, who stated the only thing		allegation of abuse and/o		
		ween 6:00 and 7:00 AM on		involve the alleged perpe	-	
		d told her that Resident #1		Aide #1). No other reside	-	
		ce, and so she went in and		abuse and/or neglect that	•	
		had been giving a bath to		alleged perpetrator. Like		
		l so it was a little while		Director of Human Reso	urces conducted	
	before she was able	•		interviews with current en		
		stated she went to Resident		were on duty on 10/26/20		
		had given report to day		6AM and 7AM to determ		
	shift, and the Resider			duty witnessed any abus		
		nen gave her a shower and ated the Resident was crying		towards Resident #1 spe Alleged Perpetrator (Nur		
		er down, told her not to cry it		other staff witness any a	,	
	would be okay, about	-		neglect. Resident s #1 al		
	bathroom. When ask	-		voiced on 10/26/2017 wa	•	
		17, that she forgot to go back		unsubstantiated based o		
		lent up, and that she had		investigation conducted.	•	
		nift before she went in to		did not care for Resident		
		ust shrugged her shoulders		investigation. It is the Ce		
		t long for the resident to wait		suspend the Alleged Per		
	and that was all she of questions were answ	could remember. Further rered in that manner.		time of investigation of a and/or Neglect.	ny alleged Abuse	
		ment by NA #2 included with		100% audit was complet	-	
		eport revealed that NA #2		Executive Director for all		
	answered the light for	r Resident #1 who was		abuse and/or neglect rep	orted to North	

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		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G		E SURVEY IPLETED
				<u> </u>		С
		345213	B. WING		1	1/16/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z		
				1995 EAST CORNELIUS HARNET	TT BOULEVARD	
UNIVERS	AL HEALTH CARE LILLI	NGION		LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETIC DATE
F 224	Continued From pag	e 30	F 22	24		
		om. The NA turned off the	1 22	Carolina Department of	Health and	
		sident she needed to get		Human Services in the I		
		er cleaned up. NA #2 walked		determine if the alleged	perpetrator(s)	
	directly to NA #1 and	told her Resident #1 needed		was/were suspended du	iring the	
		own the hall and said, "oh		investigation period. Thi		
		ack down there, I already		identified whether the 24		
		I I'm not going back." NA #2		days reports are comple		
	said she was doing s	-		to the state agency as re		
	went into another res	t back to her hall and NA #1		regulation and Elder Just manner. The audit revea	-	
				reportable in the last 12		
	On 11/13/2017 at 5:3	88 PM, a phone interview was		with detail investigation		
		2. NA #2 stated she was		Perpetrator(s) were sus	-	
		all, and went to the 600 hall		was completed on 11/15		
	-	n call light. Resident #1 was				
	already in the bathro	om, sitting in her wheelchair		100% audit of all current	t residents clinical	
	-	all light. The NA smelled BM,		documentation within the	•	
		ke some time to clean her		completed by the Direct		
		said she needed help to be		Assistant Director of Nu	-	
		tated she told the Resident		Supervisor to determine	-	
		t a gown, and then NA #2 oom NA #1 was in. NA #2		documentation in any re records that indicate alle		
		dent #1 needed her. NA #1		neglect, and/or misappro		
		oing back in that room. NA		resident s properties, if a		
		and proceeded back to the		whether a 24 hours and	•	
		ed that Resident #1 put her		investigation reports we		
	-	hift change, and NA #2		reported to the state age		
		to her room, but saw 2 NA's		officials as required by r	•	
		and they answered the call		Elder Justice Act. The a		
	-	he did not know if she had		other documented allega		
		nt and didn't know if this y issue or something else.		and/or neglect documen medical records. This at		
		y issue of something cise.		completed on 11/15/17.		
	On 11/14/2017 at 8:3	4 AM, an interview was		audit is documented on	-	
		3. NA #3 stated Resident #1		audit tool located at the		
		ind could propel herself to		compliance binder.	- 7	
		wheelchair. She has been				
	incontinent at times a	and when she had soiled		On 11/14/2017, 100% in	Iterviews was	
	I .	t clean herself up from that.	1	completed by the Direct		1

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TATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					С
		345213	B. WING		11/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOULEVA LILLINGTON, NC 27546	RD
(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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 224	NA #3 stated on the preceived report from Resident was in the preceived report from Resident was in the preceived report from Resident was in the preceived report she had been busy splight and told NA #1 ther. Shortly after report NA #5 when Residen #3 went into Residen #4 to the resident when the two, and give the On 11/13/2017 at 12: conducted with the D The DON stated she #2 stated Resident # she turned off the light The DON stated she of the resident when The DON stated she	morning of 10/26/2017, she NA #1 who stated the bathroom. NA #1 reported to NA #2 had answered the that Resident #1 had needed bort, NA #3 was standing with nt #1's call light went on. NA th #1's bathroom, and the NA's had left, and NA #3 w BM on her gown and the NA's had left, and NA #3 w BM on her gown and tathroom smelled like BM, and upset. NA #3 told the get it taken care of. NA #3 told NA #1 she couldn't leave Resident #1. NA #1 raised was some loud altercation d then NA #1 said she would	F 224		ess cords ed ny other Neglect es. ident #5 a and/or berties. ending ve con ian and #5 will tions mpleted nd/or r alert pleted Director ince tion of

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLI	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 LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	≥ 32	F	224	Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according the regulatory requirements. Effective 12/28/2017, the center nursing administrative team, which includes De Nurse supervisors, and/or SDC, initiate process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident s properties and/or injuries of unknown sources reported/documente investigated thoroughly, alleged perpetrator is suspended pending investigation, and reported to the facilit Executive Director per center s abuse policy. Effective 12/28/2017,Executive Director Director of Health Services and/or Director of Social Services will comple 24-hour and 5-days investigation report and reviewed by the Executive Director before submitted to the state agency at other officials as required by regulatior and/or Elder Justice Act. This systemic process will take place daily (Monday through Friday). Any identified issues to be addressed promptly and appropriat actions will be implemented by the Executive Director, DON, ADON, and/ Nurse Supervisor. This process will be incorporated in a daily sand up meetin Any negative findings will be documented investing the findings will be documented	on to ng ON, ed a d is ty or, te trs r nd n c will e or sg.	

Event ID: 5GBQ11

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/02/2018 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C 11/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNET	TT BOULEVARD
UNIVERS				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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 224	Continued From page	∋ 33	F 22	 on the daily stand up me maintained in the daily s binder. Effective 12/28/2017, we Registered Nurse super designated licensed nurs clinical documentation for hours, completed skin as incident reports for the la Physician orders written hours to ensure that any abuse, neglect, misappre resident s properties and unknown sources report investigated thoroughly, perpetrator is suspended investigation and reporte Executive Director. This will take place every Sat Sunday. Any negative fir documented on the wee report form and maintai clinical meeting binder. Effective 12/28/2017, All involving abuse, neglect mistreatment, including i unknown source and mis resident property, are re immediately, but not late after the allegation is ma that cause the allegation result in serious bodily ir than 24 hours if the ever allegation do not involve result in serious bodily ir will be done in person, o facility staff on duty to th 	eek end visor and/or se will review or the last 24 ssessments, ast 24 hours, and in the last 24 v allegation of opriation of d/or injuries of ted/documented is alleged d pending ed to the facility systemic process turday and ndings will be ek end supervisor ned in the daily I alleged violations c, exploitation or injuries of sappropriation of ported er than 2 hours ade, if the events n involve abuse or njury, or not later nts that cause the e abuse and do not njury. This report or via phone by

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/02/2018 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C 11/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
UNIVERS	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BO	DULEVARD
				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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 224	Continued From page	e 34	F 22	4	
				direct supervisor and the adr the facility.	ministrator of
				Effective 12/28/2017 The fac Administrator, Director of He Director of social services ar designated licensed nurse w alleged violations involving a neglect, exploitation or mistre including injuries of unknown misappropriation of resident immediately, but not later tha after the allegation is made, that cause the allegation inver- result in serious bodily injury than 24 hours if the events the allegation do not involve abur result in serious bodily injury will be made to State Survey adult protective in accordance law through established proce	ealth services, nd/or vill report all abuse, eatment, n source and property an 2 hours if the events olve abuse or v, or not later hat cause the use and do not v. The reports v Agency and ce with State cedures.
				Effective 12/28/2017, Abuse process will be discussed to and oriented residents every during resident council meet least quarterly during each re plan meeting. This process v managed by the Center Dire Services effective 12/28/201 Facility Executive Director, D Nursing (DON), and/or Director Services will complete 100% on the facility s abuse/negled including notification, protect	current alert y months ing and at esident care will be ector of Social 7. Director of ctor of Social 6 re-education ct policy
				investigation protocols. This be provided for all employee full time, part time and as ne	education will e, to include

Event ID: 5GBQ11

Facility ID: 943230

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/02/2018 1 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	LETED
		345213	B. WING			11/	_ 16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE LILLII	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
	I			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	Continued From page	e 35	F	224	This education will be completed by 12/28/2017. Any employee not educat by 12/28/2017 will not be allowed to w until educated. This education will also added on new hires orientation process for all new employees effective 12/28/2017, and will also be provided semi-annually. MONITORING PROCESS Effective 12/28/2017, Executive Direct and or Director of Social Services will review all alleged violation to ensure a thorough investigation is completed arreported to the state agency and othe officials as required by regulation and/ Elder Justice Act. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will abuse prohibition tool and filed in daily meeting binder after proper follow ups done. This monitoring process will take place daily to include Saturdays and Sundays for 2weeks, weekly x 2 more weeks, then monthly x 3 months or un the pattern of compliance is maintaine.	ork b be ss or nd r or d or d or d s d on y are e til d. this ty f he he he	

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Facility ID: 943230

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		D HUMAN SERVICES				FOR	D: 01/02/201 APPROVE <u>0. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	` '	E SURVEY IPLETED C
		345213	B. WING			11	/16/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546	BOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	Continued From page	9.36	F	224	compliance. TITLE OF THE PERSON RESPONS FOR IMPLEMENTING THE CREDIB ALLEGATION Effective 12/28/2017, the center Exec Director and the Director of Nursing v be ultimately responsible to ensure implementation of this plan of correct to ensure the facility attain and maint	LE cutive vill	
F 225 SS=J	ALLEGATIONS/INDI\ CFR(s): 483.12(a)(3)(483.12(a) The facility	/IDUALS (4)(c)(1)-(4)	F	225	the substantial compliance.		12/28/17
	 who- (i) Have been found g exploitation, misappro mistreatment by a course (ii) Have had a finding 	puilty of abuse, neglect, opriation of property, or urt of law; g entered into the State ncerning abuse, neglect, nent of residents or					
	(iii) Have a disciplinar or her professional lic body as a result of a f exploitation, mistreatr misappropriation of re	y action in effect against his ense by a state licensure inding of abuse, neglect, nent of residents or					

Facility ID: 943230

If continuation sheet Page 37 of 99

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/02/2018 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345213	B. WING			(11/ [,]) 16/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
UNIVERS	AL HEALTH CARE LILLIN	IGTON		1995 EAST CORNELIUS H LILLINGTON, NC 2754			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	actions by a court of I which would indicate nurse aide or other fa (c) In response to alle exploitation, or mistre (1) Ensure that all alle abuse, neglect, explo- including injuries of un misappropriation of re- reported immediately, after the allegation is cause the allegation is cause the allegation is cause the allegation is serious bodily injury, of the events that cause abuse and do not resis the administrator of the officials (including to the adult protective service for jurisdiction in long- accordance with State procedures. (2) Have evidence that thoroughly investigate (3) Prevent further po- exploitation, or mistre investigation is in pro- (4) Report the results administrator or his ou- representative and to with State law, including Agency, within 5 work	aw against an employee, unfitness for service as a cility staff. egations of abuse, neglect, atment, the facility must: eged violations involving itation or mistreatment, nknown source and esident property, are , but not later than 2 hours made, if the events that nvolve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to he facility and to other the State Survey Agency and ces where state law provides -term care facilities) in e law through established at all alleged violations are ed. tential abuse, neglect, atment while the gress. of all investigations to the r her designated other officials in accordance ing to the State Survey king days of the incident, and n is verified appropriate	F 22	25			

If continuation sheet Page 38 of 99

					CONCTRUCTION		0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	LETED
			A. BUILDII	NG _			C
		345213	B. WING				_ 16/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	/	10/2017
					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERS	AL HEALTH CARE LILLII	NGTON	LILLINGTON, NC 27546				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIZ TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 225	Continued From page	- 38	F	225			
		is not met as evidenced		-20			
	by:	וש הטנ חובו מש לאועלוונלע					
		n, resident interview, staff			F225		
		I review the facility failed to					
	report staff to residen	t physical abuse within 24			ROOT CAUSE		
		ency, failed to thoroughly			This alleged noncompliance resulted fr	rom	
	investigate the abuse	-			the Center s Director of Nursing #1		
	sampled residents (R	esident #1).			misinterpretation of regulatory	1	
	The immediate jeopa	rdy (11) began on			requirements related to how to conduc the detail investigation of any allegation		
		#3 did not report to the			abuse or neglect. The former DON sta		
	Nurse, the Director of	•			the way she understood is that she car		
		Resident #1 told her Nurse			only document what resident states on		
		d her by the wrists and sat			both 24 hour and a 5-day report.		
	her down hard on the	shower seat in the					
		resulting in a bruise to her			Director of Nursing #1 is no longer		
	•	is removed on 11/16/2017			employed at the Center effective		
		ceptable credible allegation			11/15/2017. New Director of Nursing		
	was verified. The fac	e and severity of D (no			employed to oversee clinical services effective 11/15/2017.		
		potential for more than			The Director of operation from the		
	-	not IJ) to allow the facility to			Management and consulting company		
		nt its plan of correction for			that manages the center, re-educated	the	
	abuse.				Center Executive Director and the		
					Director of Nursing #1 on 11/14/2017 of	on	
	Findings included:				the center s Abuse Prohibition and		
					Investigation policies and procedures,		
		admitted to the facility on			emphasized the importance of protecti	ng	
	hypertension, and co	oses to include diabetes,			resident(s), to include suspending the		
					alleged perpetrator during the investigation period, investigating		
	Review of a quarterly	Minimum Data Set (MDS)			thoroughly all alleged abuse, and/or		
		dent #1, dated 9/22/2017			neglect as well as injuries noted or		
		had intact cognition. She			reported to determine etiology, and		
	required extensive as	sistance with toileting,			reporting such in a timely manner per		
		giene and bathing. She was			state regulatory requirements. This		
	-	o transfer herself with limited			education was also provided to the new		
		bed and wheelchair. Her			Director of Nursing on 11/15/2017 by the	he	
	weight was 115 poun	as.			Director of Operation.		

Event ID: 5GBQ11

Facility ID: 943230

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			a			IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING	<u> </u>		
						С
		345213	B. WING			1/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BO	DULEVARD	
				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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 225	Continued From page	e 39	F 22	25		
				On 11/14/2017 at approxima	ately 9.00PM	
	An interview was con	ducted on 11/13/2017 at		Director of Rehabilitation at	-	
		ent #1. Resident #1 stated		followed by the facility Direc		
		t her mind was not. She		services interviewed resider		
	-	eks ago, she was not sure		Resident #1 voiced that on		
	-	a bowel movement (BM) and		approximately between 6:00		
		it 6:00 AM. The resident got		AM, she had an episode of l		
	in her wheel chair an			she wheeled herself to the b		
		I on the bathroom call light		turn the bathroom call bell o		
		and help clean her up. She		Aide #2 responded to the ca	-	
		was not her night NA, came		the resident she will notify h		
		I turned off the call light and		Nurse Aide (Nurse Aide #1),	•	
	told her if someone didn't come to help her after a			assigned aide is not back to		
		ight back on. The resident		she asked resident #1 to tu		
	-	t was from the big numbered		back on (no time lapse spec	-	
		and that faced the bathroom.		morning of 10/26/2017, duri		
		ne waited for a long time,		round, noted resident #1 to	-	
		ause she didn't want to get		Nurse Aide #3 communicate		
		r. She stated she was cold		Aide #1 about resident#1 be		
	-	elled bad, and she was		asked for Nurse Aide #1 to o	•	
	embarrassed. Resid	ent #1 stated that NA #3, the		resident#1 before leaving or	n 10/26/2017.	
		the bathroom and asked		Nurse Aide #1 provided care		
	-	en waiting, and the Resident		Resident#1 and gave her a		
		NA #3 told her she was		10/26/2017.		
	going to get NA #1. I	NA #1 came in and was real				
	mad and kept saying	that the other NA should		Resident #1 added that Nur	se Aide#1	
	have cleaned her up.	The Resident stated she		pushed her and grabbed he	r on the arm,	
	stood up and NA #1	grabbed her by the arm and		which caused a bruise. Res	dent #1	
		it here," moved her over and		added that she reported this	-	
		rd on the shower seat, then		Nurse Aide #3 on 10/26/17,		
		d. Resident #1 said she		on 10/30/2017, and Director	-	
		d. Resident #1 said she		on 10/30/2017. Interview wit		
	-	"you don't have to treat me		#4 by the Center Executive		
	-	e shower was over the		conducted on 11/13/2017 re		
		e NA's name, and the NA		reported the Allegation made		
		sident #1 stated she gave me		#1 to the Center Human Res		
	-	nd pointed to her inside right		Director on 10/30/2017. Inte		
	wrist, and indicated tl	ne bruise was about 2" by 3"		Nurse Aide #3, and Nurse A	ide # 4 did not	
		e bruise was not visible on		report this allegation to their		

Facility ID: 943230

If continuation sheet Page 40 of 99

		MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · /	IPLETED
						С
		345213	B. WING		1	1/16/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOU	JLEVARD	
UNIVERS		NGTON		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 225	Continued From page	a 40	F 22	5		
1 225				-	voqutivo	
		ident confirmed that the y by now. NA #3 came to		supervisor and the center s E		
	-	had left and the Resident		Director per facility Abuse Pro policies and procedures revis		
		e name of NA #1 was, but		2017. Director of Human Res		
		t know. Resident #1 told NA		reported the Allegation to Dire		
		ed in the shower, and NA #3		Nursing #1 on 10/30/2017 and		
		rt it to the Social Worker		executive Director via written		
		stated she wheeled herself to		on 10/30/2017 that was read		
		r 3 days after and asked to		Center Executive Director on	-	
		SW never came, so the next		Nurse Aide #3, Nurse Aide #4		
		l about it after NA #4 saw her		report this allegation to their o		
		stated she went to the		supervisor and the center s E		
		lloween, and was frustrated		Director per facility Abuse Pro		
		not contacted her. A lady at		policies and procedures revis		
		id she need to tell the SW,		2017. Director of Human Res		
	and Resident #1 state	ed she just stuck out her arm		reported the Allegation to Dire		
	with the bruise, and t	he lady said she was the		Nursing #1 on 10/30/2017 and	d to the	
	Director of Nursing ([DON), and she could help.		executive Director via written	statement	
	The DON transported	the Resident that day to the		on 10/30/2017 that was read	by the	
	SW office and said w	e need to get started on		Center Executive Director on	10/31/2017	
	interviews. The DON	I came back a couple of				
	days later and told Re	esident #1 the decision was		IMMEDIATE ACTION		
	up to the DON and sl	he decided not to fire the NA,		On 10/31/2017 and 11/3/2017		
		ifferent hall and gave her		hour report and a 5 day repor		
		e Resident stated she		to the Department of Health a		
		ces, but afterward, she was		Services respectively, related		
	worried that NA #1 w	ould let her temper explode		#1 s allegation of abuse made		
	on someone else.			10/26/2017. These reports w		
				completed and submitted by t		
		led the facility filed a 24-Hour		Director of Nursing #1. Five d	• •	
	-	epartment of Health and		completed on 11/3/2017 indic		
		10/31/2017 for resident		investigation that was not det		
		The alleged description was:		enough. On 11/13/2017 anoth		
		Aide pushed her in the		report was completed after de		
		Hour Report listed the		investigation conducted by the		
		nformation" as NA #1. The		Executive Director, Director o		
	Report was signed by	y the Director of Nursing.		Services and/or Director of N	-	
	1		1	I upo invoctigation conducted (17/17/2017	1
	Deserved	aled the facility filed a		The investigation conducted by the Center Executive Direct		

Facility ID: 943230

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						O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED
						С
		345213	B. WING		1	/16/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	AL HEALTH CARE LILLI	NCTON		1995 EAST CORNELIUS HARNETT B	OULEVARD	
UNIVERS		NGTON		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 225	Continued From page	- 41	F 2	25		
1 225	1.0		F Z.		of	
		rt to the Department of ervices on 11/1/2017 for		of Social services, Director		
	resident abuse and n			Rehabilitation Center and N interviewing 100% of all cu	-	
		sident stated that aide		oriented residents in the fac		
		throom and was rough and		determine if any other resid		
		rist. Education teaching		allegation of abuse or negle		
		emoved from Hall. (The		the alleged perpetrator (Nu		
	-	t NA #1, was a different		No other residents alleged	,	
	aide. Was not a han	d print bruise upon		neglect that involve the alle		
	investigation." The 5	-Working Day Report listed		perpetrator. Likewise, the I	Director of	
	the "Accused Individu	ual Information" as NA #1.		Human Resources conduct	ed interviews	
	The Report was signed by the Director of			with current employees who	o were on duty	
	Nursing.			on 10/26/2017 between the		
				to determine if any staff on		
		by NA #1 included with the		any abuse and/or neglect to		
		rt revealed she was in the		Resident #1 specifically fro		
		nd when NA #2 told her		Perpetrator (Nurse Aide #1	,	
		her. NA #1 said she was ent ready for an appointment		staff witness any abuse and Resident s #1 allegation of		
		ould not go back down to		on 10/26/2017 was unsubs		
		ecause her resident needed		on findings of investigation		
		the hall to get breakfast for		Nurse Aide #1 did not care		
		in finished doing her rounds		#1 at the time of investigation		
	and charting. When	•		Center practice to suspend		
		she "actually forgot about		Perpetrator at the time of in		
	going back down the	re" because she had found a		any alleged Abuse and/or N		
	few things on the hall	that needed to be corrected				
		t. NA #1 gave report to		IDENTIFICATION OF OTH		
	oncoming NA #3, and			100% audit was completed	•	
		1's call light and NA #1 had		Executive Director for all all	-	
		ident #1's room. When NA		abuse and/or neglect repor		
	-	arting NA #3 came up to her		Carolina Department of He		
		dent #1 was in a mess and		Human Services in the last		
		r in the bathroom with the		determine if the alleged per		
		got towels and wash cloths		was/were suspended during		
		the hall, and cleaned up the		investigation period. This a identified whether the 24 ho		
		e been prevented if NA #2 Resident #1 on the toilet. NA		days reports are completed		
	ι νέσαια παντ μοι σαι τ		1			1

Facility ID: 943230

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		MEDICAID SERVICES				D. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		COM	SURVEY PLETED
		345213	B. WING			C / 16/2017
NAME OF P	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
		NGTON	1	995 EAST CORNELIUS HARNETT BOU	LEVARD	
UNIVERS	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 PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 225	Continued From page	a 42	F 225			
1 220			F 225	regulation and Elder Justice A	at in a timely	
		le." After calming the		regulation and Elder Justice A	-	
		what happened and the		manner. The audit revealed al		
		d put on the call light and NA		reportable in the last 12 month		
		light and told her she was NA #2 had told the resident		with detail investigation and th Perpetrator(s) were suspender		
		me then turn on your light		was completed on 11/15/2017		
		e resident a shower and				
		around 7:30 AM on that		100% audit of all current reside	ents clinical	
		was signed on 11/1/2017 by		documentation within the last		
	NA #1.			completed by the Director of N		
				Assistant Director of Nursing a	-	
	On 11/13/2017 at 4:3	5 PM, an interview was		Supervisor to determine if ther		
	conducted with NA #	1, who requested only to be		documentation in any resident	s medical	
	interviewed with the I	DON present. NA #1 stated		records that indicate allegatior	n of abuse,	
		called was between 6:00 and		neglect, and/or misappropriation		
		told her that Resident #1		resident s properties, if any, de		
		ce, and so she went in and		whether a 24 hours and 5 days		
		had been giving a bath to		investigation reports were com	•	
		l so it was a little while		reported to the state agency a officials as required by regulat		
	before she was able	stated she went to Resident		Elder Justice Act. The audit re		
		had given report to day		other documented allegation of		
	shift, and the Resider			and/or neglect documented in		
		ed the Resident up to the		medical records. This audit wa		
		Resident grabbed hold of it		completed on 11/15/17. Findin		
		IA then gave her a shower		audit is documented on clinica		
		e stated the Resident was		audit tool located at the facility		
		med her down, told her not ly, about her being left in the		compliance binder.		
	bathroom. When ask			On 11/15/2017, 100% interview	ws was	
		17, that she forgot to go back		completed by the Director of S		
		lent up, and that she had		Services, Director of Rehabilita		
	given report to day sh	nift before she went in to		Services, Dietary Manager, Bu	isiness	
		ust shrugged her shoulders		office manager and/or Medica		
		t long for the resident to wait		clerk for all current alert and o		
		could remember. Further		residents in the facility to ident		
	questions were answ	ered with the same		resident with allegation of Abu	-	
	response.			and or Misappropriation of pro		
				Four other residents, Resident	#2,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 943230

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PRINTED: 01/02/2018 FORM APPROVED

		MEDICAID SERVICES				<u> 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	IPLE CONSTRUCTION	. ,	E SURVEY PLETED
			A. BUILDIN	IG		
		345213	B. WING			C
		545215				/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
UNIVERS	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNET	BOULEVARD	
	1			LILLINGTON, NC 27546		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	C PROVIDER'S PLAN C C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIC DATE
F 225	Continued From page	- 43	F 2	225		
	10	nent by NA #2 included with		-	and Resident #5	
		eport revealed that NA #2		Resident #3, Resident #4 voiced allegation of abuse		
		r Resident #1 who was		misappropriation of reside	-	
		om. The NA turned off the		Alleged perpetrators susp		
		ident she needed to get		investigation by the facilit		
		er cleaned up. NA #2 walked		director, 24 hour report si	-	
		told her Resident #1 needed		11/14/2017, thorough inve		
	-	own the hall and said, "oh		initiated, resident attendir	-	
		ck down there, I already		Responsible Party notifie	•	
		I'm not going back." NA #2		allegation. Resident #2, #		
	said she was doing s			be informed of the finding		
	moment. NA #2 went	t back to her hall and NA #1		taken when the investigation		
	went into another res	ident room. NA #2		by the Center Executive I	Director and/or	
	documented she was	informed of a complaint		Director of Social Service	S.	
	against her by Nurse	#1, who had received all her				
	information from NA #	#1 and not the resident.		SYSTEMIC CHANGES		
		8 PM, a phone interview was		Effective 12/28/2017, inte	erviews for alert	
	conducted with NA #2	NA #2 stated she was		and oriented residents wi	II be completed	
		all, and went to the 600 hall		by the Director of Social S		
		n call light. Resident #1 was		of Recreational Services	and/or	
	-	om, sitting in her wheelchair		designated staff member		
	-	Il light. The NA smelled BM,		every quarter to identify a		
		ke some time to clean her		Abuse, Neglect and or Mi		
		said she needed help to be		properties. This interview		
		tated she told the Resident		incorporated to social ser		
	•••	a gown and stuff, and then		assessment schedule and		
		o the room NA #1 was in. t Resident #1 needed her.		on psychosocial assessr voiced allegation of abuse	-	
		s not going back in that		misappropriation of reside	-	
		get linens and proceeded		will be reported to the Ce		
		NA #2 stated when she		Director promptly. Alleged		
		10/31/2017, Nurse #1 told		will be suspended pendin		
		ad been made against her for		by the facility, and reported		
	-	DON told NA #2 there was		the regulatory requirement	-	
		had pushed Resident #1 in		Effective 12/28/2017, the		
	-	en cut the light off. NA #2		administrative team, which	-	
		nove her to another hall to		Nurse supervisors, and/o		
		and Nurse #1, and the DON	1	process for reviewing clin		1

Facility ID: 943230

If continuation sheet Page 44 of 99

						O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	E SURVEY IPLETED
			A. BUILDING	<u> </u>		С
		345213	B. WING			
	ROVIDER OR SUPPLIER	0.0210		STREET ADDRESS, CITY, STATE, ZIP		/16/2017
				1995 EAST CORNELIUS HARNETT		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546	BOOLLVARD	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	COMPLETIC
F 225	Continued From page	e 44	F 22	25		
		part of the facility. NA #2		documentation for the last	t 24 hours.	
		ow if she had neglected the		completed skin assessme		
		ow if this incident was a		reports for the last 24 hou		
	dignity issue or some	thing else.		Physician orders written in		
				hours to ensure that any a	allegation of	
		4 AM, an interview was		abuse, neglect, misappro		
		3. NA #3 stated Resident #1		resident s properties and/		
		nd could propel herself to		unknown sources reported		
		vheelchair. She has been		investigated thoroughly, a	-	
		nd when she had soiled		perpetrator is suspended investigation, and reported		
		t clean herself up from that. norning of 10/26/2017, she		Executive Director per cer		
	received report from NA #1 that Resident #1 was			policy.		
		NA #1 had been busy so NA		policy		
		light and told NA #1 that		Effective 12/28/2017, 24-	hour and 5-days	
		ded her. Shortly after, NA #3		investigation reports are o	•	
		#5 when Resident #1's call		reviewed by the Executive		
	light went on. NA #3	went into Resident #1's		submitted to the state age	ency and other	
		ent #1 told her the NA's had		officials as required by reg		
	· ·	NA #3 looked at her and saw		Elder Justice Act. This sys		
	BM on her gown and	•		will take place daily (Mono		
		e BM, and she was crying		Friday). Any identified issu		
		d the Resident she would		addressed promptly and a		
		A #3 went up the hall and		actions will be implemented	•	
		n't leave until she cleaned up		Executive Director, DON,		
		aised her voice and there ation between the two, and		Nurse Supervisor. This pr incorporated in a daily sar		
		would go down and give the		Any negative findings will		
		NA #3 stated she had talked		on the daily stand up me		
		later that morning, and was		maintained in the daily sta	0	
		had and mean and rough		binder.	. 5	
		bbed her hard, and she was				
	scared of her. The R	esident asked the name of		Effective 12/28/2017, wee	ek end	
		I her she didn't know. NA #3		Registered Nurse supervi		
		se to anyone, and told the		designated licensed nurse		
		better if she reported it		clinical documentation for		
		ne Resident did not show NA		hours, completed skin ass		
	#3 the bruise at that t	ime, and thought the		incident reports for the las	st 24 hours, and	

Facility ID: 943230

If continuation sheet Page 45 of 99

			()(0)			<u>10. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	TE SURVEY MPLETED
			A. BUILDING	3		С
		345213	B. WING			1/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		1/10/2017
0.002 01 1				1995 EAST CORNELIUS HARNETT BO		
UNIVERS	AL HEALTH CARE LILLI	NGTON		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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 225	Continued From page	- <i>1</i> E	F 02			
F 225			F 22			
		spoken to the DON. NA #3		hours to ensure that any alleg		
		through abuse training, but		abuse, neglect, misappropria		
		e had not reported the		resident s properties and/or in		
	abuse.			unknown sources reported/do		
	On 11/12/2017 at 2.2	3 PM, an interview was		investigated thoroughly, alleg		
		lent #1's family member.		perpetrator is suspended per investigation and reported to		
		Resident had told them of		Executive Director. This syste	•	
		b her in the shower, that		will take place every Saturda		
	•	2017. The family member		Sunday. Any negative finding		
		s phone for 3 days in a row,		documented on the week en		
		d not been set up and she		report form and maintained i		
		a message. The family		clinical meeting binder.	In the daily	
		he facility's office in another				
		corporate person about a		Effective 12/28/2017, All alleg	red violations	
		member stated that by the		involving abuse, neglect, exp		
	time she met with the			mistreatment, including injurio		
		had called her about the		unknown source and misapp		
	abuse allegation.	had called her about the		resident property, are reporte	•	
				immediately, but not later tha		
	On 11/13/2017 at 1·4	7 PM, an interview was		after the allegation is made, i		
		4. NA #4 stated Resident #1		that cause the allegation invo		
		d, and could tell you about		result in serious bodily injury,		
		remembered who NA #4		than 24 hours if the events th		
		d Resident #1 needed help		allegation do not involve abus		
		ssing. Resident #1 could		result in serious bodily injury.		
	take herself to the toil	-		will be done in person, or via	•	
		nt accident, she needed help		facility staff on duty to the em		
		b. NA #4 stated Resident #1		direct supervisor and the adn		
		her right inner wrist to her,		the facility.	-	
		been pushed when in the				
		dled, and was so scared and		Effective 12/28/2017 The fac	lity	
		t to be at the facility. The		Administrator, Director of Hea	-	
		patient Bill of Rights to see		Director of social services an		
		out it. The NA stated this		designated licensed nurse wi		
		loween, but was not sure of		alleged violations involving al		
		ted she left the Resident's		neglect, exploitation or mistre		
	room to see about ge	tting her a Bill of Rights, and		including injuries of unknown		
		er tell someone of the		misappropriation of resident		

Facility ID: 943230

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · /	E SURVEY PLETED
			A. BUILDING	<u> </u>		С
		345213	B. WING		11	/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I	
				1995 EAST CORNELIUS HARNETT BOULE	/ARD	
UNIVERS	AL HEALTH CARE LILLI	NGTON		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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 225	Continued From page	e 46	E 22	55		
1 225			F 22		h a	
		the HR manager at the d her there was abuse in the		immediately, but not later than 2		
		ager stated the Administrator		after the allegation is made, if the that cause the allegation involve		
	and DON needed to	-		result in serious bodily injury, or i		
		N and then wrote a report.		than 24 hours if the events that c		
	Manager tola the De			allegation do not involve abuse a		
	A review of a docume	ent dated 10/30/2017, written		result in serious bodily injury. The		
		Irce Manager (HR) was		will be made to State Survey Age		
		Manager reported she was		adult protective in accordance wi		
		lurse's Station when she was		law through established procedu		
	notified by NA #4 tha	t abuse was going on in the				
	facility. NA #4 told he	er Resident #1 was scared to		Effective 12/28/2017, Director of	Health	
	stay at the facility, an	id the NA saw bruises on		Services, Director of Social Servi	ces	
		IR told NA #4 she was going		and/or Assistant Director of Heal		
	1 · ·	tor of Nursing (DON) about		Services will report the results of		
		told the DON and the DON		investigations to the administrato		
		ng and stated she was going		or her designated representative		
	to address it.			other officials in accordance with		
				law, including to the State Survey		
		ducted on 11/13/2017 at		within 5 working days of the incid	ent, and	
	4:04 PM, with the HR	-		if the alleged violation is verified		
	-	was at the 500/600 Hall		appropriate corrective action mus	st de	
	-	NA #4 had called her over		taken.	orting	
		ident #1 was scared to stay e NA #1 had been really		Effective 12/28/2017, Abuse report process will be discussed to curr		
	-	e her a bruise. NA #4		and oriented residents every mo		
	-	he saw the bruise on the		during resident council meeting a		
		someone would've grabbed		least quarterly during each reside		
		er told NA #4 we have to		plan meeting. This process will b		
		e HR Manager talked to the		managed by the Center Director		
)17 before she went home.		Services effective 12/28/2017.	-	
		R Manager she would take				
		vas late, and so the HR		Facility Executive Director, Director	tor of	
		and wrote up the report, and		Nursing (DON), and/or Director c		
	took it to the Adminis	trator when she came in on		Services will complete 100% re-e		
	10/31/2017.			on the facility s abuse/neglect po	licy	
				including notification, protection,		
		12 PM, an interview was		investigation protocols. This educ		
	conducted with the D	irector of Nursing (DON).		be provided for all employee, to i	ncluda	1

Facility ID: 943230

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		ND HUMAN SERVICES				FO	ED: 01/02/20 RM APPROVE
TATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345213	B. WING _				C 1/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		1/10/2011
					5 EAST CORNELIUS HARNETT BOULEVARI)	
UNIVERS	AL HEALTH CARE LILLI	NGTON			LINGTON, NC 27546	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 225		d repeated many times, that	F 2	225	full time, part time and as needed sta	aff.	
	nurse's desk and said SW. The DON told F	esident #1 came to the d she was looking for the Resident #1 that she could			This education will be completed by 12/28/2017. Any employee not educ by 12/28/2017 will not be allowed to until educated. This education will all	work so be	
	bruise on it. Resider grabbed and pushed DON stated she imm	1 showed her arm with the at #1 told her the NA had her in the shower. The rediately wheeled Resident d the SW the bruise, and			added on new hires orientation proce for all new employees effective 12/28/2017, and will also be provide semi-annually.		
	told the SW she was interviews. The DON Report, and then talk				MONITORING PROCESS Effective 12/28/2017, Executive Dire and or Director of Social Services wi		
	wrist, and it wasn't a indicated that if a NA	nd bruise on the Resident's hand print bruise. The DON had grabbed Resident #1's eft a hand print bruise,			review all alleged violation to ensure thorough investigation is completed reported to the state agency and oth officials as required by regulation an	and ner	
	always see the hand The DON stated the	n Caucasians, you could print if they were grabbed. bruise must have come from cation, as she was on Plavix			Elder Justice Act. Any issues identifi during this monitoring process will be addressed promptly. Findings from t monitoring process will be document	e his	
	(a blood thinner), and after she talked to NA not the NA who had p	d aspirin. The DON stated A #1, she realized that was pushed the resident to the he Resident was already in			abuse prohibition tool and filed in da meeting binder after proper follow up done. This monitoring process will ta place daily to include Saturdays and	aily os are	
	the bathroom when N The DON stated that #1 into the bathroom	NA #1 went in to shower her. NA #2 had pushed Resident , but she had no proof that used, so she decided to give			Sundays for 2weeks, weekly $x 2$ mol weeks, then monthly $x 3$ months or u the pattern of compliance is maintain	Intil	
	NA #2 a second char different hall, and tha The DON stated she	nce and moved NA #2 to a at had been her decision. had called Resident #1's			Effective 12/28/2017, Director of Nur will report findings of this monitoring process to the facility Quality Assura and Performance Improvement	-	
	meeting with the corp person had told her e family, so she though	old her they already had a porate people. A corporate everything was fine with the ht everything was settled.			Committee for any additional monito or modification of this plan monthly x months, or until the pattern of compl	3 ance	
		ked Resident #1 if she had d, or any of the details of the			is maintained. The QAPI committee modify this plan to ensure the facility		

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PRINTED: 01/02/2018 FORM APPROVED

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345213	B. WING		C 11/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				1995 EAST CORNELIUS HARNETT BOU	
UNIVERS	AL HEALTH CARE LILLI	NGTON		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIN
F 225	Continued From page	<u>- 48</u>	F 22	5	
	incident, and her only	documentation of what dent was the sentence she		remains in substantial complia	ince.
	wrote on the 24-Hour DON stated the Admi abuse allegation on 1	and 5-Day Reports. The inistrator had told her of the 0/31/2017, but she had told v. When the DON was		TITLE OF THE PERSON RES FOR IMPLEMENTING THE C ALLEGATION	
asked if she knew about the abuse allegation from the Human Resource Manager on 10/30/2017, the DON stated again that the first she heard of the allegation was when the Resident told her on 10/31/2017.		out the abuse allegation ource Manager on I stated again that the first gation was when the		Effective 12/28/17, the center Director and the Director of Na be ultimately responsible to er implementation of this plan of to assure the facility remains i substantial compliance.	ursing will nsure correction
	4:18 PM, with Nurse a did not know anything morning of 10/26/201 when she and NA #1 500/600 hall, so the s reviewed. The Nurse the next night, which 10/26/2017, by NA #7 Resident #1 to the ba while she went to tell she worked the even to NA #2 on the morn her why she had take bathroom and not con her she had to finish resident. Nurse #1 to been filed against her according to a report and she did not think dignity. She had told resident to the bathroo Nurse #1 stated she 11/2/2017 that NA #2	mpleted the task. NA #2 told taking care of her own old NA #2 that a report had			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/02/2018 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345213	B. WING		_		_ 16/2017
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLIN	IGTON		1995 EAST CORNELIUS H LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	abuse allegation when report from the HR Ma informed the DON abu- his opinion the 24-Hoo Report reflected a tho- interview with the resi- concerning that NA #4 was fearful, but would On 11/14/2017 at 11:0 conducted with the SV had brought Resident and showed the SW t SW stated the bruise size on her inner right would handle it. The steps taken to investig that the DON had to r On 11/14/2017 at 5:57 of IJ. The facility prov allegation of complian DATE: 11/15/2017 PROCESSES THAT I DEFFICIENCY CITED This alleged noncomp Center's Director of N of regulatory requirem conduct the detail inve of abuse or neglect. "" way she understood is document what reside and a 5-day report Director of Nursing #1 the Center effective 1	Iministrator. The e had been informed of the n he received a written anager on 10/31/2017. He but the report. He stated in ur Report and the 5-Day rough investigation and dent. He stated it was a had reported the Resident make no other comments. 00 AM, an interview was N. The SW stated the DON #1 to her on 10/31/2017, he Resident's bruise. The was a little less than quarter wrist. The DON stated she SW was not familiar with the gate abuse, and only knew eport it to the State. 7 PM the facility was notified ided the following credible ce on 11/16/2017. EAD TO THE ALLEGED Miance resulted from the ursing #1 misinterpretation tents related to how to estigation of any allegation The former DON stated the	F 225				

Facility ID: 943230

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUR	938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· /	<u> </u>	COMPLETE		
					С		
		345213	B. WING		11/16/2017		
NAME OF PF	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP		CODE		
UNIVERSA	L HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	EVARD		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO		(XE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE CO E APPROPRIATE	(X5) DMPLETIO DATE	
F 225	Continued From page	2 50	F 22	25			
	effective 10/15/2017.						
		tion from the Management					
	and consulting compa	-					
		he Center Executive Director					
	and the Director of N	ursing #1 on 11/14/2017 on					
		ohibition and Investigation					
		es, and emphasized the					
		ing resident(s), to include					
		ed perpetrator during the					
	÷ .	investigating thoroughly all					
		r neglect as well as injuries letermine etiology, and					
	-	nely manner per state					
		nts. This education was also					
	provided to the new [
	11/15/2017 by the Dir						
		proximately 9:00PM Director					
	of Rehabilitation at th	e center followed by the					
		cial services interviewed					
	resident #1. Residen						
		ately between 6:00 AM and					
		episode of loose stool, she					
		e bathroom and turn the					
		Nursing Aide #2 responded					
		d the resident she will notify ide (Nurse Aide #1), and if					
	•	not back to care for her, she					
	-	turn the light back on (no					
	time lapse specified).						
		itial round, noted resident #1					
	•	ide #3 communicated to					
	Nurse Aide #1 about	resident#1 being soiled and					
		#1 to clean the resident#1					
	-	26/2017. Nurse Aide #1					
		dent#1 and gave her a					
	shower on 10/26/201	7.					
	Desides (14 11 11 11)	at Nicona Add. #4					
		hat Nurse Aide#1 pushed her he arm, which caused a					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/02/2018 M APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345213	B. WING				C / 16/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			1995 EAST CORNELIUS HARNETT BOULEVARI LILLINGTON, NC 27546)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Aide #4 on 10/30/201 #1 on 10/30/2017. Int by the Center Executi 11/13/2017 revealed a made by Resident #1 Resources Director of Nurse Aide #3, and N this allegation to their center's Executive Din Prohibition policies ar 2017. Director of Hur Allegation to Director 10/30/2017 and to the written statement on the Center Executive Nurse Aide #3, Nurse allegation to their direc center's Executive Din Prohibition policies ar 2017. Director of Hur Allegation to their direc center's Executive Din Prohibition policies ar 2017. Director of Hur Allegation to Director 10/30/2017 and to the written statement on the Center Executive On 10/31/2017 and to the written statement on the Center Executive On 10/31/2017 and 1 and a 5 day report we of Health and Human related to resident #1' on 10/26/2017. Thes and submitted by the #1. Five days report of indicated an investigat enough. On 11/13/20 completed after detail the Center Executive Services and/or Director The investigation con	de #3 on 10/26/17, Nurse 7, and Director of Nursing erview with Nurse Aide #4 ive Director conducted on she reported the Allegation to the Center Human in 10/30/2017. Interview with urse Aide # 4 did not report direct supervisor and the rector per facility Abuse and procedures revised June man Resources reported the of Nursing #1 on e executive Director via 10/30/2017 that was read by Director on 10/31/2017 Aide # 4 did not report this act supervisor and the rector per facility Abuse and procedures revised June man Resources reported the of Nursing #1 on e executive Director via 10/30/2017 that was read by Director on 10/31/2017 Aide # 4 did not report this act supervisor and the rector per facility Abuse and procedures revised June man Resources reported the of Nursing #1 on e executive Director via 10/30/2017 that was read by Director on 10/31/2017 1/3/2017, the 24 hour report ere sent to the Department Services respectively, 's allegation of abuse made e reports were completed former Director of Nursing completed on 11/3/2017 ation that was not detailed 17 another 5 day report was l investigation conducted by Director, Director of Social	F	225			

Facility ID: 943230

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/02/2018 // APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				.	1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 225	MDS nurse by intervie alert and oriented res determine if any other allegation of abuse or alleged perpetrator (N residents alleged abu involve the alleged abu involve the alleged abu involve the alleged abu interviews with currer duty on 10/26/2017 b determine if any staff abuse and/or neglect specifically from Alleg #1). No other staff wit neglect. Resident's # on 10/26/2017 was un findings of investigation #1 did not care for Re investigation. It is the the Alleged Perpetrate investigation of any a Neglect. THE PROCEDURES ACCEPTABLE CRED THE ALLEGED IMME 100% audit was comp Executive Director for and/or neglect reported Department of Health last 12 months to dete perpetrator(s) was/we investigation period. T whether the 24 hours completed and submi required by regulation timely manner. The a reportable in the last	Rehabilitation Center and ewing 100% of all current idents in the facility to r resident voiced and r neglect that involve the Nurse Aide #1). No other use and/or neglect that erpetrator. Likewise, the esources conducted at employees who were on etween the 6AM and 7AM to on duty witnessed any towards Resident #1 ged Perpetrator (Nurse Aide tness any abuse and/or 1 allegation of abuse voiced non conducted. Nurse Aide esident #1 at the time of Center practice to suspend or at the time of lleged Abuse and/or FOR IMPLEMENTING THE DIBLE ALLEGATION FOR EDIATE JEOPARDY. pleted by the Center r all allegation of abuse ed to North Carolina and Human Services in the	F	225	5		

If continuation sheet Page 53 of 99

CENTER STATEMENT (AND PLAN OF NAME OF PI		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345213	. ,	ING _	E CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARI LILLINGTON, NC 27546	FORI OMB NC (X3) DATE COMF	D: 01/02/2018 M APPROVED D. 0938-0391 E SURVEY PLETED C /16/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ı. IX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Director of Nursing an determine if there is a resident's medical rec of abuse, neglect, and resident's properties, 24 hours and 5 days i completed and report other officials as requi- Elder Justice Act. The documented allegatio documented in reside audit was completed of audit is documented of tool" located at the fact On 11/15/2017, 100% by the Director of Soc Rehabilitation Service Business office mana- clerk for all current alle the facility to identify a allegation of Abuse, N Misappropriation of pr residents, Resident#2 and Resident #5 voice neglect and/or misapp properties. Alleged pe pending investigation director, 24 hour repo thorough investigation Physician and Respon allegation. Resident #5	t was completed on ent residents' clinical the last 30 days was ector of Nursing, Assistant ad/or Nurse Supervisor to iny documentation in any cords that indicate allegation d/or misappropriation of if any, determine whether a investigation reports were ed to the state agency and ired by regulation and/or e audit revealed no other n of abuse, and/or neglect int's medical records. This on 11/15/17. Findings of this on "clinical records audit cility compliance binder. • interviews was completed cial Services, Director of es, Dietary Manager, ger and/or Medical Records ert and oriented residents in any other resident with leglect and or roperties. Four other 2, Resident #3, Resident #4 ed allegation of abuse, propriation of resident's	F	225			

Facility ID: 943230

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	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345213	B. WING				C 16/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		10-01		1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		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
F 225	Executive Director an Services. Effective 11/15/2017, oriented residents will Director of Social Ser Recreational Services member at least once any allegation of Abus Misappropriation of pup process will be incorp quarterly assessment on "psychosocial asse allegation of abuse, n misappropriation of re reported to the Cente promptly. Alleged per pending investigation according to the regul Effective 11/15/2017, administrative team, v supervisors, and/or S reviewing clinical doc hours, completed skir reports for the last 24 orders written in the la any allegation of abus of resident's propertie sources reported/doc thoroughly, alleged per pending investigation Executive Director per Effective 11/15/2017, investigation reports a by the Executive Dire	interviews for alert and be completed by the vices, Director of and/or designated staff every quarter to identify se, Neglect and or roperties. This interview forated to social services eschedule and documented essment tool". Any voiced eglect and/or esident's properties will be r Executive Director petrators will be suspended by the facility, and reported latory requirements. the center nursing which includes DON, Nurse DC, initiated a process for umentation for the last 24 n assessments, incident hours, and Physician ast 24 hours to ensure that se, neglect, misappropriation es and/or injuries of unknown umented is investigated erpetrator is suspended , and reported to the facility r center's abuse policy. 24-hour and 5-days are completed and reviewed ctor before submitted to the	F	225			
	by the Executive Dire						

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DEPARTMENT OF HEALTH AND F CENTERS FOR MEDICARE & MEI					FORM	D: 01/02/2018 APPROVED D: 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345213	B. WING				C 16/2017
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSAL HEALTH CARE LILLINGT	ON			1995 EAST CORNELIUS HARNETT BOULEVARD		
				LILLINGTON, NC 27546		
PREFIX (EACH DEFICIENCY ML	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
	ustice Act. This systemic aily (Monday through sues will be addressed e actions will be cutive Director, DON, pervisor. This process daily sand up meeting. I be documented on the form" and maintained in ng binder. ek end Registered Nurse ated licensed nurse will ation for the last 24 ssessments, incident urs, and Physician 24 hours to ensure that neglect, misappropriation nd/or injuries of unknown ented is investigated etrator is suspended d reported to the facility systemic process will ay and Sunday. Any documented on the port form" and inical meeting binder. alleged violations exploitation or njuries of unknown tion of resident property, <i>y</i> , but not later than 2 n is made, if the events involve abuse or result or not later than 24 hours he allegation do not t result in serious bodily	F	225			

Facility ID: 943230

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE LILLIN	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD 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
F 225	other officials (includii Agency and adult pro law provides for juriso facilities) in accordance established procedure Effective 11/15/2017, investigations to the a designated represent: accordance with State Survey Agency, within incident, and if the all appropriate corrective Effective 11/15/2017, be discussed to currer residents every monter meeting and at least of resident care plan me managed by the Cent Services effective 11/ Facility Executive Director complete 100% re-ed abuse/neglect policy in protection, and invest education will be provinclude full time, part This education will be province include full time, part This education will also be orientation process for effective 11/15/2017, semi-annually.	ng to the State Survey tective services where state diction in long-term care ce with State law through es. Report the results of all administrator or his or her ative and to other officials in e law, including to the State in 5 working days of the eged violation is verified e action must be taken. Abuse reporting process will nt alert and oriented ths during resident council quarterly during each eterng. This process will be ter Director of Social 15/2017. ector, Director of Nursing or of Social Services will ucation on the facility's including notification, igation protocols. This rided for all employee, to time and as needed staff. e completed by 11/15/2017. ucated by 11/15/2017 will k until educated. This added on new hires or all new employees and will also be provided	F	225			

Facility ID: 943230

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	Director of Nursing ar determine if there is a resident's medical rec of abuse, neglect, and resident's properties, 24 hours and 5 days completed and report other officials as requ Elder Justice Act. The documented allegatio documented in reside audit was completed audit is documented of tool" located at the far On 11/15/2017, 100% by the Director of Soo Rehabilitation Service Business office mana clerk for all current at the facility to identify a allegation of Abuse, N Misappropriation of p residents, Resident#2 and Resident #5 voic neglect and/or misapp properties. Alleged pe pending investigation director, 24 hour repor thorough investigation physician and Respo allegation. Resident # informed of the finding the investigation is co Executive Director an Services.	nd/or Nurse Supervisor to any documentation in any cords that indicate allegation d/or misappropriation of if any, determine whether a investigation reports were ed to the state agency and ired by regulation and/or e audit revealed no other n of abuse, and/or neglect ent's medical records. This on 11/15/17. Findings of this on "clinical records audit cility compliance binder. b interviews was completed cial Services, Director of es, Dietary Manager, ger and/or Medical Records lert and oriented residents in any other resident with Neglect and or roperties. Four other 2, Resident #3, Resident #4 ed allegation of abuse, oropriation of resident's erpetrators suspended by the facility Executive ort submitted on 11/14/2017, n initiated, resident attending nsible Party notified of the #2, #3, #4 and #5 will be gs and actions taken when ompleted by the Center d/or Director of Social	F	225			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345213	B. WING				C 16/2017
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLIN	IGTON			1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	member at least once any allegation of Abus Misappropriation of pro- process will be incorp quarterly assessment on "psychosocial asse allegation of abuse, n misappropriation of re- reported to the Center promptly. Alleged per pending investigation according to the regul Effective 11/15/2017, administrative team, w supervisors, and/or S reviewing clinical doct hours, completed skir reports for the last 24 orders written in the la any allegation of abus of resident's propertie sources reported/doct thoroughly, alleged per pending investigation, Executive Director per Effective 11/15/2017, investigation reports a by the Executive Director state agency and other regulation and/or Elde	vices, Director of and/or designated staff every quarter to identify se, Neglect and or operties. This interview orated to social services schedule and documented essment tool". Any voiced eglect and/or sident's properties will be r Executive Director petrators will be suspended by the facility, and reported atory requirements. the center nursing which includes DON, Nurse DC, initiated a process for umentation for the last 24 assessments, incident hours, and Physician ast 24 hours to ensure that se, neglect, misappropriation s and/or injuries of unknown umented is investigated erpetrator is suspended and reported to the facility r center's abuse policy.	F	225			
	promptly and appropr implemented by the E	issues will be addressed iate actions will be xecutive Director, DON, Supervisor. This process					

Facility ID: 943230

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/02/2018 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345213	B. WING				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From page		F	225	5		
	Any negative findings	a daily sand up meeting. will be documented on the ng form" and maintained in eting binder.					
	supervisor and/or des review clinical docum hours, completed skir reports for the last 24 orders written in the la any allegation of abus of resident's propertie sources reported/doc thoroughly, alleged pe pending investigation Executive Director. The take place every Satu negative findings will "week end supervisor maintained in the dail	ast 24 hours to ensure that se, neglect, misappropriation as and/or injuries of unknown umented is investigated erpetrator is suspended and reported to the facility his systemic process will urday and Sunday. Any be documented on the report form" and y clinical meeting binder.					
	(DON), and/or Director complete 100% re-ed abuse/neglect policy is protection, and invest education will be provinclude full time, part This education will be Any employee not ed not be allowed to wor education will also be orientation process for effective 11/15/2017, semi-annually. 100% clinical documentation completed by the Director	igation protocols. This rided for all employee, to time and as needed staff. completed by 11/15/2017. ucated by 11/15/2017 will k until educated. This added on new hires					

Facility ID: 943230

If continuation sheet Page 60 of 99

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345213	B. WING				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2011
	AL HEALTH CARE LILLIN	ICTON		1	1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERS	AL HEALTH CARE LILLI	NGTON .		L	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	resident's medical rec of abuse, neglect, and resident's properties, 24 hours and 5 days completed and report other officials as requi- Elder Justice Act. The documented allegation documented in reside audit was completed audit is documented of tool" located at the fai Effective 11/15/2017, oriented residents will Director of Social Ser Recreational Services member at least once any allegation of Abus Misappropriation of pr process will be incorp quarterly assessment on "psychosocial asse allegation of abuse, n misappropriation of re reported to the Cente promptly. Alleged per pending investigation according to the regui- Effective 11/15/2017, administrative team, of supervisors, and/or S reviewing clinical doc hours, completed skir reports for the last 24	any documentation in any cords that indicate allegation d/or misappropriation of if any, determine whether a investigation reports were ed to the state agency and ired by regulation and/or e audit revealed no other n of abuse, and/or neglect ent's medical records. This on 11/15/17. Findings of this on "clinical records audit cility compliance binder. interviews for alert and I be completed by the vices, Director of a and/or designated staff e every quarter to identify se, Neglect and or roperties. This interview forated to social services e schedule and documented essment tool". Any voiced eglect and/or esident's properties will be r Executive Director petrators will be suspended by the facility, and reported latory requirements. the center nursing which includes DON, Nurse DC, initiated a process for umentation for the last 24 n assessments, incident	F	225			
	orders written in the la	-					

Facility ID: 943230

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345213	B. WING				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			995 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	sources reported/doc thoroughly, alleged pe pending investigation Executive Director pe Effective 11/15/2017, investigation reports a by the Executive Dire state agency and othe regulation and/or Elde process will take plac Friday). Any identified promptly and appropri implemented by the E ADON, and/or Nurse will be incorporated in Any negative findings "daily stand up meetin the daily stand up meetin the	es and/or injuries of unknown umented is investigated erpetrator is suspended , and reported to the facility r center's abuse policy. 24-hour and 5-days are completed and reviewed ctor before submitted to the er officials as required by er Justice Act. This systemic e daily (Monday through d issues will be addressed iate actions will be executive Director, DON, Supervisor. This process a daily sand up meeting. will be documented on the ofform" and maintained in eting binder. week end Registered Nurse signated licensed nurse will entation for the last 24 assessments, incident hours, and Physician ast 24 hours to ensure that se, neglect, misappropriation and/or injuries of unknown umented is investigated erpetrator is suspended and reported to the facility his systemic process will irday and Sunday. Any be documented on the report form" and y clinical meeting binder.	F	225			
	Facility Executive Dire	ector, Director of Nursing					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		NOTON		1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERS	AL HEALTH CARE LILLIN	IGION		L	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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	complete 100% re-ed abuse/neglect policy is protection, and invest education will be prov- include full time, part This education will be Any employee not ed not be allowed to wor education will also be orientation process for effective 11/15/2017, semi-annually. THE MONITORING F THAT THE CREDIBL EFFECTIVE AND RE IMMEDIATE JEOPAR Effective 11/15/2017, Director of Social Ser violation to ensure a t completed and report other officials as requ Elder Justice Act. Any monitoring process w Findings from this mo documented on "abus in daily meeting binde done. This monitoring daily to include Saturd 2weeks, weekly x 2 m 3 months or until the p maintained. Effective 11/15/2017, report findings of this facility Quality Assura Improvement Commit	br of Social Services will function on the facility's including notification, figation protocols. This vided for all employee, to time and as needed staff. e completed by 11/15/2017. ucated by 11/15/2017 will k until educated. This e added on new hires or all new employees and will also be provided PROCEDURE TO ENSURE E ALLEGATION IS MOVE THE ALLEGED RDY Executive Director and or vices will review all alleged thorough investigation is ed to the state agency and ired by regulation and/or y issues identified during this ill be addressed promptly. onitoring process will be se prohibition tool" and filed er after proper follow ups are g process will take place days and Sundays for nore weeks, then monthly x pattern of compliance is Director of Nursing will monitoring process to the ince and Performance	F	225			

Facility ID: 943230

If continuation sheet Page 63 of 99

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	
		345213	B. WING				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
		10701			1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERS	AL HEALTH CARE LILLIN	IGION			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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 225	months, or until the paramaintained. The QAP plan to ensure the fact compliance. TITLE OF THE PERS IMPLEMENTING THE Effective 11/15/17, the and the Director of He ultimately responsible of credible allegation immediate jeopardy. Compliance Date: 11/ The Credible Allegation 11/16/2017 by the foll 1. The survey team current resident's med records audit tool", wh documentation that w of abuse, neglect, mis properties and /or inju 2. The survey team incidents within the la completed to identify injuries. 3. The survey team provided by staff and team conducted staff staff. The staff intervi in-service regarding a reporting, and recogn staff burnout. 4. The survey team and oriented residents	attern of compliance is I committee can modify this ility remains in substantial ON RESPONSIBLE FOR E CREDIBLE ALLEGATION e center Executive Director ealth services will be to ensure implementation to remove this alleged 15/2017 on was verified on owing: reviewed the audit of dical records titled "clinical nich reviewed ould indicate any allegation appropriation of resident's ries of unknown sources. reviewed the audit of all st 30 days which was any unknown source of reviewed the in-service signed by staff. The survey interviews with 16 on-duty ewed confirmed the recent	F	22	5		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/02/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345213	B. WING				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER	I	- I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLI	NGTON			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From page	e 64	F	226			
F 226 SS=J	DEVELOP/IMPLMEN POLICIES CFR(s): 483.12(b)(1)	IT ABUSE/NEGLECT, ETC	F	226			12/28/17
	CFR(S). 403. 12(D)(1)	-(3), 403.95(0)(1)-(3)					
	483.12 (b) The facility must c written policies and p	levelop and implement rocedures that:					
		ent abuse, neglect, and nts and misappropriation of					
	(2) Establish policies investigate any such	•					
	(3) Include training as §483.95,	s required at paragraph					
	the freedom from aburequirements in § 483	nd exploitation. In addition to use, neglect, and exploitation 3.12, facilities must also eir staff that at a minimum					
		onstitute abuse, neglect, appropriation of resident at § 483.12.					
		reporting incidents of abuse, or the misappropriation of					
	prevention.	agement and resident abuse					
	Based on observatio	n, resident interview, staff I review the facility failed to			F226 ROOT CAUSE		

Facility ID: 943230

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,		· · ·	IPLETED
				·		С
		345213	B. WING	·····	1	1/16/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT	BOULEVARD	
UNIVERSA	AL HEALTH CARE LILLI	NGTON		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 226	Continued From page	2 65	F 22	6		
		he areas of prevention,	1 22	This alleged noncomplianc	e resulted from	
		on and reporting for staff to		the Center s former Directo		
		se for 1 of 1 sampled		#1, Nurse Aide #3 and Nur	-	
	residents (Resident #	1).		failure to follow the Abuse		
				Policies and procedures re		
	The immediate jeopa			2017. Director of Nursing #		
		rse Aide (NA) #1 grabbed		follow the facility policies p		
	•	rists and sat her down hard		she failed report an allegat		
		the resident's bathroom,		resident #1 to the Executiv		
	-	o her right wrist, and not ation. The IJ was removed		timely. Former Director of I failed to protect the resider		
		the facility's acceptable		abuse as she did not susp	•	
		as verified. The facility		#1 during investigation per		
	remains out of compl			failed to notify the resident		
		al harm with the potential for		#1 responsible party of the		
	more than minimal ha	arm that is not IJ) to allow		investigation and actions ta	aken post	
	•	and implement its plan of		investigation for Resident	#1 allegation of	
	correction for abuse.			abuse voiced on 10/26/207		
				Director of Nursing #1 is no		
	Findings included:			employed at the Center eff		
				11/15/2017. New Director	•	
	Deview of the facility!	a Abuse Drevention Deliev		employed to oversee clinic	al services	
		s Abuse Prevention Policy, ated: "It is the responsibility		effective 11/15/2017.		
	of employees to prom			IMMEDIATE ACTION		
		ident or suspected incident		The Director of operation f	rom the	
		abuse Staff are state		Management and consultir		
	-	and must comply with		that manages the center, r	• • •	
	state regulations rega			Center Executive Director		
	reasonable suspicion	-		Director of Nursing #1 on 7		
		vidual receiving care by the		the center s Abuse Prohibi		
	-	sted under Investigation:		Investigation policies and p		
	#5. "Investigations w			emphasized the importanc		
		y listed under Protection: "		resident(s), to include susp	-	
		ons accused or suspected of nt abuse is immediately		alleged perpetrator during		
		urse of the investigation		investigation period,		
	-	-				
1	nenninn me niircome	of the investigation."		neglect as well as injuries	noted or	

Facility ID: 943230

If continuation sheet Page 66 of 99

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,	G	COM	PLETED
						С
		345213	B. WING			/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT E	BOULEVARD	
				LILLINGTON, NC 27546		-1
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 226	Continued From page	e 66	F 22	26		
	Resident #1 was adm			reporting such in a timely n	nanner per	
		oses to include diabetes,		state regulatory requirement		
	hypertension, and co			education was also provide		
		Minimum Data Set (MDS)		Director of Nursing on 11/1	5/2017 by the	
		dent #1, dated 9/22/2017		Director of Operation.		
	revealed the resident	had intact cognition.		The Center Executive Dire		
				Director of Social Services		
		ducted on 11/13/2017 at		Nurse Aide #3, and Nurse		
		ent #1. She stated a couple as not sure of the date, she		11/15/2017 on the center s Prohibition and Investigation		
		ent (BM) and soiled herself at		procedures, and emphasiz	•	
		resident got in her wheel		importance of protecting re		
		f to the bathroom, and		reporting any allegation of		
		om call light for someone to		Neglect to their Direct supe		
		her up. Nursing Assistant		Executive Director in a time		
	(NA) #1 came in and	was real mad and kept		to exceed 2 hours after for	ming suspicion,	
		NA should have cleaned her		witness the abuse and/or a		
		ated she stood up and NA #1		another staff and/or family	member	
		rm and said, "I want you to		alleged abuse.		
		over and sat her down very		On 11/14/2017 at approxim		
		eat, then she scrubbed her		Director of Rehabilitation a		
		iid she was crying and the NA was too mad.		followed by the facility Dire services interviewed reside		
		finally said to the NA, "you		Resident #1 voiced that on		
		e like a dog." When the		approximately between 6:0		
		resident asked for the NA's		AM, she had an episode of		
		ouldn't tell her. Resident #1		she wheeled herself to the		
	stated she gave me a	a bruise right here, and		turn the bathroom call bell	on. Nursing	
	•	right wrist, and indicated the		Aide #2 responded to the c		
	bruise was about 2" b			the resident she will notify	•	
		#3 what had happened in the		Nurse Aide (Nurse Aide #1		
		aid she (the resident) should		assigned aide is not back t		
	-	Worker (SW). The resident erself to the nurse's station		she asked resident #1 to back on (no time lapse spe	-	
		isked to see the SW, but the		morning of 10/26/2017, du		
	-	she asked NA #4 about it		round, noted resident #1 to	-	
		pruise. The resident stated		Nurse Aide #3 communicat		
		e's station on Halloween, and		Aide #1 about resident#1 b		
	was frustrated becau			asked for Nurse Aide #1 to	-	

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
			A. BUILDING	3	С
		345213	B. WING		11/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
0.002 01 1				1995 EAST CORNELIUS HARNET	
UNIVERS	AL HEALTH CARE LILLII	NGTON		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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETIC O THE APPROPRIATE DATE
F 226	Continued From page	67	F 22		
1 220			F 22		n on 10/26/2017
		y at the desk asked what she /, and Resident #1 stated		resident#1 before leaving Nurse Aide #1 provided of	
		arm with the bruise, and		Resident#1 and gave her	
		the Director of Nursing		10/26/2017.	
	(DON), and she could			Resident #1 added that N	
		sported the Resident to the		pushed her and grabbed	
		e need to get started on		which caused a bruise. F	
		l came back a couple of , and told Resident #1 the		added that she reported Nurse Aide #3 on 10/26/	
	-	e DON and she decided not		on 10/30/2017, and Direc	
		d moved her to a different		on 10/30/2017. Interview	•
		other chance. The Resident		#4 by the Center Executi	
	stated she believed ir	n 2nd chances, but		conducted on 11/13/2017	7 revealed she
		orried that NA #1 would let		reported the Allegation m	-
	her temper explode o			#1 to the Center Human	
		ed the facility filed a 24-Hour tate Agency on 10/31/2017		Director on 10/30/2017. I Nurse Aide #3, and Nurs	
	-	d neglect. The allegation		report this allegation to the	
		that Aide pushed her in the		supervisor and the cente	
		used individual information"		Director per facility Abuse	
		IA #1. The report was		policies and procedures	
	signed by the Directo	r of Nursing.		2017. Director of Humar	
				reported the Allegation to	
	Record reviews revea	rt to the State Agency on		Nursing #1 on 10/30/201 executive Director via wr	
		t abuse and neglect. The		on 10/30/2017 that was r	
		dent stated that aide pushed		Center Executive Directo	-
	-	ind was rough and left a		On 10/31/2017 and 11/3/	
		Education teaching given and		hour report and a 5 day r	-
		om Hall. (The NA at fault)		to the Department of Hea	
		a different aide. Was not a		Services respectively, rel	
	hand print bruise upo	n investigation." The		#1 s allegation of abuse 10/26/2017. These repo	
		as signed by the Director of		completed and submitted	
	Nursing.			Director of Nursing #1. F	-
				completed on 11/3/2017	
	On 11/13/2017 at 4:3	5 PM, an interview was		investigation that was no	t detailed
		1, who requested only to be		enough. On 11/13/2017 a	
	interviewed with the [DON present. NA #1 stated		report was completed aft	or dotail

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If continuation sheet Page 68 of 99

						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			С
		345213	B. WING		11	U/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		10/2017
				1995 EAST CORNELIUS HARNETT		
UNIVERS	AL HEALTH CARE LILLI	NGTON		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 000						
F 226			F 22	-		
		called was between 6:00 and		investigation conducted by		
		017, NA #2 had told her that		Executive Director, Directo		
		her assistance, and so she		Services and/or Director of	0	
		her. NA #1 had been giving		The investigation conducte		
		ident, and so it was a little		by the Center Executive Di		
		able to go down and help		of Social services, Director		
		stated she went to Resident		Rehabilitation Center and I	•	
		had given report to day		interviewing 100% of all cu		
	shift, and the Resider	-		oriented residents in the fa		
		ed the Resident up to the		determine if any other resid		
		Resident grabbed hold of it		allegation of abuse or negl		
		shower. The NA then gave essed her. She stated the		the alleged perpetrator (Nu No other residents alleged		
		and NA #1 calmed her down,		neglect that involve the alle		
		vould be okay, about her		perpetrator.	geu	
	-	room. When asked about		On 11/15/2017, Director of	Human	
	-	of 11/1/2017, that she forgot		Resources conducted inter		
		an her up, NA #1 just		current employee who wer		
		ers and said it wasn't that		10/26/2017 between the 6/	•	
		to wait and that was all she		determine if any staff on du		
		nen asked about her written		any abuse and/or neglect t	•	
		17 that she had given report		Resident #1 specifically fro		
	to day shift before sh			Perpetrator (Nurse Aide #1		
		aid it wasn't that long, and		staff witness any abuse an		
		er. Further questions were		interview.	5	
	answered with the sa	•		On 11/13/2017 another 5 d	ay report was	
				completed after detail invest	• •	
	On 11/13/2017 at 5:3	8 PM, a phone interview was		completed by the Center E	•	
		2. NA #2 stated she was		Director, Director of Social		
	working on the 500 h	all, and went to the 600 hall		and/or Director of Nursing		
	to answer a bathroon	n call light, on the morning of		Resident s #1 allegation of	abuse voiced	
	10/26/2017. Resider	nt #1 was already in the		on 10/26/2017 was unsubs	stantiated.	
	bathroom, sitting in h	er wheelchair facing towards		Nurse Aide #1 did not care	for Resident	
	-	A smelled BM, and knew it		#1 at the time of investigation		
		e to clean her up, and the		Facility Director of Social S		
		eded help to be cleaned up.		resident #1 of the findings		
		the Resident she needed to		investigation and actions ta		
	go get a gown and st	uff, and then NA #2 went		Alleged Perpetrator to inclu	ude customer	
		IA #1 was in. NA #2 told NA		service re-education.		

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	TE SURVEY
CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
					С
	345213	B. WING		1	1/16/2017
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	θE	
AL HEALTH CARE LILLIN	NGTON			ULEVARD	
			LILLINGTON, NC 27546		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
Continued From page	e 69	F 2	26		
			-	25	
				-	
			-	-	
			-		
	-		-		
-	-				
requested the DON move her to another hall to					
-					
•				•	
	-				
	-		11/15/2017.	•	
0,	0		100% audit of all current resi	dents clinical	
On 11/14/2017 at 8:34	4 AM, an interview was		documentation within the last	30 days was	
conducted with NA #3	3. NA #3 stated she had				
talked to Resident #1	, later that morning on		Assistant Director of Nursing	and/or Nurse	
	-				
				-	
-	-		-		
			-		
told her she didn't kno	ow. NA #3 did not report the		resident s properties, if any, o	determine	
abuse to the DON that	at day, and told the Resident		whether a 24 hours and 5 da	ys	
	•				
	-				
			-		
•			-		
•					
	-				
				ty	
#1 had been mistreat #3 stated she talked t	ed during the shower. NA		compliance binder.		
	Continued From page #1 that Resident #1 n she was not going ba to get linens and proc NA #2 stated that Res back on at shift chang gone back to her roor at her door, and they # 2 stated she waited to arrive, and the DO allegation that she ha bathroom, and then o requested the DON n get away from NA #1 moved her to another stated she did not kno resident and didn't kno dignity issue or some On 11/14/2017 at 8:3 conducted with NA #3 talked to Resident #1 10/26/2017, and was and mean and rough her hard, and she wa Resident asked the n told her she didn't kno abuse to the DON that it would be better if sh SW. The Resident did at that time, and thou her the bruise on 10/2 had spoken to the DO been through abuse to why she had not repor had advised Resident #3 stated she talked to of 10/26/2017, but did	345213 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 69 #1 that Resident #1 needed her. NA #1 stated she was not going back in that room. NA #2 went to get linens and proceeded back to the 500 hall. NA #2 stated that Resident #1 put her call light back on at shift change, and NA #2 would've gone back to her room, but saw 2 NA's standing at her door, and they answered the call light. NA # 2 stated she waited after her shift for the DON to arrive, and the DON told NA #2 there was an allegation that she had pushed Resident #1 in the bathroom, and then cut the light off. NA #2	A BUILDING BUMINARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 69 #1 that Resident #1 needed her. NA #1 stated she was not going back in that room. NA #2 went to get linens and proceeded back to the 500 hall. NA #2 stated that Resident #1 put her call light back on at shift change, and NA #2 would've gone back to her room, but saw 2 NA's standing at her door, and they answered the call light. NA # 2 stated she waited after her shift for the DON to arrive, and the DON told NA #2 there was an allegation that she had pushed Resident #11 in the bathroom, and then cut the light off. NA #2 requested the DON move her to another hall to get away from NA #1 and Nurse #1, and the DON moved her to another part of the facility. NA #2 stated she did not know if she had neglected the resident and didn't know if this incident was a dignity issue or something else. On 11/14/2017 at 8:34 AM, an interview was conducted with NA #3. NA #3 stated she had talked to Resident #1, later that morning on 10/26/2017, and was told that NA #1 was mad and mean and rough with her and had grabbed her hard, and she was scared of her. The Resident asked the name of NA #1, but NA #3 told her she didn't know. NA #3 did not report the abuse to the DON that day, and told the Resident it would be better if she reported it herself to the SW. The Resident did not show NA #3 the bruise at that time, and thought the Resident showed her the bruise on 10/31/2017 after the resident had solves Resident #1 to report it herself. NA #3 stated she talked to Nurse #2 on the morning	345213 B. WING COVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE, 2P COL 1995 EAST CORRELUIS HARNET BO LILLINGTON, NC 27546 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY WARS TO PROFENDER PROFEDE OFFICIENCY (EACH OFFICIENCY WARS TO PROFENDATION) ID PREFIX (EACH OCRRECTIVE ACTION CONTINUED FIND WARS TO PROFENDATION) Continued From page 69 #1 that Resident #1 needed her. NA #1 stated she was not going back in that room. NA #2 went to get linens and proceeded back to the 500 hall. NA #2 stated that Resident #1 put her call light back on at shift change, and NA #2 would've gone back to her room, but saw 2 NA's standing at her door, and they answered the call light. M #2 stated she waited after her shift for the DON to arrive, and the DON told NA #2 there was an allegation that she had pusched Resident #1 in the bathroom, and then cut the light off. NA #2 requested the DON told NA #3 there was an callegation that she had pusched Resident #1 in the bathroom, and then cut the light off. NA #2 requested the DON move her to another hall to get away from NA #1 and Nurse #1, and the DON moved her to another part of the facility. NA #2 stated she did not know if this incident was a conducted with NA #3. NA #3 stated she had talked to Resident #1, later that morning on 10/26/2017, and was told that NA #1 was mad and mean and rough with her and had grabed her hard, and she was scared of her. The Resident and outpy with her and had grabed her hard, and she was scared of her. The Resident and rough with was 3 stated she had talked to Resident #1, but NA #3 told her she tol Ma #3 stated she had ther ther busce nerself, and had spoken to the DON. NA #3 stated she had been through abuse training, but could not say why she had not reported it herself. NA #3 stated she talked to Nurse #2 on the morning of 10/26/2017, but did not Nurse #2 no the morni	JAS213 B. WING

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,	G	COMPLETED
					С
		345213	B. WING		11/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE
UNIVERS	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT B LILLINGTON, NC 27546	OULEVARD
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLET HE APPROPRIATE DATE
F 226	Continued From page	e 70	F 22	26	
	and stated to her that with NA #1. NA #3 di Resident #1 had been the shower by NA #1 On 11/13/2017 at 1:4 conducted with NA #4 was alert and orienten her day, and always in was. NA #4 indicated with bathing, and dre- take herself to the toi occasional incontinent with being cleaned up showed the bruise on and told her she had shower and manhand upset, and didn't wan Resident asked for a what she could do ab happened before Hal the date. The NA sta room to see about ge decided she had bett	Resident #1 had a problem d not tell the DON that n mistreated and harmed in 7 PM, an interview was 4. NA #4 stated Resident #1 d, and could tell you about remembered who NA #4 d Resident #1 needed help ssing. Resident #1 could let, but when she had nt accident, she needed help b. NA #4 stated Resident #1 her right inner wrist to her, been pushed when in the dled, and was so scared and t to be at the facility. The patient Bill of Rights to see iout it. The NA stated this loween, but was not sure of ted she left the Resident's tting her a Bill of Rights, and er tell someone of the		On 11/15/2017, 100% interv completed by the Director of Services, Director of Rehab Services, Dietary Manager, office manager and/or Medi clerk for all current alert an residents in the facility to idu resident with allegation of A and or Misappropriation of p Four other residents, Resid Resident #3, Resident #4 a voiced allegation of abuse, misappropriation of residen Alleged perpetrators suspen investigation by the facility B director, 24 hour report sub 11/14/2017, thorough invest initiated, resident attending Responsible Party notified of allegation. Resident #2, #3, be informed of the findings taken when the investigatio by the Center Executive Dir Director of Social Services.	of Social ilitation Business ical Records d oriented entify any other buse, Neglect properties. ent#2, nd Resident #5 neglect and/or t s properties. nded pending Executive mitted on tigation Physician and of the #4 and #5 will and actions n is completed
	nurse's desk, and tok facility. The HR Man and DON needed to H Manager told the DO A review of a docume by the Human Resou conducted. The HR H at the 500/600 Hall N notified by NA #4 that facility. NA #4 told he stay at the facility, an	the HR manager at the d her there was abuse in the ager stated the Administrator be notified. The HR N and then wrote a report. ent dated 10/30/2017, written rce Manager (HR) was Manager reported she was urse's Station when she was t abuse was going on in the er Resident #1 was scared to d the NA saw bruises on IR told NA #4 she was going		SYSTEMIC PROCESS Effective 12/28/2017, All all involving abuse, neglect, ex- mistreatment, including inju unknown source and misap resident property, are repor immediately, but not later the after the allegation is made, that cause the allegation inv- result in serious bodily injur- than 24 hours if the events allegation do not involve ab	xploitation or ries of propriation of ted nan 2 hours , if the events volve abuse or y, or not later that cause the

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION		NO. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		S		MPLETED
						С
		345213	B. WING		1	1/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	
	AL HEALTH CARE LILL	INGTON		1995 EAST CORNELIUS HARNETT BOU	LEVARD	
UNIVERS		INGTON		LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 226	Continued From pag	je 71	F 22	26		
		told the DON and the DON		administrator of the facility and	to other	
		ng and stated she was going		officials (including to the State		
	to address it.			Agency and adult protective se	-	
				where state law provides for ju		
		nducted on 11/13/2017 at		long-term care facilities) in acc		
	4:04 PM, with the HI	-		with State law through establis	shed	
		was at the 500/600 Hall		procedures.		
		0/26/2017, when NA #4 had told her that Resident #1 was		Effective 12/28/2017, Report to		
		facility because NA #1 had		all investigations to the admini his or her designated represer		
	-	her and gave her a bruise.		to other officials in accordance		
	-	er that she saw the bruise on		law, including to the State Sur		
	-	like someone would've		within 5 working days of the in		
		R Manager told NA #4, "we		if the alleged violation is verifie		
	have to report this",	and so the HR Manager		appropriate corrective action n	nust be	
		n the 10/30/2017 before she		taken.		
		ON told the HR Manager she		Effective 12/28/2017, the Cent		
		. The time was late, and so		of Social Services, Director of		
		nt home and wrote up the		Recreational Services and/or of	•	
		the Administrator when she		staff member will conduct inter		
	came in on 10/31/20			each current employee at leas year. The interview will be interview		
	On 11/13/2017 at 12	:12 PM, an interview was		determine the employee under		
		Director of Nursing (DON).		the Center Abuse policies and	-	
		facility did not have a policy		and ensure that each employe		
		ved State guidelines, which		the Abuse education at least o		
	· · ·	id to be reported within 2		six months. This interview proc	•	
		ated, and repeated many		incorporated to the annual em		
		neard of the abuse allegation		evaluating. Any staff member		
		ident #1 came to the nurse's		interviewed by the anniversary		
		as looking for the SW.		not be allowed to work until ed	-	
		DON that a NA had grabbed		voiced allegation of abuse, neg	-	
		ie shower, and had showed a The DON stated she then		misappropriation of resident s will be reported to the Center I		
		1 to the SW, showed the SW		Director promptly. Alleged per		
		the SW she was going to		will be suspended pending inv		
		vs. The DON stated she filed		by the facility, and reported ac		
		at day, and then talked to NA		the regulatory requirements.		
	1					1

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		MEDICAID SERVICES				<u>O. 0938-03</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		E SURVEY IPLETED	
			A. BUILDING	·	c		
		345213	B. WING			/16/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 1	1/10/2017	
				1995 EAST CORNELIUS HARNETT BOULEV	/ARD		
UNIVERS	AL HEALTH CARE LILLII	NGTON		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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 226	Continued From page	- 72	E 22	e			
1 220			F 22		rting		
		ruise was just a round bruise st, and it wasn't a hand print		Effective 12/28/2017, Abuse report process will be discussed to curr			
		licated that if a NA had		and oriented residents every mo			
		's wrist, it would have left a		during resident council meeting a			
	-	e DON stated the bruise		least quarterly during each reside			
	must have come from			plan meeting. This process will b			
	medication, as she w			managed by the Center Director			
		The DON stated after she		Services effective 12/28/2017.			
		realized that was the wrong					
	NA, because the Res	ident was already in the		100% of current alert and oriente	d		
	bathroom when NA #	1 went in to shower her.		residents in the facility re-educate	ed on		
		NA #2 had pushed Resident		12/28/2017 by the center Directo			
		, but she had no proof that		Social Services, Director of Reha			
		sed, so she decided to give		Services, Dietary Manager, Busin			
		ice and moved NA #2 to a		office manager and/or Medical R			
		t had been her decision.		clerk to ensure that each know a			
		ked Resident #1 if she had		resident council meeting and who			
		d, or any of the details of the		report to in the event an abuse, r	•		
		v documentation of what		and/or misappropriation of reside	nts		
		dent was the sentence she		properties is noted or witnessed. Residents re-educated to report	ab <i>i</i> (
		and 5-Day Reports. The nistrator had told her of the		allegation, actual or suspicion of	•		
		0/31/2017, but she had told		the nurse, any administrative sta			
		v. When asked if she had		and/or the facility Executive Direct			
	been notified of the a			effective 12/28/2017. The reporti			
		Iman Resources Manager,		be made verbally or in writing.	.g can		
		that she found out about		20 maao 10 20 j or maage			
		he resident talked to her on					
	10/31/2017.			Effective 12/28/2017, the facility	nitiated a		
				process of open door policy, will			
	On 11/14/2017 at 11:	00 AM, an interview was		staff meeting once a month to en	courage		
		W. The SW stated the DON		staff to express concerns and rec	-		
	-	t #1 to her on 10/31/2017,		training in challenging situations.			
		the Resident's bruise. The		12/28/2017, the center administration			
		was a little less than quarter		will observe employees while on			
	-	t wrist. The DON stated she		any signs of burnout (example de			
		SW talked to the DON on		in job performance, increase nun			
		ON reported that NA #2 had the bathroom, and another NA		unexplained absences, less socia	alizing		
		a la adda ya a ya a la ya adda ya NIA		etc.).			

Facility ID: 943230

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE SUR	938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	B	COMPLET	
					С	
		345213	B. WING		11/16/2	2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BOULE	VARD	
UNIVERS				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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE CO	(X5) DMPLETIC DATE
F 226	Continued From page	e 73	F 22	26		
		it #1 could take herself to the				
		stated she couldn't say		Effective 12/28/2017, the nursing	a	
		ho did what, so she just		administrative team, which inclu		
		rom the hall. The SW		Nurse supervisors, and/or SDC,		
		to mean that the bruise		process for reviewing clinical		
		to the bathroom, and since		documentation for the last 24 ho		
		Resident to the bathroom,		completed skin assessments, in		
		The SW reported that		reports for the last 24 hours, and		
		t and oriented. The SW was		Physician orders written in the la		
		teps taken to investigate		hours to ensure that any allegati		
	-	v that the DON had to report		abuse, neglect, misappropriation		
	it to the State.			resident s properties and/or injur		
	Op 11/14/2017 at 5.5	7 PM the facility was notified		unknown sources reported/docu investigated thoroughly, alleged	menteuis	
		vided the following credible		perpetrator is suspended pendin	a	
	allegation of compliar	-		investigation and reported to the Executive Director.	-	
	DATE: 11/15/2017					
		LEAD TO THE ALLEGED		Effective 12/28/2017, 24 hours	and 5	
	DEFFICIENCY CITE	D		days investigation reports is com	pleted	
	This alleged noncom	pliance resulted from the		and reviewed by the Executive I	Director	
		tor of Nursing #1, Nurse		before submitted to the state age	ency and	
		de #4 failure to follow the		other officials as required by reg		
		licies and procedures		and/or Elder Justice Act per regu		
		virector of Nursing #1 failed		requirement. This systemic proc		
		olicies procedure as she		take place daily (Monday throug		
		ation from resident #1 to the		Any identified issues will be add		
		nely. Former Director of d to protect the resident who		promptly and appropriate actions implemented by the DON, ADO		
		did not suspend Nurse Aide		and/or Nurse Supervisor. This p		
	•	in period and also failed to		be incorporated in a daily clinica		
		d/or resident #1 responsible		Any negative findings will be doo		
	-	of the investigation and		on the daily clinical checklist for		
		vestigation for Resident #1		maintained in the daily clinical m		
	allegation of abuse vo			binder.	-	
		1 is no longer employed at				
		1/15/2017. New Director of		Effective 12/28/2017, week end		
		oversee clinical services		Registered Nurse supervisor and		
	effective 11/15/2017.			designated licensed nurse will re	view	

Facility ID: 943230

If continuation sheet Page 74 of 99

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DA	TE SURVEY		
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	MPLETED		
						С		
		345213	B. WING		1	1/16/2017		
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
	L HEALTH CARE LILLIN	NGTON		1995 EAST CORNELIUS HARNETT BO	ULEVARD	/ARD		
		NOTON .		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 THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE		
F 226	Continued From page	2 74	F 22	26				
		tion from the Management		clinical documentation for the	a last 24			
	and consulting compa	•		hours, completed skin asses				
	• .	ne Center Executive Director		incident reports for the last 2				
		ursing #1 on 11/14/2017 on		Physician orders written in th				
		ohibition and Investigation		hours to ensure that any alle				
	policies and procedur	es, and emphasized the		abuse, neglect, misappropria	ation of			
		ing resident(s), to include		resident s properties and/or i	-			
		ed perpetrator during the		unknown sources reported/d				
	÷ .	investigating thoroughly all		investigated thoroughly, alleg	-			
	-	r neglect as well as injuries		perpetrator is suspended per				
	-	letermine etiology, and		investigation and reported to				
		nely manner per state nts. This education was also		Executive Director. This syst will take place every Saturda				
	provided to the new E			Sunday. Any negative finding				
	11/15/2017 by the Dir	-		documented on the week er				
	-	Director, and the Director		report form and maintained				
		educated Nurse Aide #3,		clinical meeting binder.	,			
	and Nurse Aide #4 or	11/15/2017 on the center's		-				
	Abuse Prohibition and	d Investigation policies and		Facility Executive Director, D				
	-	hasized the importance of		Nursing (DON), and/or Direc				
	protecting resident(s)			Services will complete 100%				
		Neglect to their Direct		on the facility s abuse/negled				
		Recutive Director in a timely		including notification, protect				
		d 2 hours after forming		investigation protocols. This				
	-	e abuse and/or after a f and/or family member		be provided for all employee full time, part time and as ne				
	alleged abuse.			This education will be comple				
	anogoa abase.			12/28/2017. Any employee n	•			
				by 12/28/2017 will not be allo				
	On 11/14/2017 at app	proximately 9:00PM Director		until educated. This educatio				
		e center followed by the		added on new hires orientati				
		cial services interviewed		for all new employees effecti	ve			
	resident #1. Residen			12/28/2017, and will also be	provided			
		ately between 6:00 AM and		semi-annually.				
		episode of loose stool, she						
		e bathroom and turn the		MONITORING PROCESS				
		Nursing Aide #2 responded		Effective 12/28/2017, Execut				
	to the call bell and tol her assigned Nurse A	d the resident she will notify		and or Director of Social Ser review all alleged violation to				

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				T IE · · ·			O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ECONSTRUCTION		E SURVEY IPLETED
							С
		345213	B. WING			11	/16/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE LILLI	NCTON		1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSI		NGTON		L	LILLINGTON, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 226	Continued From page	75	Í –	226			
1 220			F.	226		a d	
		not back to care for her, she o turn the light back on (no			thorough investigation is completed a		
	time lapse specified).				reported to the state agency and othe officials as required by regulation and		
		itial round, noted resident #1			Elder Justice Act. Any issues identifie		
		Aide #3 communicated to			during this monitoring process will be	a	
		resident#1 being soiled and			addressed promptly. Findings from the	s	
		#1 to clean the resident#1			monitoring process will be documente		
	before leaving on 10/	26/2017. Nurse Aide #1			abuse prohibition tool and filed in dail	y	
	provided care to Resi	ident#1 and gave her a			meeting binder after proper follow ups		
	shower on 10/26/201				done. This monitoring process will tak	е	
		hat Nurse Aide#1 pushed her			place daily to include Saturdays and		
	-	he arm, which caused a			Sundays for 2weeks, weekly x 2 more		
		idded that she reported this			weeks, then monthly x 3 months or un		
	-	ide #3 on 10/26/17, Nurse I7, and Director of Nursing			the pattern of compliance is maintaine	a.	
		terview with Nurse Aide #4			Effective 12/28/2017, Director of Nurs	ina	
		ive Director conducted on			will report findings of this monitoring	ing	
		she reported the Allegation			process to the facility Quality Assuran	ce	
		to the Center Human			and Performance Improvement		
	Resources Director o	n 10/30/2017. Interview with			Committee for any additional monitori	ng	
	Nurse Aide #3, and N	lurse Aide # 4 did not report			or modification of this plan monthly x 3	3	
	this allegation to their	r direct supervisor and the			months, or until the pattern of complia		
		rector per facility Abuse			is maintained. The QAPI committee c	an	
		nd procedures revised June			modify this plan to ensure the facility		
		man Resources reported the			remains in substantial compliance.		
	Allegation to Director						
		e executive Director via 10/30/2017 that was read by			TITLE OF THE PERSON RESPONSI FOR IMPLEMENTING THE CREDIBL		
		Director on 10/31/2017			ALLEGATION		
		1/3/2017, the 24 hour report			Effective 12/28/2017, the center Exec	utive	
		ere sent to the Department			Director and the Director of Nursing w		
		Services respectively,			be ultimately responsible to ensure		
	related to resident #1	's allegation of abuse made			implementation of this plan of correcti	on	
		se reports were completed			to assure the facility remains in the		
		former Director of Nursing			substantial compliance.		
		completed on 11/3/2017					
		ation that was not detailed					
		17 another 5 day report was I investigation conducted by					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERS	AL HEALTH CARE LILLIN	IGTON		1	LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Services and/or Direct The investigation con Center Executive Direct services, Director of F MDS nurse by intervite alert and oriented rest determine if any other allegation of abuse or alleged perpetrator (N residents alleged abui involve the alleged per On 11/15/2017, Direct conducted interviews were on duty on 10/20 and 7AM to determine witnessed any abuse Resident #1 specificat (Nurse Aide #1). No ct and/or neglect per intt On 11/13/2017 another completed after detail the Center Executive Services and/or Direct Resident's #1 allegati 10/26/2017 was unsu did not care for Resid investigation. Facility Director of So resident #1 of the find actions taken for the A include customer serv THE PROCEDURES ACCEPTABLE CRED THE ALLEGED IMME 100% audit was complexed	Director, Director of Social etor of Nursing #1. ducted 11/13/2017 by the ector, Director of Social Rehabilitation Center and ewing 100% of all current idents in the facility to r resident voiced and r neglect that involve the Nurse Aide #1). No other ise and/or neglect that erpetrator. tor of Human Resources with current employee who 6/2017 between the 6AM e if any staff on duty and/or neglect towards ally from Alleged Perpetrator other staff witness any abuse erview. er 5 day report was I investigation completed by Director, Director of Social etor of Nursing #1 services. on of abuse voiced on abstantiated. Nurse Aide #1 ent #1 at the time of total Services notified lings of the investigation and Alleged Perpetrator to vice re-education. FOR IMPLEMENTING THE DIBLE ALLEGATION FOR EDIATE JEOPARDY. obteted by the Center all allegation of abuse tted in the last 12 months to	F	226	5		

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES	-1				D: 01/02/2018 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í			COMF	SURVEY PLETED
		345213	B. WING				0 /16/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			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 PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	as well as 5 days repusubmitted to the state regulation and Elder of manner. The audit reveres reportable in the last investigation and the suspended. This audit 11/15/2017. 100% audit of all current documentation within completed by the Director of M Supervisor to determine documentation in any that indicate allegation misappropriation of re- determine whether a investigation reports of reported to the state a required by regulation The audit revealed no allegation of abuse, a in resident's medical completed on 11/15/1 documented on "clinic located at the facility of Don 11/15/2017, 100% by the Director of Soor Rehabilitation Services Business office mana- clerk for all current al the facility to identify a allegation of Abuse, N Misappropriation of puresidents, Resident#2	estigation and the 24 hours orts are completed and e agency as required by Justice Act in a timely vealed all completed 12 months noted with detail Alleged Perpetrator (s) were t was completed on ent residents' clinical the last 30 days was ector of Nursing #1, Nursing and/or Nurse ne if there is any resident's medical records n of abuse, neglect, and/or esident's properties, if any, 24 hours and 5 days were completed and agency and other officials as n and/or Elder Justice Act. o other documented nd/or neglect documented records. This audit was 7. Findings of this audit is cal records audit tool" compliance binder.	F	226	δ		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345213	B. WING			C 11/16/2017		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE LILLIN	IGTON			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 PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 226	neglect and/or misapp properties. Alleged pe pending investigation director, 24 hour repo- thorough investigation Physician and Respon- allegation. Resident # informed of the finding the investigation is co- Executive Director an Services. Effective 11/15/2017, involving abuse, negle mistreatment, includir source and misapprop are reported immedia hours after the allegat that cause the allegat in serious bodily injury if the events that cause involve abuse and do injury, to the administ other officials (includin Agency and adult pro- law provides for jurisc facilities) in accordance established procedure Effective 11/15/2017, investigations to the a designated represent accordance with State Survey Agency, withir incident, and if the alle appropriate corrective Effective 11/15/2017, Social Services, Direc and/or designated state	propriation of resident's erpetrators suspended by the facility Executive ort submitted on 11/14/2017, in initiated, resident attending nsible Party notified of the 42, #3, #4 and #5 will be gs and actions taken when ompleted by the Center d/or Director of Social All alleged violations ect, exploitation or ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events tion involve abuse or result y, or not later than 24 hours se the allegation do not not result in serious bodily rator of the facility and to ng to the State Survey tective services where state diction in long-term care ce with State law through	F	226	5			

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CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES					FORM OMB NC	D: 01/02/2018 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>					SURVEY PLETED
		345213	B. WING	' <u> </u>				
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C			
UNIVERSA	AL HEALTH CARE LILLIN	IGTON			1995 EAST CORNELIUS HARNETT B LILLINGTON, NC 27546	OULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD B		(X5) COMPLETION DATE
F 226	determine the employ Center Abuse policies ensure that each emple education at least ond interview process will annual employee evan not interviewed by the allowed to work until e allegation of abuse, n misappropriation of re- reported to the Center promptly. Alleged per- pending investigation according to the regul Effective 11/15/2017, be discussed to curre- residents every mont- meeting and at least of resident care plan me managed by the Center Services effective 11/ 100% of current alert the facility re-educate center Director of Soo Rehabilitation Services Business office mana- clerk to ensure that ea council meeting and v an abuse, neglect, an residents' re-educate actual or suspicion of administrative staff on Executive Director effective for	erview will be intended to vee understanding of the s and Procedures and bloyee receives the Abuse ce every six months. This be incorporated to the duating. Any staff member e anniversary date will not be educated. Any voiced reglect and/or esident's properties will be r Executive Director petrators will be suspended by the facility, and reported latory requirements. Abuse reporting process will ent alert and oriented ths during resident council quarterly during each eeting. This process will be ter Director of Social 15/2017. and oriented residents in ed on 11/15/2017 by the cial Services, Director of es, Dietary Manager, ger and/or Medical Records ach know about resident who to report to in the event ad/or misappropriation of	F	226				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		PLETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLIN	IGTON			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From page	80	F	226			
	meeting once a month express concerns and challenging situations center administrative while on duty for any decrease in job perfor unexplained absence Effective 11/15/2017, team, which includes and/or SDC, initiated clinical documentation completed skin assess the last 24 hours, and the last 24 hours, and the last 24 hours, and the last 24 hours to en abuse, neglect, misage properties and/or injur reported/documented alleged perpetrator is investigation and report Director. Effective 11/15/2017, investigation reports i by the Executive Dire state agency and other regulation and/or Elder requirement. This sys place daily (Monday t identified issues will b appropriate actions w	policy, will hold a staff h to encourage staff to d request training in a. Effective 11/15/2017, the staff will observe employees signs of burnout (example rmance, increase number of s, less socializing etc.). the nursing administrative DON, Nurse supervisors, a process for reviewing n for the last 24 hours, sements, incident reports for I Physician orders written in nsure that any allegation of opropriation of resident's ries of unknown sources is investigated thoroughly, suspended pending orted to the facility Executive 24 hours and 5 days s completed and reviewed ctor before submitted to the er officials as required by er Justice Act per regulatory stemic process will take hrough Friday). Any be addressed promptly and ill be implemented by the					
	process will be incorp rounds. Any negative on the "daily clinical c	nd/or Nurse Supervisor. This porated in a daily clinical findings will be documented hecklist form" and y clinical meeting binder.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345213	B. WING			C 11/16/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
UNIVERS	AL HEALTH CARE LILLIN	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546	30ULEVARD		
(X4) ID PREFIX TAG				х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
TAG F 226	Continued From page Effective 11/15/2017, supervisor and/or des review clinical docum hours, completed skir reports for the last 24 orders written in the la any allegation of abus of resident's propertie sources reported/doc thoroughly, alleged po pending investigation Executive Director. The take place every Satur negative findings will "week end supervisor maintained in the dail Facility Executive Director complete 100% re-ed abuse/neglect policy in protection, and investig	e 81 week end Registered Nurse signated licensed nurse will entation for the last 24 n assessments, incident hours, and Physician ast 24 hours to ensure that se, neglect, misappropriation es and/or injuries of unknown umented is investigated erpetrator is suspended and reported to the facility his systemic process will urday and Sunday. Any be documented on the report form" and by clinical meeting binder.	F	226		AIE		
	include full time, part This education will be Any employee not ed not be allowed to wor education will also be orientation process for effective 11/15/2017, semi-annually. THE MONITORING F THAT THE CREDIBL EFFECTIVE AND RE IMMEDIATE JEOPAR	time and as needed staff. e completed by 11/15/2017. ucated by 11/15/2017 will k until educated. This e added on new hires or all new employees and will also be provided PROCEDURE TO ENSURE E ALLEGATION IS MOVE THE ALLEGED						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345213	B. WING				C / 16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
UNIVERS	AL HEALTH CARE LILLIN	IGTON			1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 226	violation to ensure a t completed and report other officials as requ Elder Justice Act. Any monitoring process w Findings from this mo documented on "abus in daily meeting binde done. This monitoring daily to include Saturd 2weeks, weekly x 2 m 3 months or until the p maintained. Effective 11/15/2017, report findings of this facility Quality Assura Improvement Commit monitoring or modifica months, or until the pa maintained. The QAP plan to ensure the fac compliance. TITLE OF THE PERS IMPLEMENTING THE Effective 11/15/17, the and the Director of He ultimately responsible of credible allegation immediate jeopardy. Compliance Date: 11/ The Credible Allegatio 11/16/2017 by the foll 1. The survey team	vices will review all alleged horough investigation is ed to the state agency and ired by regulation and/or y issues identified during this ill be addressed promptly. nitoring process will be se prohibition tool" and filed er after proper follow ups are process will take place days and Sundays for hore weeks, then monthly x pattern of compliance is Director of Nursing will monitoring process to the nce and Performance tee for any additional ation of this plan monthly x 3 attern of compliance is 1 committee can modify this sility remains in substantial SON RESPONSIBLE FOR E CREDIBLE ALLEGATION e center Executive Director ealth services will be to ensure implementation to remove this alleged	F	226			

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	-	D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345213	B. WING _				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	IGTON			995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 226 F 241 SS=G	of abuse, neglect, mis properties and /or inju 2. The survey team incidents within the la completed to identify injuries. 3. The survey team provided by staff and team conducted staff staff. The staff intervi in-service regarding a reporting, and recogn staff burnout. 4. The survey team and oriented residents education they had re abuse to. DIGNITY AND RESP CFR(s): 483.10(a)(1) (a)(1) A facility must the resident in a manner promotes maintenance her quality of life reco- individuality. The facil promote the rights of This REQUIREMENT by: Based on observation and resident interview maintain a resident's resident soiled and un the resident feeling en	hich reviewed ould indicate any allegation sappropriation of resident's iries of unknown sources. reviewed the audit of all st 30 days which was any unknown source of reviewed the in-service signed by staff. The survey interviews with 16 on-duty ewed confirmed the recent ibuse identification, izing signs and symptoms of interviewed 41 current alert s. The residents confirmed beceived on whom to report ECT OF INDIVIDUALITY reat and care for each and in an environment that we or enhancement of his or gnizing each resident's ity must protect and the resident. is not met as evidenced in, record review and staff vs, the facility failed to		2226	F241D ROOT CAUSE This alleged noncompliance resulted fr the Nursing aide #1 failure to follow the facility abuse prohibition policy and procedures and lack of understanding what constituted neglect or violation of resident s dignity. When interviewed by	e on	12/28/17

Event ID: 5GBQ11

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	PLETED
						С
		345213	B. WING		11/	16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOULE	VARD	
		NGTON		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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 241	Continued From page	e 84	F 24	11		
	hypertension, and co Review of a quarterly assessment for Resid revealed the resident required extensive as dressing, personal hy not steady, but able t assistance between the weight was 115 poun An interview was con 11:05 AM with Reside couple of weeks ago, date, she had a bowe herself at about 6:00 her wheel chair herse bathroom, and turned for someone to come indicated a NA, who in about 6:15 AM and told her if someone d while, to put her call I could see what time if clock on her night sta Resident #1 stated st and was very still bed any mess on the floor and the bathroom sm embarrassed. Reside	oses to include diabetes, ntracture of left hand. Minimum Data Set (MDS) dent #1, dated 9/22/2017, had intact cognition. She ssistance with toileting, giene and bathing. She was o transfer herself with limited bed and wheelchair. Her		the former Director of Nursing, r #1 indicated she did not think he constituted neglect or violation of s dignity. Nurse aide number #1 longer employed at the center. I Director of Nursing #1 is no long employed at the Center effective 11/15/2017 following this event. Director of Nursing employed to clinical services effective 11/15/2 On 11/14/2017 at approximately Director of Rehabilitation at the followed by the facility Director of services interviewed resident #1 Resident #1 voiced that on 10/2 approximately between 6:00 AM AM, she had an episode of loos she wheeled herself to the bath turn the bathroom call bell on. N Aide #2 responded to the call be the resident she will notify her a Nurse Aide (Nurse Aide #1), and assigned aide is not back to car she asked resident #1 to turn t back on (no time lapse specified morning of 10/26/2017, during in round, noted resident #1 to be s Resident # 1 alleged that she wa the bathroom for about an hour aide #1, she added she was em by this event. Nurse Aide #3 communicated to Nurse Aide #3	er acts of resident is no ikewise ger New oversee 2017. 9:00PM center of Social 6/2017 I and 7:00 e stool, room and ursing ell and told ssigned d if the e for her, he light I). On the nitial oiled. as left in by nursing barrassed	
	the resident replied for she was going to get kept saying that the c	en sitting here waiting, and or an hour. NA #3 told her NA #1. NA #1 came in and other NA should have ident #1 stated she was		resident#1 being soiled and ask Nurse Aide #1 to clean the resid before leaving on 10/26/2017. I #1 provided care to Resident#1 her a shower on 10/26/2017.	lent#1 Nurse Aide	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/02/2018 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345213	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERS	AL HEALTH CARE LILLIN	NGTON		LI	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 SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		COMPLETION DATE
					BEHOLENOT)		
F 241	Continued From page	85	F	241			
					IMMEDIATE ACTION		
	Review of statement of	dated 11/1/2017, by Nursing			On the morning of 10/26/2017, during		
	Assistant (NA #1) incl	uded with a 5-Working Day			initial round, noted resident #1 to be		
	Report revealed she v	was in the middle of her last			soiled. Nurse Aide #3 communicated f	0	
	round when NA #2 tol	ld her Resident #1 needed			Nurse Aide #1 about resident#1 being		
	her. NA #1 said she v	was getting another resident			soiled and asked for Nurse Aide #1 to		
	ready for an appointm	nent and told NA #2 she			clean the resident#1 before leaving on		
	could not go back dow	wn to Resident #1's room			10/26/2017. Nurse Aide #1 provided of		
	because her resident	needed breakfast. NA #1			to Resident#1 and gave her a shower	on	
	-	akfast for that resident, and			10/26/2017.		
		er rounds and charting.					
		th her resident on the hall			Resident On 10/31/2017 and 11/3/201		
		bout going back down there"			the 24 hour report and a 5 day report v	vere	
		nd a few things on the hall			sent to the Department of Health and		
		rected before change of			Human Services respectively, related t		
	shift. NA #1 wrote that				resident #1 s allegation of neglect mad	е	
	oncoming NA #3, and				on 10/26/2017. These reports were		
		1's call light and NA #1 had			completed and submitted by the forme		
	was signed on 11/1/2	ident #1's room. The report 017 by NA #1.			Director of Nursing #1. Five days report completed on 11/3/2017 indicated an		
	On 11/13/2017 at 4:3	5 PM, an interview was			investigation that was not detailed eno and did not include the allegation of	ugh	
		I. NA #1 stated the only			neglect. On 11/13/2017 another 24 hor	Jr	
		s between 6:00 and 7:00			and 5 day report was completed after		
		ad told her that Resident #1			detail investigation conducted by the		
		e, and so she went in and			Center Executive Director, Director of		
		had been giving a bath to			Social Services and/or Director of Nurs	sing	
	another resident, and				#1.	-	
	before she was able t						
		stated she had gone to			IDENTIFICATION OF OTHERS		
		efore she had given report					
	to day shift, and the F	Resident was already in the			The investigation conducted 11/14/201	7	
	bathroom. NA #1 the	n gave her a shower and			by the Center Executive Director, Di	ctor	
		ted Resident #1 was crying			of Social services, Director of		
	and she calmed her d	lown, and told her not to cry,			Rehabilitation Center and MDS nurse	су	
	it would be okay. Wh	en asked about her written			interviewing 100% of all current alert a	nd	
	-	7, that she forgot to go back			oriented residents in the facility to		
		NA #1 just shrugged her			determine if any other resident voiced	and	
	shoulders and said it	wasn't that long for the			allegation of abuse and/or neglect that	t	

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ND PLAN OF	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED
		345213	B. WING		C
	ROVIDER OR SUPPLIER	545215		STREET ADDRESS, CITY, STATE, ZIP	CODE 11/16/2017
				1995 EAST CORNELIUS HARNETT	
UNIVERSA	L HEALTH CARE LILLIN	NGTON		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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 241	Continued From page	2 86	F 24	11	
	resident to wait and th		1 24	involve the alleged perpe	
	remember.			Aide #1). No other reside	•
	A review of the staten	nent, undated, by NA #2		abuse and/or neglect that alleged perpetrator. Like	
		Working Report revealed		Director of Human Resou	
	-	the light for Resident #1		interviews with current en	nployees who
	-	e bathroom. The NA turned		were on duty on 10/26/20	
		he Resident she needed to		6AM and 7AM to determine	
		t her cleaned up. NA #2 #1 and told her Resident #1		duty witnessed any abuse towards Resident #1 spec	
		boked down the hall and		Alleged Perpetrator (Nurs	-
		going back down there, I		other staff witness any ab	
		ere and I'm not going back."		neglect. Resident s #1 all	
		loing something else at the		voiced on 10/26/2017 wa	
	moment.			unsubstantiated based or	-
	On $\frac{11}{13}$	8 PM, a phone interview was		investigation conducted. did not care for Resident	
		2. NA #2 stated she went to		investigation. It is the Cer	
		all light. Resident #1 was		suspend the Alleged Perp	•
		om, sitting in her wheelchair		time of investigation of an	
	-	Il light. The NA smelled BM,		and/or Neglect.	
		e some time to clean her		On 12/08/2017 and 12/11	
	-	said she needed help to be		all current alert and orient	
	-	tated she told the resident a gown, and then NA #2		the facility were interview Executive Director, Direct	-
		om where NA #1 was		services, Activity Director	
		ther resident. NA #2 told NA		of Nursing to determine if	
	#1 that Resident #1 n	eeded her.		resident voiced concerns	0,
				specifically being left soile	
		4 AM, an interview was		period of time. No other r	
		 NA #3 stated Resident #1 nd could propel herself to 		complained of being left u long time (more than 1 ho	
		heelchair. She had been			
		nd when she had soiled		100% audit of all current	residents clinical
		clean herself up. NA #3		documentation within the	
	stated on the morning			completed by the Director	
		1's call light at 7:00 when		Assistant Director of Nurs	
		the day shift (7:00 AM to d the resident was in the		Supervisor to determine i documentation in any res	

Facility ID: 943230

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '	G	COMPLETED
					С
		345213	B. WING		11/16/2017
ME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	L HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOULE	VARD
		NOTON		LILLINGTON, NC 27546	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y 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 COMPLET
F 241	Continued From page	e 87	F 24	11	
		upset, and reported the NA's		records that indicate dignity con	cerns. if
	, ,	ooked at her and saw BM on		any, determine whether appropr	
	her gown and under	pad, and the bathroom		actions were taken. The audit re	
	smelled like BM.			zero residents had documentation	
	.			indicate dignity concerns or viola	
		ducted on 11/13/2017 at		resident s medical records. This	
		#1. She stated she was t of 10/26/2017, by NA #1,		completed on 12/08/17 and 12/1 Findings of this audit is docume	
		ed Resident #1 to the		clinical records audit tool locate	
		r there, and then went to tell		facility compliance binder.	
		ted she worked the evening			
	of 10/31/2017 and ta	Iked to NA #2 on the morning			
		/1/2017 and asked her why she had taken		SYSTEMIC CHANGES	
		athroom and not completed			r
		her she had to finish taking lent. Nurse #1 stated she		Effective 12/28/2017, interviews and oriented residents will be co	
		DON on 11/2/2017 that NA		by the Director of Social Service	
	#2 had been assigne			of Recreational Services and/or	
				designated staff member at leas	t once
	On 11/13/2017 at 12:	12 PM, an interview was		every quarter to identify any alle	gation of
		irector of Nursing (DON).		Abuse, Neglect and or Misappro	-
		talked to NA #2, and that NA		properties. This interview proces	
		1 was in the bathroom when		incorporated to social services q	
		ht and went to get NA #1. expected NA #2 to take care		assessment schedule and docu on psychosocial assessment to	
		she answered the call light.		voiced allegation of abuse, negle	-
		decided to give NA #2 a		misappropriation of resident s pr	
		moved her to a different hall.		will be reported to the Center Ex	
				Director promptly. Alleged perpe	
				will be suspended pending inves	
				by the facility, and reported according the regulatory requirements.	braing to
				Effective 12/28/2017, the center	-
				administrative team, which inclu-	
				Nurse supervisors, and/or SDC,	initiated a
4 ONS 2557			011	Effective 12/28/2017, the center administrative team, which inclu	des DON, initiated a ours,

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Facility ID: 943230

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/02/2 FORM APPRO OMB NO. 0938-03
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345213	B. WING		11/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	AL HEALTH CARE LILLIN	IGTON		1995 EAST CORNELIUS HARNETT BOUL	EVARD
				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 A DEFICIENCY)	HOULD BE COMPLETI
F 241	Continued From page	88	F 24	1 reports for the last 24 hours, an Physician orders written in the I hours to ensure that any docum related to dignity violation and e any dignity related concerns is investigated following the facility policy and procedures. Effective 12/28/2017, the facility the revised assignment sheet a that each assignment s acuity I maintained. The Director of Nursing, S Development Coordinator and/C Coordinators will adjust the ass sheets whenever necessary to the acuity level is maintained ef 12/28/2017. Director of Nursing, Assistant D Nursing, Staff Development Coordinators will co and/or Unit Coordinators will co 100% education for all current f employees, to include full time, and as needed employees abo maintaining resident dignity and The emphasis of this education the importance of attending to r needs in a timely manner and e resident s needs are anticipated employee not educated by 12/2 not be allowed to work until edu This education will also be adde hires orientation process for all employees effective 12/28/2017. Director of Nursing, Assistant D Nursing, Staff Development Co and/or Unit Coordinators will co nad/or Unit Coordinators will co nad/or Unit Coordinator will co nad/or Unit Coordinator will co nad/or Unit Coordinators will co nad/or Unit Coordinators will co not be allowed to work until edu This education will also be added hires orientation process for all employees effective 12/28/2017. Director of Nursing, Assistant D Nursing, Staff Development Co and/or Unit Coordinators will co nad/or Unit C	ast 24 hentation ensure that y grievance y will utilize nd ensure evel is rsing, taff for Unit ignment ensure that fective hirector of ordinator implete facility part time ut d respect. was on resident s ensure d. Any 28/2017 will icated. ed on new new 7. hirector of ordinator implete

Event ID: 5GBQ11

Facility ID: 943230

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/02/2018 1 APPROVED 0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMP	LETED
		345213	B. WING				_ 16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE LILLIN	ICTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERO				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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From page	89	F	241	staff to include licensed nurses and certified nurse aides, to include full tim part time and as needed nursing employees about incontinent care. The emphasis of this education was on the importance of providing incontinent car for each resident in a timely fashion a ensure resident s needs are anticipate Any nursing staff not educated by 12/28/2017 will not be allowed to work until educated. This education will also added on new hires orientation process for all new nursing employees effective 12/28/2017. MONITORING PROCESS Effective 12/28/2017, Executive Direct Director of Nursing, Assistant Director Nursing, Staff Development Coordina Director of Social Services, will comple the random audit of five residents to s any resident is noted to be soiled. Any identified dignity related violation will the addressed promptly. Findings from this monitoring process will be documented a Call light response audit form maintained in the facility compliance binder. This monitoring process will the place daily (Monday through Friday) for weeks then 3x/week for two more week then weekly for 2 weeks then monthly 3 months or until the pattern of compliance is maintained. Director of Nursing, Assistant Director Nursing, and/or Director of Social Services will observe residents for any potential for dignity violation to include signs of being soiled or left unattender extended period of time by activating to call bell in resident s room/bathroom a	e arre and ad. c be ss e tor, of tor, ete ee if / be s d on ake pr 2 eks, for c of	

Event ID: 5GBQ11

Facility ID: 943230

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/02/2 FORM APPRON OMB NO. 0938-03	VED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 11/16/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLIN	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
				LI	ILLINGTON, NC 27546	1	
(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)		
F 241	Continued From page	99) 90	F	241	observe and document response time. Effective 12/28/2017, Executive Direct Director of Nursing, Assistant Director Nursing, Staff Development Coordinat and/or Director of Social Services, will complete the random audit of call light response for five rooms to determine t call light response time. Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Developmen Coordinator, Director of Social Services (#1 or #2), will activate the call bell in resident s room/bathroom and observe and document response time. Findings from this monitoring process will be documented on a Call light response audit form maintained in the facility compliance binder. This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/w for two more weeks, then weekly for 2 weeks then monthly for 3 months or ut the pattern of compliance is maintaine Executive Director, Director of Nursing Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will report findings of this monitoring process to t facility Quality Assurance and Performance Improvement Committee any additional monitoring or modificati of this plan monthly for three months, ountil the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. TITLE OF THE PERSON RESPONSIB FOR IMPLEMENTING THE CREDIBL	or, of or, he t t t ss e e s s e e e k htil d. l, he for on or s BLE	
	7(02-99) Previous Versions Obs	olete Event ID: 5GB	011	Eas	sility ID: 943230 If contin	uation sheet Page 91 (

Event ID: 5GBQ11

Facility ID: 943230

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/02/2018 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION	(X3) DATE	
		345213	B. WING _				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE LILLIN	ICTON		19	95 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSI		GION		LI	LLINGTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page	91	F 2	241	ALLEGATION Effective 12/28/17, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction to ensure the facility remains in evolution of the provided to the second	I	
F 333 SS=E		OF SIGNIFICANT MED Errors.	F3	333	substantial compliance.		12/28/17
	by: Based on record revi physician interviews, physician's orders wh administration of sche of 3 residents reviewe #3). Findings included: 1-Record review reve admitted to the facility diagnoses which inclu and Coronary Artery I Review of Resident # revealed an order initi for 12 units of insuling	ee of any significant is not met as evidenced ew, staff, resident and the facility failed to follow ich resulted in late eduled insulin injections for 3 ed (Residents # 1, #2 and aled Resident #1 was on 5/12/2017 with ided Diabetes, Hypertension Disease. 1's signed physician orders iated and dated 5/13/2017			F333E ROOT CAUSE This alleged noncompliance was result from the Center's Licensed staff not signing medication on the electronic health records immediately after medication is administered and/or not administering Insulin within 60 minutes administration window of opportunity, a the facility lack of awareness of requirements related to notification to Physician of medication administered of of time frame as specified in the center medication administration Policy and Procedures. IMMEDIATE ACTION On 12/08/2017 Resident #1, #6, #7	of nd out	

Event ID: 5GBQ11

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF	938-039 RVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,	G	COMPLET	ED
					C	
		345213	B. WING		11/16/	2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
UNIVERS	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNE	IT 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 (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE C TO THE APPROPRIATE	(X5) OMPLETIO DATE
F 333	Continued From page	e 92	F 33	33		
		ued monthly and signed by		attending physician(s) w	vere notified of	
	the physician.			incidents of late adminis		
				that happen in the last 3		
		num Data Set (MDS) dated		Assistant Director of Nu	-	
		Resident #1 was cognitively		orders received from thi		
		nited assistance of 1 person		IDENTIFICATION OF O	-	
		aily living (ADLs). The MDS t received insulin injections		100% audit of all curren insulin orders completed		
	daily.			by Director of Nursing, a		
				Director of Nursing to id		
	Review of Resident #	1's care plan dated		resident with the docum		
		ne resident was at risk for		administration beyond the		
		lycemia (low blood sugar		window in the last 30 da		
		ar levels). The interventions		whether Physician was		
	administered as orde	nedications and insulin to be		The audit revealed 29 o identified with insulin or		
		ieu.		documented times of ac		
	Record review of the	Medication Administration		beyond 60 minutes, atte		
	Record (MAR) for Re	sident #1 from 10/19/2017		for each resident notifie		
	through 11/14/2017 r	evealed 11 documented late		by the Director of Nursir	ng. No new orders	
		for the resident's 8:30 AM		received from this notifie	cation.	
	insulin dose and 7 do					
		for the 4:30 PM insulin dose.		SYSTEMIC CHANGES	d	
		es for administration were e window of administration		Effective 12/28/2017, ar all insulin orders will be	-	
	opportunity.			within 60 minutes of adr		
	opportunity.			opportunity window. Lice		
	An interview and med	dication administration		document administration		
		ducted with Resident #1 on		after administration is de		
	11/15/2017 at 8:55 Al			Health Record. In the ev		
	• •	bed, well kempt, and alert		administration will take		
	and oriented. Nurse #	≉5 prepared and dent's insulin without any		60 minutes window of a opportunity, resident att		
		Nurse #5 exited the room		will be notified immediat		
		vas administered. During the		Effective 12/28/2017, ar	-	
		ident she indicated her		If a Licensed nurse dela		
		ninistered at 8:30 AM and		in Electronic Medication	-	
		ed there were times the		Record (eMAR) immedi	-	
	insulin administration	was late. The resident also		administration insulin ac	Iministered within	

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						IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
			A. BUILDING	<u> </u>		С
		345213	B. WING		1	1/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	1/10/2017
				1995 EAST CORNELIUS HARNETT BOUL	EVARD	
UNIVERS	AL HEALTH CARE LILLI	NGTON		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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
Г 222		- 00				
F 333			F 33			
		e nurses had an hour past		60 minutes of administration op		
		administer it before they		window, the Licensed nurses w		
		e resident indicated there		document administration both o		
		veral hours late. The resident		immediately after is able and w		
	reported her 4:30 PM			an addendum in resident s nurs		
		8:30 PM by Nurse #2 the		indicating the time of administra		
		nterview. The resident stated aware when she had issues		will clarify auto stamped time of		
		s, but felt the insulin should		In this event the physician will r notified as the insulin administr		
	be administered as o			place within the 60 minutes win		
		idered.		administration opportunity.		
	An interview was con	ducted with Nurse #5 on		Effective 12/28/2017, the cente	r nursina	
		M. Nurse #5 indicated		administrative team, which inclu	•	
		her regular assignment and		Director of Nursing, Assistant D		
		with her care. Nurse #5		Nursing, and/or Staff Developm		
		imes she administered the		Coordinator will initiate a proces		
		sulin late but tried to be very		reviewing clinical documentatio		
	•	. Nurse #5 indicated most		last 24 hours, 24 hour report sh		
		inistered within the hour of		incident reports for the last 24 h		
	-	were mornings she just		Physician orders written in the l		
		e to other situations. Nurse #		hours to ensure any needed no		
		notify the physician when the		changes to the physician, and/o		
	insulin was administe			responsible party was done in a		
				manner. This systemic process		
	An interview was con	ducted with Nurse #2 on		place daily (Monday through Fr		
	11/15/2017 at 10:40	AM. Nurse #2 confirmed he		identified issues will be address	sed	
	was the nurse who w	orked with Resident #1 on		promptly and appropriate action	ns will be	
	11/14/2017. Nurse #	2 indicated the resident's		implemented by the DHS, ADH		
	4:30 PM insulin was a	administered at around 8:30		and/or Unit coordinators. This p	orocess will	
	PM. The nurse stated	he apologized to the		be incorporated in a daily clinic	al rounds.	
		dministration. Nurse #2		Any negative findings will be do		
		administered the insulin late		on the daily clinical checklist for		
	because he was busy			maintained in the daily clinical r	neeting	
	-	e # 2 indicated there were		binder.		
		to get the resident's insulin				
		ious reasons. Nurse #2		Effective 12/28/2017, week end		
		locument the reason when it		Registered Nurse supervisor ar		
		e and he did not notify the		designated licensed nurse will r		
	physician. Nurse #2 f	urther indicated if the		clinical documentation for the la	ast 24	

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	0938-03 URVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	· · · · · · · · · · · · · · · · · · ·	COMPL	
					C	
		345213	B. WING			6/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOUL	EVARD	
				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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 333	Continued From page	e 94	F 33	3		
		gns or symptoms of blood		hours, 24 hour report sheets, in	ncident	
		d notify the physician.		reports for the last 24 hours an		
				orders written in the last 24 ho	urs to	
		ducted with Resident #1's		ensure any needed notification		
	physician on 11/16/20			to the physician, and/or respon		
		e was very familiar with		was done in a timely manner.		
		medication regimen. The ed he reviewed her blood		systemic process will take plac Saturday & Sunday. Any identi		
		n he made his facility visits		will be addressed promptly and		
	-	no concerns or issues with		appropriate actions will be imp		
	her diabetic manager	ment. The physician		by the DHS, ADHS, SDC and/o		
	indicated he was una	ware of any scheduled		Registered Nurse supervisor.	This	
		ate. The physician stated		process will be incorporated in	•	
	there was an hour of	· · ·		clinical rounds. Any negative fi		
		e expected the insulin to be . The physician indicated the		be documented on the daily cl form and maintained in the da		
		d for the well-being of the		meeting binder.		
		be given as he ordered.				
				Director of Nursing (DHS), Ass	istant	
	An interview was con	ducted with the Director of		Director of Nursing (ADHS) an		
		/16/2017 at 3:32 PM. The		Development Coordinator (SD		
		pectation was for insulin to		complete 100% education for a		
		cheduled and per the facility		nurses and Medication aides, t		
	policy.			full time, part time and as need The emphasis of this education		
	2-Record review rev	ealed Resident #6 was		the importance of administering		
	admitted to the facility			medication as ordered by phys		
		uded Diabetes, Hypertension		a timely manner for any medic		
		alysis on one side of the		specifically insulin. The educat		
	body).			cover rites of medication admir		
				and crushing of medication wh		
		6's signed physician orders		appropriate. This education w		
		November 2017 revealed an insulin to be administered		completed by 12/28/2017. Any Nurse or Medication Aide not e		
		cted between the skin and		12/28/2017 will not be allowed	-	
		at 9:00 AM and 5:00 PM.		until educated. This education added on new hires orientation	will also be	
	Review of Resident #	6's Annual Minimum Data		for all new licensed nurses and		
		revealed the resident was		Medication Aides effective 12/2		

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		MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '	G		MPLETED
						С
		345213	B. WING		1	1/16/2017
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
				1995 EAST CORNELIUS HARNETT BO	DULEVARD	
UNIVERS	AL HEALTH CARE LILLI	NGION		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 333	Continued From non	- 05	For			
F 333			F 33	33		
		ly impaired and required the				
		of 2 persons for all activities . The MDS indicated the		MONITORING PROCESS Effective 12/28/2017, Direct	or of Nursing	
	resident received ins			Assistant Director of Nursing		
				Development Coordinator, v		
	Review of the Reside	ent #6's care plan updated		compliance with timely, and		
		the resident was at risk for		medication administration by		
	alteration in blood su	gars related to Diabetes.		administration records from		
	The interventions for	-		to ensure timely administrat	ion and	
	medications and insu	llin to be administered as		documentation as ordered b	y physician.	
	ordered.			This audit will be completed		
				through Friday and ensure t		
		Medication Administration		appropriate actions are take		
		esident #6 from 10/19/2017		instance that ordered insulir		
	-	evealed 7 documented late		administered in deviation of		
		for the resident's 9:00 AM		orders. Findings from this m		
	insulin dose and 7 do	for the 5:00 PM insulin dose.		process will be documented Medication administration re		
		es for administration were		filed in the facility compliance	•	
		e window of administration		monitoring process will take		
	opportunity.			Monday through Friday for 2	•	
	opportanity.			3x/week for two more weeks		
		nducted with Nurse #6 on AM. Nurse #6 indicated she		for 2 weeks then monthly af		
		t #6 regularly. Nurse #6		Effective 12/28/2017, Direct	or of Nursing	
		would wheel around the		will report findings of this mo	•	
		hair and the insulin is given		process to the facility Qualit		
	-	ent not being available at the		and Performance Improvem	•	
		lered. The nurse indicated		Committee for any additiona		
		as administered outside of		or modification for three mo		
		pportunity to administer		pattern of compliance is ma		
		rse stated she did not		QAPI committee can modify		
		n the insulin was given late.		ensure the facility remains in		
		licated there were times the		compliance.		
	insulin was administe	ered on time and she just did				
		ministration until later in the		RESPONSIBLE PARTY		
	shift, due to being tie	d up with other things.		Effective 12/28/2017, the ce		
				Director and the Director of		
	An interview was cor	nducted with Resident #6 on		be ultimately responsible to	ensure	

Event ID: 5GBQ11

Facility ID: 943230

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345213		(X2) MULTIPL	(X3) DAT	OMB NO. 0938-039 (X3) DATE SURVEY				
			A. BUILDING	· · ·	COMPLETED			
		B. WING		11/16/2017				
NAME OF PROVIDER OR SUPPLIER					ET ADDRESS, CITY, STATE, ZIP CODE EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSAL HEALTH CARE LILLINGTON				LILLINGTON, NC 27546	EVARD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPI DEFICIENCY)		SHOULD BE	ILD BE COMPLETIC		
F 333	Continued From page 96		F 333					
	 11/16/2017 at 11:45 AM. The resident was in a wheelchair and appeared well kempt. The resident was alert and oriented. The resident indicated he didn't keep up with the time the nurse administered insulin. An interview was conducted with Resident #6's physician on 11/16/2017 at 2:20 PM. The physician reported he was very familiar with Resident #6 and his medication regimen. The physician also reported he reviewed the 			implementation of this plan of o for this alleged noncompliance the facility remains in substant compliance. Compliance Date: 12/28/2017	to ensure			
	resident's blood suga his facility visits to en or issues with diabetic physician indicated he scheduled insulin dos stated there was an h administration and he administered on time insulin was scheduled	rs and labs when he made sure there were no concerns						
	Nursing (DON) on 11, DON indicated the ex	ducted with the Director of /16/2017 at 3:32 PM. The pectation was for insulin to cheduled and per the facility						
	admitted to the facility diagnoses which inclu Review of Resident # for November 2017 re of insulin to be admin	aled Resident #7 was y on 11/2/2017 with uded Diabetes and Gout. 7's signed physician orders evealed an order for 10 units istered subcutaneously e skin and muscle) twice a						

Facility ID: 943230

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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 A. BUILDING			ID HUMAN SERVICES				FORM	D: 01/02/2018
Image: I	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA				COMPLETED	
1995 EAST CORNELIUS HARNETT BOULEVARD 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (K5) COMPLE DATE DEFICIENCY F 333 Continued From page 97 was severely cognitively impaired and required the extensive assistance of 1 to 2 persons for all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily. F 333	345213		B. WING					
UNIVERSAL HEALTH CARE LILLINGTON 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 97 F 333 Continued From page 97 was severely cognitively impaired and required the extensive assistance of 1 to 2 persons for all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily. F 333	NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE DATE F 333 Continued From page 97 was severely cognitively impaired and required the extensive assistance of 1 to 2 persons for all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily. F 333 F 333	UNIVERSAL HEALTH CARE LILLINGTON							
was severely cognitively impaired and required the extensive assistance of 1 to 2 persons for all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	x	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	3E	(X5) COMPLETION DATE
11/14/2017 revealed the resident was at risk for alteration in blood sugars related to Diabetes. The interventions for the risk included medications and insulin to be administration Record review of the Medication Administration Record (MAR) for Resident #7 from 11/9/2017 through 11/14/2017 revealed 7 documented late administration times for the resident's 9:00 AM insulin dose and 4 documented late administration times for the 9:00 PM insulin dose. The documented times for administration opportunity. An interview was conducted with Nurse #6 on 11/16/2017 at 10:15 AM. Nurse #6 indicated she worked with Resident #7 regularly. The nurse indicated there were times the insulin was administeration. The nurse stated she did not document the reason the nursus indicated sometimes the usual was given late. The nurse stated she did not document the reason the insulin was agiven late. The nurse administration until later in the shift, due to being tied up with other things. An interview was conducted with Resident #7's	F 333	was severely cognitiv the extensive assistant activities of daily living indicated the resident daily. Review of Resident # 11/14/2017 revealed alteration in blood sug The interventions for medications and insu ordered. Record review of the Record (MAR) for Re through 11/14/2017 re administration times f insulin dose and 4 do administration times f The documented time beyond the 60 minute opportunity. An interview was con 11/16/2017 at 10:15 A worked with Resident indicated there were f administered outside opportunity to administ indicated sometimes get to everything on ti did not document the given late. The nurse times the insulin was she just did not docur later in the shift, due f	ely impaired and required nee of 1 to 2 persons for all g (ADLs). The MDS received insulin injections 7's care plan updated the resident was at risk for gars related to Diabetes. the risk included lin to be administered as Medication Administration sident #7 from 11/9/2017 evealed 7 documented late for the resident's 9:00 AM cumented late for the 9:00 PM insulin dose. es for administration were e window of administration Multiple administration aducted with Nurse #6 on AM. Nurse #6 indicated she for the insulin was of the hour window of ster medications. The nurse she was busy and could not ime. The nurse stated she reason the insulin was further indicated there were administration until to being tied up with other	F	333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 01/02/2018 FORM APPROVED OMB NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345213		B. WING				C 11/16/2017		
NAME OF PROVIDER OR SUPPLIER			•		STREET ADDRESS, CITY, STATE, ZIP			
UNIVERSAL HEALTH CARE LILLINGTON					1995 EAST CORNELIUS HARNETT LILLINGTON, NC 27546	BOULEVARD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAC	IX	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE
F 333	physician on 11/16/20 physician reported he Resident #7 and his r physician also reporter resident's blood suga his facility visits to en- or issues with diabetic physician indicated he scheduled insulin dos stated there was an h administration and he administered on time. insulin was scheduled residents and should An interview was con Nursing (DON) on 11/ DON indicated the ex	017 at 2:20 PM. The e was very familiar with nedication regimen. The ed he reviewed the rs and labs when he made sure there were no concerns	F	333				

Facility ID: 943230

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