PRINTED: 07/23/2018 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C 06/08/2018
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	·
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F 000	INITIAL COMMENTS A recertification & co		F 00	00	
	conducted from 6/04/ Immediate Jeopardy	18 through 6/08/18 was identified at:			
	CFR 483.12 at tag F6 CFR 483.70 at tag F6	600 at a scope and severity J 607 at a scope and severity J 335 at a scope and severity J			
	Quality of Care.	607 constituted Substandard			
E 505	removed on 6/07/18. conducted.	began on 6/04/18 and was An extended survey was	F 5.		74040
F 565 SS=E	Resident/Family Grou CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 56	00	7/10/18
	and participate in res (i) The facility must p group, if one exists, v	ident has a right to organize ident groups in the facility. rovide a resident or family vith private space; and take			
	to make residents an upcoming meetings i (ii) Staff, visitors, or o	ther guests may attend			
	the respective group' (iii) The facility must	nily group meetings only at solve invitation. Sorovide a designated staff over the resident or family			
	providing assistance requests that result from	and who is responsible for and responding to written om group meetings.			
	resident or family gro the grievances and re groups concerning is	up and act promptly upon ecommendations of such sues of resident care and life			
AROBATORY	in the facility.	SUPPLIER REPRESENTATIVE'S SIGNATUR	DE	TITLE	(X6) DATE

Electronically Signed 07/04/2018

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.

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED	
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response and rationa (B) This should not b facility must impleme	le for such response. e construed to mean that the nt as recommended every					
family member(s) or representative(s) me families or resident re residents in the facilit This REQUIREMENT	other resident et in the facility with the epresentative(s) of other y.					
Based on interviews members and review the facility failed to re the Resident Council previous 5 of 8 month	of Resident Council minutes esolve concerns voiced by members during the hly meetings.		constitutes a written allegation compliance. Preparation and s of this plan of correction does constitute an admission or agrethe provider of the truth of the	of submission not eement by facts		
Resident Council Me 2017, November 201 2018, February 2018	eting minutes from October 7, December 2017, January , March 2018, April 2018,		conclusions set forth by the su on-site. This plan is solely prep because of requirement under federal law, and to demonstrat faith attempts by the provider t	rveyors pared state and the the good o improve		
October 31, 2017 ind concerns regarding no requested. The Resi November 2017, Jan April 2018, and May ice primarily on 2nd siminutes for November 2017.	icated residents voiced not receiving ice as dent Council minutes from uary 2018, February 2018, 2018 indicted not receiving shift. The Resident Council er 2017, January 2018, and		F565 ROOT CAUSE Root cause analysis conducted facility Executive director, Director nursing, Activities director and Clinical Officer from the management.	d by the ctor of the Chief gement and		
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page (A) The facility must I response and rational (B) This should not be facility must impleme request of the resident family member(s) or representative(s) meresidents in the facility This REQUIREMENT by: Based on interviews members and reviews the facility failed to resident the Resident Council previous 5 of 8 month. The findings included Resident Council previous 5 of 8 month. The findings included Resident Council previous 5 of 8 month. The findings included Resident Council previous 5 of 8 month. The findings included Resident Council previous 5 of 8 month. The findings included Resident Council previous 5 of 8 month. The findings included the fin	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced	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 1 (A) The facility must be able to demonstrate their response and rationale for such response. 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The Resident Council minutes from November 2017, January 2018, February 2018, April 2018, and May 2018 indicated not receiving ice primarily on 2nd shift. The Resident Council minutes for November 2017, January 2018, and May 2018 indicated that snacks or ice were not	ROYIDER OR SUPPLIER AL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 1 (A) The facility must be able to demonstrate their response and rationale for such response. 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WING STREETADDRESS, CITY, STATE, 2IP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCICIPED BY PTUL. REQUIATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident for family group. \$483.10(f)(6) The resident has a right to have family member(s) or other resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews with Resident Council members and review of Resident Council minutes the facility failed to resolve concerns voiced by the Resident Council members during the previous 5 of 8 monthly meetings. 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F 565	Continued From page	e 2	F 5	65		
	with the facility's resident residents present meeting residents expresolution of grievand meeting reported not on promptly by the facxplanation given as resolved. The resident they discussed the satisfactive received reeducation tasks but there was not requested for snacks residents reported the ice would be provided Residents stated a stresident CouncCouncil	they have repeatedly and ice to be provided. The ey were told that snacks and don evening shift. aff member was present at		unresolved resident complair the employee culture within the Among other factors it was collack of resident centered care culture, customer service cultion of consistent staffing who progresidents in the facility play a alleged non-compliance. IMMEDIATE ACTION No resident named in this alle non-compliance. Resident council minutes dat 31st, 2017, November 2017, 2018, February 2018, April 20 2018 reviewed by the facility Director and Activity Director New grievances related to loo by the facility Activity Director nursing ensured residents re-	he facility. concluded that e delivery ture and lack evide care for role in this eged ed October January, 018, and May Executive on 7/2/2018. e completed r. Director of	
	Director on June 8, 2 reported that she is p Resident Council merconcerns. She indicated concerns with the Demorning's daily clinicated that she received a rethe Department Head Activities Director stated Resident Council merverbally at the next mass aware some commonth. The Activities was unsure why the seach month by the resident council merverbally at the next mass aware some conmonth.	ducted with the Activities 018 at 10:15 AM. She resent during monthly etings and recorded resident ated she discusses the partment Heads in the next al meeting. She reported esponse to the concern from ds within 3-5 days. The ted she informed the mbers of the resolution neeting. She stated she explaints were repeated each es Director stated that she same concerns were voiced esidents at the resident ne indicated the resolution to		appropriately on 7/2/2018. Resident council minutes dat 31st, 2017, November 2017, 2018, and May 2018 reviewe facility Executive Director and Director on 7/2/2018. New gr related to snacks or Ice compfacility Activity Director. Directors appropriately on 7/2/2018 and forth. IDENTIFICATION OF OTHEI All residents in the facility has to be affected by this alleged noncompliance.	January, Id by the Id Activity	

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F 565	Continued From page	÷ 3	F 5	65				
	the Director of Nursin to be offered. An interview with the	g that snacks and ice were Director of Nursing was		fi C C	100% audit for Resident Council minut from January, 2018 to June 2018 was completed on 7/2/2018 by the Activity Director to identify any other unresolve epeated grievances. One other area w	d /as		
	reported each time he he provided reeducat	, 2018 at 10:45 AM. He e was advised of a concern ion to his staff. He stated it ce and snacks were passed		F H	noted to be repeated and unresolved. Resident council minutes reveals that Housekeeping area, specifically cleanliness of the facility was identified unresolved repeated grievance Februa	as		
	An interview was con Clinical Officer on Jur He stated he believed resident complaints is culture within the faci was working towards their services by recru staff.	ducted with the Chief ne 8, 2018 at 10:50 AM. If the reason for repeated Is due to the employee Ility. He stated the facility a culture change to improve uiting and retaining capable		2 2 7 11 5 7 0	2018, March, 2018, April, 2018, May, 2018 and June, 2018. New grievances elated facility cleanliness completed be facility Activity Director on 7/2/2018 Director of House Keeping and Laundr Services cleaned the identified areas of 7/2/2018. Findings of this audit is documented on "Resident council minualit tool located in the facility compliant binder.	y s. y n		
	stated he was aware and snacks were freq Resident Council med stated that these conforming meeting afte meetings. He stated to address this issue improvement process that it was his expect.	e 8, 2018 at 11:00 AM. He that concerns regarding ice quently repeated in the etings. The Administrator cerns were shared in the r Resident Council that the facility was working through the facility's quality s. The Administrator stated ation that department heads d to issues brought up at the		E n s c F S e ttl E d a li n r	EYSTEMIC CHANGES Effective 7/10/2018 resident council ninutes will be discussed on the daily stand up meeting by the Activity Director designated staff daily (Monday throus friday) until the resolution is obtained. Stand up meeting consist of members each department in the facility and led the facility Executive Director. Effective 7/10/2018; Concerns voiced during the resident council meeting will addressed using Performance mprovement Process (PIP) with monitoring process in place until the esolution is obtained. Findings and esolution of resident council	ugh of by be		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 565	Continued From page	e 4	F	565	the facility receive ice and are offered bedtime nutritional snack as appropriat by the facility certified nursing staff to include licensed nurses, Medication aid and/or certified nursing assistants. Effective 7/2/2018 nutritional snacks arkept available in the two nourishment rooms in the facility to accommodate a requests for snacks from any facility resident. Facility Director of Nursing (DON), Assistant Director of Nursing and/or Urmanager will complete 100% education on the importance of delivering ice eves shift for resident who are appropriate to receive ice per physician orders, offering bedtime snacks for all active residents appropriate based on individual resider diet restrictions, and the location of snacks on the units to be offered. This education will be provided for all license nurses, medication aides and nursing assistant to include full time, part time as needed licensed nursing staff. This education will be completed by 7/10/2018 will not be allowed to work uneducated. This education will also be added on the new hire orientation processor of all new licensed nurses and nursing aides effective 7/10/2018, Director of Nursing Assistant Director of Nursing, Unit manager and or designated licensed	e ny iit n ry ng as nt ed and 18. In ntil ess	

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F 565	Continued From page	• 5	F 50	nurse , will monitor compliance with resident resident's ice delivery and offering of snacks to residents by randomly checking ten randomly select residents in different halls on each shift ensure ice is offered as appropriate as well as bedtime snacks. Any issues identified during this monitoring process will be addressed promptly. Findings for this monitoring process will be documented on a "Snack & Ice monitot tool "and filed in the facility compliance binder after proper follow up is done. To monitoring process will take place daily two weeks, weekly x 2 more weeks, the monthly x 3 months or until the pattern compliance is maintained. Effective 7/10/2018, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement. Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee camodify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/2018, the center Execut Director and the Director of Nursing with the pattern of correction of this plan of correction of this alleged noncompliance to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation in substantial compliance.	it to ss soom ring chis y for en of g se se sive sive sil	

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	The provider or supplier RSAL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 Free from Abuse and Neglect		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	·	
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F 600 F 600 SS=J	Free from Abuse an CFR(s): 483.12(a)(1) §483.12 Freedom fr Exploitation The resident has the neglect, misappropriand exploitation as includes but is not licorporal punishmen any physical or chell treat the resident's rich §483.12(a) The faci §483.12(a) The faci facility for the facility for th	d Neglect) om Abuse, Neglect, and e right to be free from abuse, iation of resident property, defined in this subpart. This mited to freedom from t, involuntary seclusion and mical restraint not required to nedical symptoms. ity must- se verbal, mental, sexual, or coral punishment, or n; T is not met as evidenced view, staff, resident, artment of Social Services facility failed to protect 1 of 3 #84) from physical abuse was witnessed by facility staff		F600 ROOT CAUSES This alleged noncompliance resulthe center's failure to protect one with prior history of suspected do abuse from a spouse. On 4/25/2 facility admitted resident #84 for rehabilitation and long term care placement. Resident #84 had a porder named "Ex parte order" file	e resident omestic 018 the protective
	both arms in front of identified as his wife bed close to Reside stomping on Reside were assessed. Imm removed on 6/7/18 implemented an acc	r speaking loudly and shaking his head. A female visitor, was observed seated on the nt #84 hitting, kicking and nt #84. No physical injuries hediate jeopardy was when the facility provided and reptable allegation of removal. The facility		Harnett County Clerk of Superior 4/24/2018. The protective order presented to the facility at the tin admission on 4/25/2018 by the a Social worker from the Departme Social Services. The protective concluded information that the "de of Social services is concerned to possibility of physical abuse and	was ne of assigned ent of order partment with the

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	severity of "D" (no ha more than minimal ha	iance at a lower scope and rm with the potential for arm that is not immediate nonitoring systems put in			it also added that "Without a protective order department of Social Services is concerned the wife will remove respondent from the hospital/rehab."			
	Findings included:				The root cause analysis, concluded that the systemic failure that resulted onto resident #84 incident on 6/4/2018	at,		
	4/25/18 under an ord Petition for Ex Parte (Department of Social Protective Services (A part, "The undersigned of the county DSS) at representative (APS) having sufficient known respondent (Resident protective services at (Resident #84) is a di of protective services specific facts, j. witho	Social Worker-SW #1) wledge to believe the t #84) is in need of leges: 3. The respondent isabled adult who is in need based on the following ut a protective order DSS is ill remove respondent			includes, broken communication proce from admission for necessary informat to include protective orders for residen #84. As a result the resident #84 multiplitimes with no appropriate interventions protect resident #84. The broken communication process resulted from a lack of a systemic process set forth on how protective orders was to be communicated by the admission Direct to the rest of the IDT. Although the facility received the documentation on admission on 4/25/2018, and was notified by the DS social worker of the protective orders of this resident, there is no indication that	ion t e to a tor		
	read, in part, "Probler pubic ramus; (3) fract closed (forearm); (4) (7) neglected elder. S (Resident #84) wife." An incident report datallegation of visitor to witnessed by 2 staff room. A narrative of walking past resident	the summary dated 4/25/18 ms: (2) closed fracture of the cure of radius, distal right, masal fracture; (5) assault; suspected abuse by pt.'s ted 6/4/18 revealed an resident abuse was members in the resident's the incident read, "Staff was 's room at 4:42 PM when with his hands in the air and			facility put forth measures to protect Resident #84 from his wife. Admission Director failed to communicate the pertinent information to the interdisciplinary team necessary to insi resident #84 was protected while in the facility from his wife. On 6/4/2018 the resident's spouse was witnessed by the facility Activity Aide, & Central Supply Aide #1 in the room wit the Resident #84. Activity Aide and Central Supply Aide stated they witnes	ure e s & k h		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COM	E SURVEY PLETED
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F 600 Continued From	page 8	F 60	0		
yelling. The reside him on the legs a Resident denied evident. Resident police were notificated resident's wife spoulding and is not a nursing note display and is not a nursing note display and is not the air and yelling noted kicking him feet. Resident devident. Resident police were notificated with a statement prown witness #1 read #84) being physically abusing stomping on his approximately at An interview was with Witness #1. The hall Resident speaking loudly a shaking. She stath is wife was obstomping his feet.	lent's spouse was noted kicking and stepping on his feet. pain and no bruising was t was supervised for safety and ed and responded. The bouse was escorted from the lot to return until further notice." ated 6/4/18 at 7:27 PM read, g past resident's room at 4:42 bed resident with his hands in g. The resident's spouse was non the legs and stepping on his enied pain and no bruising was t was supervised for safety and ed and responded. The bouse was escorted from the lot to return until further notice." aided on 6/4/18 to the facility by in part, "I witnessed (Resident cally abused by his wife. I was e hall Resident #84 resided on) Resident #84's) wife was ig him by kicking his legs and feet. This incident happened	F 60	resident's spouse kicking reside and stepping on his feet. Reside spouse were immediately separ the Central Supply Aide. A Com Head to toe body assessment we completed by the Registered nut Supervisor #1. No injuries noted denied any signs and symptoms discomforts. Initial report for the abuse was completed and sent 6/4/2018, DSS social worker an attending Physician notified. IMMEDIATE ACTION TAKEN On 6/04/2018 at approximately the Central supplies aide separaresident #84 from his wife by purout of the room to the hallway. It is supplies aide remained with resent he hallway, and notified Assent Director of nursing who was staten the proximity at the nurse's static ADON walked towards the residuance accompanied by the Unit Managarelieved the central supplies aid over supervision and protection resident #84. Unit Manager #1 of a head to toe assessment of the and noted no injuries. Resident pain or discomforts. Central supplies aide notified a records supervisor who was state the nurse station #1. Medical rewalked to the resident's room in and met Unit Manager #1 in the Medical records aide assisted Unit Medical record	ent and the rated by plete vas arse d, resident sof pain or alleged on d the standard by the s	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345213	B. WING _				C 08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		L	ILLINGTON, NC 27546		
(X4) ID		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 APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	Continued From page		F	600			
	#84 from the room an	•			and Medical Records supervisor		
	common area where				transferred resident #84 to the wheel c	hair	
	,	cords Director) stayed with			and moved the resident to the dining a	rea.	
		d. She also stated, "This is			Medical Records supervisor remained		
		lmission here. I think he was			with resident #84 until the police arrive		
		ve order the second time			with a brief period when she was reliev		
		sically abused him. This is			by the transportation aide who stayed	vith	
		nd I believe he's under			the resident when Medical Records		
		w." She stated the wife			supervisor departed.		
		ng the second admission, often this admission. She			Likewise the ADON who left Unit		
		a positive identification			Likewise, the ADON who left Unit Manager #1 with resident#84 walked to		
	6/4/18.	a positive identification			the Executive Director's office for	,	
	0/4/10.				notification. On 06/04/2018 the 24 hour	r	
	A statement provided	on 6/4/18 to the facility by			initial report was sent to the Departmen		
		art, "I, (Witness #2) walked			of Health and Human Services related		
		sident #84) and saw him			resident #84's witnessed abuse by the		
	and his wife hitting ea				spouse. These reports were completed	1	
					and submitted by the Director of Nursir	ıg.	
	An interview was con	ducted on 6/5/18 at 1:10 PM			The Five day report was completed on		
	with Witness #2. She	stated she walked by			6/7/2018 after a detail investigation wa	s	
	Resident #84's room	and observed Resident #84			conducted by the Center Executive		
		nch other. She stated, "I			Director, Director of Social Services an	d	
		sit quite often but I had never			Director of Nursing. The incident on		
		action before. When he was			6/4/2018 against resident #84 was		
		tation) hall she stayed with			substantiated based on findings of the		
		nis admission she wasn't			investigation conducted by the Facility,		
	here so much. When	•			Department of Social Services, and		
		hitting him we took him out			Harnett county Police Department.		
		ely. We put him in the TV			Resident #84's spouse is ordered by th		
		nd had (Medical Records			court not to visit or be in contact with the		
	Director) stay with the	em.			resident effective 6/5/2018. Facility has		
	An intorvious	duated with Desident #04 are			yet to receive a confirmation of actions		
		ducted with Resident #84 on			taken legally against the spouse. Facili	ιy	
		ne resident stated he had			will keep resident on 1 on 1 until	c	
		years and she was not			confirmation is obtained of the spouse' inability to come to the facility.	5	
	hitting me is baloney.	ed, "All this talk about her			mability to come to the facility.		
	many me is baloney.				The photograph of the alleged perpetra	ator	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345213	B. WING _				C 08/2018
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILL	INGTON			ILLINGTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From pag	ge 10	F 6	600			
F 600	No care plan related Resident #84 was in witnessed physical at An interview was co with APS SW #1. She the hospital in April In #84's) 3rd admission October 2017 for must he also stated they was harming him. She also stated they was harming him. She also stated they was harming him. I spoke was put in a didn't he abuse him. I have a significant with the second him in because of beginning of April he because we didn't he abuse he went home re-admitted to the he again in April, and refacility and hospital sphysically abusing he at the time of his last left alone with her forme they would only common areas, his was put in a room up	I to safety measures for ititated until after the abuse. Inducted on 6/5/18 at 3:00 PM are stated she was called to related to (r/t) (Resident in to the hospital since altiple fractures and bruises. If (APS) suspected his wife the stated, "The facility was his admission in April antial for his wife to physically with the Admission's at the time of his admission. The swas his 3rd admission to great him out against medical and 17 and tried to do the same cond admission) but she the protective order. So in the amproved tremendously and the avec concrete evidence of the with her. He was apspital with multiple fractures are admitted to the facility. The speculated his wife was im. I explained to the facility admission he was not to be reformed to meet in door was to be kept open, he of front near the	F	600	(resident#84 wife) is currently posted at the front desk, and at each nurse's staffor easy identification and notification effective 6/6/18. The photograph is located on the pertinent location where employees can identify resident #84's wife. Facility Executive Director, Director of Nursing, and Social worker from Department of Social Services met brie on 6/5/2018 to discuss the incident that happened on 6/4/2018. The team discussed the possible actions necessate to protect the resident from the spouse Multiple ideas were discussed, such as room change, identify the resident with different name, or transfer resident #84 another location that the spouse will not be aware of. On 6/5/2018, the facility a well as the DSS social worker reached conclusion that, the best course of activithat will protect resident #84 from his spouse, while maintaining his dignity, self-determination, and reduce risk for deterioration from this event is to relocate resident #84 to another part of the facil Resident #84's name was changed on 6/5/2018 to an alias to ensure his protection by the facility Director of Nursing, Executive Director and Admission Director.	efly t ary a to ot s a on	
	Administrator's office approximately 100 for office) so it would be was going on, and h room with an alert a				Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was change Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was	e d.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(.	X3) DATE SURVEY COMPLETED
						С
		345213	B. WING _			06/08/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	
				1995 EAST CORNELIUS HARNETT	BOULEVARD	
UNIVERSA	AL HEALTH CARE LIL	LINGTON		LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 600	Continued From pa	-	F 6	600		
F 600	know that woman is disagree, but we no room assignment a were put into place time. So the facility situation. When I as happened they told all the time. Now we a Domestic Violence police are pressing be arrested this after that was a considered with AC #1. She state that the safety discussions was under APS for investigation." She admitted in Septem against medical add 2017. He was re-act and discharged hor third time by APS Sthey had suspicions Resident #84 and he An additional intervion 6/6/18 at 9:05 A plans in place for R was admitted because facility what to do. Satisfacion and denies	shurting him.' I told her I didn't seeded proof of abuse. His and those protective measures before he was admitted last was well aware of the sked them today what me they couldn't monitor him are are in the process of getting to e Protective Order, the (local) assault charges, and she will the ernoon." I tonducted on 6/5/18 at 3:55 PM and the had no recall of any with APS SW #1, just that he "some type of on-going stated Resident #84 was aber 2017 and signed out vice by his wife in October of dimitted 3/8/18 by APS SW #1 me 4/5/18. He was admitted a tow #1 on 4/25/18. She said as of domestic violence but both	F	initiated on 6/5/2018 in whemployee observe the resident while in the facility. One on one supervision won 6/27/2018, after the factor and Improvem determine that resident ### protected from his wife wineasures in place such a means of egress, residen another room and changename. IDENTIFICATION OF OT 100% audit of current resifles was completed by the Admission Director and Benanger on 6/6/2018 to irresident with protective of validated the facility has replace to protect the resident alleged perpetrator. The action of the resident has protect related to abuse/neglect. audit are documented on files audit tool" located in compliance binder. On 06/06/2018, 100% intrompleted by Director of Center, Business office Modern points of the protect of the pure to protect the resident has protect and the protect of the protect of the protect of the pure tool of the protect of the protect of the protect of the pure tool of the protect	vas discontinue cility Quality nent Committee 84 is safe and ith the other as locking the trelocation to e resident □s HERS idents financial e Facility any other ders and measures in ent from the audit revealed relocation to the facility entire orders Findings of this the "financial the facility erviews was Rehabilitation lanager, Activities Supervisor ar	ed er no s
	An additional interv at 3:35 PM with AP #1 stated she had s	iew was conducted on 6/6/18 S SW #1 and AC #1. APS SW spoken to AC #1 on the day of) and explained why Resident		residents in the facility to resident with an allegation and/or Neglect. Two othe Resident #2, and Resider allegation of abuse and/o	identify any oth n of Abuse r residents, nt #3 voiced	ner

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				OIVID INC	<u>7. 0936-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY
						(C
		345213	B. WING			06/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HNIVERS	AL HEALTH CARE LILLI	NGTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
ONIVERS	AL IILALIII CANL LILLI	NGTON		LI	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
					,		
F 600	Continued From page	e 12		600			
			1	000	Alleged permeters identified ways		
		der a protective order and			Alleged perpetrators identified were		
	I .	eing protected. It had always			suspended while the investigation is		
	I .	vife was abusing him, but he			conducted by the facility Executive		
	, ,	nitively intact, until this			director and/or Director of Nursing. 24	10	
		always denied abuse. He			hour reports were submitted on 6/6/20	10.	
		#1 his wife was the abuser			A thorough investigation initiated. The		
	on 6/5/18. APS SW #			resident's attending Physician and			
	admission (AC #1) to			Responsible Party were notified of the			
	wife was abusing him			allegation. Resident #2 and #3, will be			
		he abuse. We discussed			informed of the findings and actions tal		
	1 -	-private room for safety, on			when the investigation is completed by		
		e traffic and (AC #1) and I			Center Executive Director and/or Direct	lOI	
		oor open when the wife			of Social Services.	nt	
	I .	out keeping visits to the			The Director of Social services, Assista	arit	
		alized she could hit him just			Director of Nursing, Unit manager, Admission Director and Director of		
		non area as in his room. I v visits with the wife behind			Rehabilitation Services interviewed the		
		otective order I gave them			responsible parties for residents who w		
		protected from his wife			not able to answer questions during thi		
		it I needed proof of physical			interview due to mental capacity.	3	
		ad that until Monday. Now			interview due to mental capacity.		
	I .	iolence Order of Protection			SYSTEMIC CHANGES		
	(DVPO) in place."	loience order or rotection			Effective 6/7/2018, interviews for alert	and	
	(BVI O) III place.				oriented residents will be completed by		
	A review of the DVP0	O revealed it was issued			the Director of Social Services, Directo		
		d named Resident #84's wife			Recreational Services and/or designate		
	the defendant.	a named resident #5 r5 wile			staff member at least once every mont		
					identify any allegation of Abuse and/or		
	An interview was con	nducted with MDS Nurse #1			Neglect. This interview will be		
		on 6/6/18 at 11:20 AM. She			documented on the psychosocial		
	'	was involved when (Resident			assessment tool. Any voiced allegation	of	
	I .	e, but I didn't know there was			abuse, and/or neglect will be reported		
	1	place until after the incident.			the Center Executive Director promptly		
		for safety today." No care			Alleged perpetrators will be suspended		
	, ,	nterventions APS SW #1 and			pending investigation by the facility, an		
	AC #1 agreed to on 4				reported according to the regulatory		
	admission).	•			requirements.		
	,				The Director of Social services, Assista	ant	
	An interview was con	nducted on 6/6/18 at 12:50			Director of Nursing, Unit manager,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345213	B. WING		06	6/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
LIMIVEDO	AL HEALTH CARE LILLI	NCTON		1995 EAST CORNELIUS HARNETT BOI	JLEVARD		
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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 13	F 60	00			
	(DON). They stated to residents would be possibility she wasn't from. If I had concret would have had interest at the time of hire and incident. The Administ systems failed (Residucouldn't predict the word possibility she wasn't from. If I had concret would have had interest and abuse had interest.	rator and Director of Nursing heir expectations were all rotected at all times from behavior could not be histrator stated systems were diprotect residents (rounds, if were in serviced on abuse diannually, and after an strator stated, "I don't feel our dent #84) because we life's behavior. There's a who he needed protection e evidence it was her we ventions in place. I had no		Admission Director and Director Rehabilitation Services will in responsible parties for reside not able to answer questions interview related to allegation and/or Neglect due to mental deficit. This interview will be con the psychosocial assessm voiced allegation of abuse, are will be reported to the Center Director promptly. Alleged pewill be suspended pending in by the facility, and reported a the regulatory requirements.	terview the ints who will during the of Abuse capacity documented ent tool. Any ind/or neglect Executive rpetrators vestigation		
	Administrator on 6/6/ Admission's Coordinate APS protective of the	w was conducted with the 18 at 4:00 PM. He stated the ator had not informed him of order at the time of admission. Iducted on 6/6/18 at 9:15 AM ords Director. She stated the lon abuse annually and as g done was the resident in and brought to safety. They until told by administration to ated, at the time of Resident safety measures in place in a room with high traffic, remained open when his were kept in the common esible. She stated there was on he was being abused by . She also stated when she f he was alright he said yes in to hurt me." The Medical o stated the facility had kept		Effective 6/7/2018 a copy of a resident sprotective orders admission or readmission by admission director or designaturing the admission process placed in the medical file und advance directive tab for easidentification and accessibility nursing staff. Effective 6/7/2018, the center administrative team, which in Nurse supervisors, Unit Mana SDC, added reviewing of DS orders to an existing process clinical documentation for the hours, which includes complet assessments, incident reports 24 hours, and Physician ordet the last 24 hours. By adding the DSS protective orders to this will ensure that any resident whistory of allegation of abuse, and/or injuries of unknown so	received on the the ted person is, will be er the your by the received by the last 24 by the last received by the last received by the receive		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING				C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	1 11211			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	06/2016	
	1011211101110011121211				1995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLI	INGTON			LILLINGTON, NC 27546			
					<u> </u>		ı	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From pag	e 14	F	600				
		n his room since his 2nd	' `	000	the resident from the alleged perpetrat	or		
	admission.	This footh since his 2nd			effective 6/7/2018. This process with ta			
	admission.				place daily Monday through Fridays	ike		
	An interview was co	nducted on 6/6/18 at 9:30			effective 6/7/2018. The result of this			
		hysician (MD). He stated he			systemic process will be documented of	on		
		ent #84 was here under APS			the clinical meeting form maintained in			
		he was notified of the			Daily Clinical meeting binder.			
	resident's assault on Tuesday (6/5/18) morning.				Effective 6/7/2018, the week end			
	He also stated, "If the facility was aware he was				Registered Nurse supervisor and/or			
		ection they never should			designated licensed nurse will review			
	have let the wife visit him alone under any				clinical documentation for the last 24			
		y he is remarkably alert and			hours, completed skin assessments,			
		his wife in no way abused			incident reports for the last 24 hours, a	nd		
		der he came in with is very			Physician orders written in the last 24			
		have been left alone with any			hours to ensure that any allegation of			
		APS SW #1). It was the			abuse, neglect and/or injuries of unkno	wn		
		y to protect this man from if they could not prevent her			sources reported/documented is investigated thoroughly, the alleged			
		ey never should have left			perpetrator is suspended pending			
	_	nember should have been			investigation, and ensure the event is			
		sits. I was notified Tuesday			reported to the facility Executive Direct	or		
		was seen abusing him. I			This process will also incorporate	01.		
	_	assessed him for injuries, and			reviewing of any DSS protective orders	s to		
	I saw him today."	•			ensure the facility put measures in place			
	•				to address such orders. This systemic			
	An interview was cor	nducted with Resident #84's			process will take place every Saturday			
	roommate on 6/6/18	at 11:30 AM. He stated, "I			and Sunday. Any negative findings will	be		
	was in the room whe	en his wife was shoving and			documented on the week end supervis			
	_	hit him before too. When			report form and maintained in the daily			
		old the Nursing Assistants			clinical meeting binder, effective 6/7/20			
		ame in closed the door and			Effective 6/7/2018 the Admission Direct			
		When she's in here, and I'm			(AD) will print any protective order for a	-		
		upposed to be open. I don't			referral to the facility before bed is offe	red.		
		nim." The roommate was not			The AD will then provide copies of the	_		
		IA's he told or when he told			protective order to the facility Executive			
	them about what he	saw.			Director, Director of Nursing, Director of Special sequences and/or designated licen			
	The Administrates D	ON and Cornerate			social services and/or designated licen			
	The Administrator, D	ified of the immediate			nurse. The IDT team will then review a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		С		
		345213	B. WING				08/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010	
					995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLI	NGTON			ILLINGTON, NC 27546			
					 T		I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	e 15	F	600				
		t 2:55 PM. On 6/7/18 at	'	000	to admitting resident to the facility to			
	, ,	provided the following			ensure measures are put in place to			
	-	compliance and immediate			protect the resident when admitted to t	he		
	jeopardy removal:	compliance and immediate			facility.	10		
		npliance resulted from the			Effective 6/7/2018; received protective			
	_	tect one resident with prior			orders will be added to resident s care			
	I -	domestic abuse from a			plan by the Admitting nurse and/or			
		spouse. On 4/25/2018 the facility admitted			Nursing supervisor and nursing aide ca	ıre		
	resident #84 for rehabilitation and long term care				guide for accessibility by both license			
	placement. Resident	#84 had a protective order			nurses and nurse aides. If the protective	е		
	named "Ex parte order" filed in Harnett County				order includes guidelines such as			
	•	urt on 4/24/2018. The			supervised visits, no visitation, or not			
	I -	presented to the facility at			allowed on the premises such measure			
	the time of admission				will be added to resident s face sheet			
	_	ker from the Department of			and appropriate information posted suc	:h		
		protective order included			as the perpetrator picture and/or	··		
	information that the "	-			description in a readily accessible local	.ION		
		d with the possibility of			in the facility.			
		neglect", it also added that order department of Social			Facility Director of Nursing (DON), Assistant Director of Nursing and/or Ur	sit.		
		d the wife will remove			manager will complete 100% education			
	respondent from the				on the location of protective orders in	1		
	respondent nom the	nospitamenas.			each resident □s medical charts and th	_		
	The root cause analy	rsis, concluded that, the			location of intervention necessary to			
		resulted onto resident #84			protect the resident with protective order	ers.		
	incident on 6/4/2018				This education will also cover process			
		ess from admission for			be taken if the protective order to include			
	-	n to include protective orders			adding the protective order intervention	ıs		
	for resident #84. As a	a result the resident's alleged			to resident □s care plan and to nursing			
	perpetrator visited re-	sident #84 multiple times			aide care guide for accessibility by botl	1		
		nterventions to protect			license nurses and nurse aides.			
		oken communication process			Guidelines such as supervised visits, n			
		of a systemic process set			visitation, or not allowed on the premis			
	forth on how protective				will also be covered in this education.	he		
		e admission Director to the			education will also emphasize on the			
	rest of the IDT.				process that such information will be			
	Althorope (I. C. 199	and the day of the Control of the Co			added to resident □s face sheet and			
		received the documentation			appropriate information posted such as			
	⊢on admission on 4/25	5/2018, and was notified by			the perpetrator picture and/or description	ווכ	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 06/08/2018		
NAME OF D	ROVIDER OR SUPPLIER	0.02.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	•	6/06/2016	
NAME OF FI	NOVIDER OR SUFFLIER			, , ,			
UNIVERSA	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BO	DULEVARD		
				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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From page	e 16	F 6	00			
F 600	the DSS social worker this resident, there is put forth measures to his wife. Admission D communicate the per interdisciplinary team resident #84 was profrom his wife. On 6/4/2018 the reside by the facility Activity #1 in the room with the Aide and Central Supwitnessed resident's and stepping on his fispouse were immedia Central Supply Aide. body assessment was Registered nurse Supnoted, resident denie of pain or discomforts abuse was completed social worker and the notified. IMMEDIATE ACTION On 6/04/2018 at approvement of the proximity at the notification of the proximity at the notification.	er of the protective orders of no indication that the facility of protect Resident #84 from Director failed to tinent information to the necessary to insure tected while in the facility. Ident's spouse was witnessed Aide, & Central Supply Aide he Resident #84. Activity only Aide stated they spouse kicking resident's leguet. Resident and the ately separated by the A Complete Head to toe is completed by the Dervisor #1. No injuries do any signs and symptoms is. Initial report for the alleged do and sent on 6/4/2018, DSS is attending Physician I TAKEN TOXIMATELY 5:00PM the reseparated resident #84 ining him out of the room to tral supplies aide remained the hallway, and notified nursing who was standing in urse's station #2. ADON esident accompanied by the	F 6	to be a readily accessible local facility. This education will be provided licensed nurses, nursing assessincted full time, part time are licensed nursing staff. This educated by 6/7/2018. Anot educated by 6/7/2018 with allowed to work until educated education will also be added hire orientation process for a licensed nurses and nursing effective 6/7/2018, and will approvided annually. Effective 6/7/2018 the facility Director, Director of Nursing Director of social services with new admits and re-admits to during their daily department meeting to validate that any readmitted resident with profit has measures in place to professional resident against the alleged Effective 6/7/2018 any alleged with restraining orders for visit be allowed to visit the facility facility exit doors are locked be accessed using an approvisitors will utilize the facility entrance to enter the premis 6/7/18. All the facility exit docusing a magnetized lock that case of fire. In case of any of emergency, each locked facilis equipped with an emerger	ded for all sistant to and as needed education will any employee all not be ed. This on the new aides also be I Executive and/or ill discuss the facility thead admitted or tective orders otect the perpetrators ed perpetrator sitation will not and can only ved card. I main es, effective ors are locked treleases in ther illity exit door		
	protection of resident	ok over supervision and #84. Unit Manager #1 toe assessment of the		override switch located beside door to allow the door to denopen from the inside. The m	nagnetize and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345213	B. WING			06	6/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIMINEDO	AL UEALTU CADE LILI	INCTON		19	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILL	LINGTON		L	ILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC 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 600	Continued From page	ge 17	F (600				
	resident and noted	no injuries. Resident denied			system is also equipped with a master			
	pain or discomforts.				override switch located at each nurse			
	Central supplies aid	le notified a Medical records			station. This is in compliance with Nort	h		
	supervisor who was	standing at the nurse station			Carolina life safety code. Signs have b	een		
	#1. Medical records	aide walked to the resident's			posted on all exit doors to direct visitor	s to		
	room immediately a	nd met Unit Manager #1 in			the main entrance, effective 6/7/18.			
	the room. Medical re	ecords aide assisted Unit			Facility Executive Director, Director of			
	manager #1 while the Unit manager was				Nursing (DON), Assistant Director of			
	assessing the patient. Unit Manager #1 and				Nursing and/or Director of Social Servi			
		pervisor transferred resident			will complete 100% re-education on the	9		
		air and moved the resident to			location of protective orders in each			
the dining area. Medical Reco					resident□s medical charts and the			
		ent #84 until the police arrived			importance of implementing approache			
		hen she was relieved by the			to ensure the resident s protection. Th			
		who stayed with the resident			education will be provided for all licens			
	when Medical Reco	rds supervisor departed.			nurses, to include full time, part time at as needed licensed nursing staff. This	ıd		
	Likewise, the ADON	I who left Unit Manager #1			education will be completed by 6/7/201	8.		
	with resident#84 wa	alked to the Executive			Any employee not educated by 6/7/20	18		
	Director's office for	notification. On 06/04/2018			will not be allowed to work until educat	ed.		
		port was sent to the			This education will also be added on the	ie		
	· ·	th and Human Services			new hire orientation process for all nev			
		84's witnessed abuse by the			licensed nurses effective 6/7/2018, and	t		
		orts were completed and			will also be provided annually.			
		rector of Nursing. The Five						
		pleted on 6/7/2018 after a			MONITORING PROCESS			
	_	was conducted by the Center						
		Director of Social Services			Effective 6/7/2018, Director of Nursing			
		sing. The incident on 6/4/2018			Assistant Director of Nursing, and/or S			
		4 was substantiated based on			Development Coordinator, will monitor			
	_	stigation conducted by the			compliance with resident protection,			
		t of Social Services, and			thorough investigation, injuries of	h		
	Harnett county Police	· ·			unknown sources and resident neglect	рÀ		
	•	use is ordered by the court not			conducting clinical meeting daily. This			
		act with the resident effective			meeting will allow the team to review a			
	6/5/2018. Facility ha				allegation of abuse, incidents or accide	nts		
		ons taken legally against the			that occurred from the prior clinical	.d		
	spouse. Facility will keep resident on 1 on 1 until				meeting. Any DSS protective orders are			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C 06/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.00.2010
				1995 EAST CORNELIUS HARNETT BOULEVAR	RD
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 600	Continued From page	e 18	F 600		
	to come to the facility	<i>/</i> .		suspicion of abuse will be reviewed	to
	-			ensure measures are in place to pro	otect
	The photograph of th	e alleged perpetrator		the resident. Any issues identified d	uring
		currently posted at the front		this monitoring process will be addr	essed
	desk, and at each nurse's station for easy			promptly. Findings from this meeting	
	I .	ification effective 6/6/18.		be documented on a daily clinical re	
	The photograph is located on the pertinent			form and filed in the clinical meeting	
		ployees can identify resident		binder after proper follow up is done	
	#84's wife.			monitoring process will take place d	-
	Escility Executive Dir	rector, Director of Nursing,		4weeks, weekly x 2 more weeks, th monthly x 3 months or until the pattern	l l
and Social wo		om Department of Social		compliance is maintained.	eiii oi
	I .	on 6/5/2018 to discuss the		compliance is maintained.	
		ed on 6/4/2018. The team		Effective 6/7/2018, Director of Nursi	ina will
		le actions necessary to		report findings of this monitoring pro	
	1	rom the spouse. Multiple		to the facility Quality Assurance and	l l
		d, such as room change,		Performance Improvement Commit	
	identify the resident v	with a different name, or		any additional monitoring or modific	ation
		to another location that the		of this plan monthly x 3 months, or u	l l
	-	vare of. On 6/5/2018, the		the pattern of compliance is maintai	
	_	DSS social worker reached		The QAPI committee can modify thi	s plan
	· ·	e best course of action that		to ensure the facility remains in	
	•	#84 from his spouse, while		substantial compliance.	
		ty, self-determination, and oration from this event is to		RESPONSIBLE PARTY	
		to another part of the		ILOFONOIBLE PARTT	
		's name was changed on		Effective 6/7/2018, the center Execu	ıtive
	_	to ensure his protection by		Director and the Director of Nursing	l l
		f Nursing, Executive Director		be ultimately responsible to ensure	
	and Admission Direct			implementation of this plan of corre	ction
				for this alleged noncompliance to er	l l
	Resident #84 was rel	located to another room in		the facility remains in substantial	
		18 and the posted name in		compliance."	
		ged. Resident #84 was			
	1 -	ninutes watch from 7pm on			
		e on one supervision was			
		in which an employee			
		at all times while in the			
	tacility. One on one o	care will continue until the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345213	B. WING	B. WING		06/08/2018	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOUL LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	wife is arrested. IDENTIFICATION Of 100% audit of currencompleted by the Fa Business office manany other resident with validated the facility protect the resident of The audit revealed in protective orders related in protective orders audit the compliance binder. On 06/06/2018, 1000 by Director of Rehab office Manager, Active Records Supervisor and oriented resident with a Neglect. Two other resident #3 voiced and protective in protect	t residents financial files was cility Admission Director and ager on 6/6/2018 to identify th protective orders and has measures in place to rom the alleged perpetrator. The other resident has ated to abuse/neglect. The are documented on the facility of interviews was completed illitation Center, Business wity Director, Medical and MDS for all current alert alts in the facility to identify any in allegation of Abuse and/or desidents, Resident #2, and allegation of abuse and/or desidents in the facility of its incompleted investigation initiated. The Physician and Responsible of the allegation. Resident #2 and the investigation is completed investigation in the facility and he investigation is completed investigation in the physician and Responsible of the findings and the investigation is completed	F 60				
	of Social Services. The Director of Social of Nursing, Unit man	al services, Assistant Director ager, Admission Director and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345213	B. WING		06/08/2018	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE 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 API DEFICIENCY)	IOULD BE COMPLETION	
F 600	able to answer quest to mental capacity. MONITORING PRODE Effective 6/7/2018, Director of Nursing, a Coordinator, will morprotection, thorough unknown sources an conducting clinical mwill allow the team to abuse, incidents or a the prior clinical mee orders and any docu indicate suspicion of ensure measures are resident. Any issues monitoring process v Findings from this madaily clinical report meeting binder after This monitoring proceduseks, weekly x 2 is 3 months or until the maintained. Effective 6/7/2018, Directive forms and capacity and capacity and capacity and capacity and capacity and capacity.	cer residents who were not tions during this interview due CESS Director of Nursing, Assistant and/or Staff Development nitor compliance with resident investigation, injuries of diresident neglect by neeting daily. This meeting or review all allegation of accidents that occurred from ting. Any DSS protective mented information that abuse will be reviewed to be in place to protect the identified during this will be addressed promptly. The identified in the clinical proper follow up is done. The identified during this will take place daily for more weeks, then monthly x pattern of compliance is	F 60	,		
	Quality Assurance an Improvement Comm monitoring or modific months, or until the paramaintained. The QAI	ittee for any additional cation of this plan monthly x 3 pattern of compliance is PI committee can modify this cility remains in substantial				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345213	B. WING		C 06/08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546	1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 600	Continued From page	21	F 60	0		
	and the Director of Nuresponsible to ensure	e center Executive Director ursing will be ultimately implementation of this plan illeged noncompliance to nains in substantial				
	removal was validated the IJ on 06/07/18, as interviews, in-service observations. The in strict Resident #84's new and what action was to observed on the facility observations included Resident #84, monito facility's main entrance Resident #84's wife p station and ante room 6/6/18 and focused of and social isolation r/1 goals included maintal Interventions included relocation to another name, 1:1 supervision change, room change	record reviews, and service included information valias, new room number, to be taken if his wife was ty property. Other I one on one (1:1) staff with red entry and exits from the e, and a photograph of osted at every nursing a. A care plan was initiated in "Safety: At risk for injury is spousal abuse." The stated safety from his wife. It, but were not limited to, room, identify by a different in, staff education on name e, safety interventions, as in mood or behavior, and				
F 607 SS=J	Develop/Implement A	buse/Neglect Policies	F 60	77	7/10/18	
	§483.12(b) The facility implement written pol	y must develop and icies and procedures that:				
	§483.12(b)(1) Prohibi neglect, and exploitat					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/08/2018	
	345213		B. WING			
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 607	Continued From page		F 607	7		
	\$483.12(b)(3) Include paragraph \$483.95, This REQUIREMENT by: Based on record rev facility failed implement resident, prevent abuse residents (Resident # physical abuse. The firmeasures specified by Services Adult Protect	sh policies and procedures ch allegations, and e training as required at is not met as evidenced iew and staff interviews, the ent the policy to screen the se and protect 1 of 3 text (184) from visitor to resident facility failed to implement by the Department of Social ctive Services Social Worker		F607 This alleged noncompliance resulted f the center's failure to follow the abuse policy and procedures that led to not protecting one resident with prior histo of suspected domestic abuse from a spouse. On 4/25/2018 the facility adm	itted	
	Services Adult Protective Services Social Worker prior to Resident #84's admission on 4/25/18 to protect him from being physically abused. Following the physical assault Resident #84 was assessed and did not have any physical injuries and did not require medical treatment. Immediate jeopardy began on 6/4/18 when 2 witnesses observed Resident #84 seated in his room in a wheelchair speaking loudly and shaking both arms in front of his head. A female visitor, identified as his wife, was observed seated on the bed close to Resident #84 hitting, kicking and stomping on Resident #84. No physical injuries were assessed. Immediate jeopardy was removed on 6/7/18 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.			resident #84 for rehabilitation and long term care placement. Resident #84 ha protective order named "Ex parte orde filed in Harnett County Clerk of Superi Court on 4/24/2018. The protective order was presented to the facility at the time admission on 4/25/2018 by the assign Social worker from the Department of Social Services. The protective order included information that the "departm of Social services is concerned with the possibility of physical abuse and negle it also added that "Without a protective order department of Social Services is concerned the wife will remove respondent from the hospital/rehab." This alleged noncompliance resulted for the facility failure to implement abuse policies and procedures on the area of proper screening, identification, protect and reporting that resulted from the broken communication process from	d a or or der e of ed ent e ect",	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345213 B. WING			C 06/08/2018				
NAME OF PE	ROVIDER OR SUPPLIER		 		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	06/2016	
TO THE OT TH	TO VIDER OR OUT FEIER				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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page	e 23	F6	307				
	Findings included:				resident's admission to the facility for			
	· ···a···ge ····o·a·aea·				necessary information to include			
	The facility's Abuse P	Prevention, intervention,			protective orders for resident #84. As the	he		
		igation policy dated 11/2016			result the resident's alleged perpetrator			
	_	17 read, in part, "Purpose:			visited resident #84 multiple times with			
	The purpose of this p	olicy is to ensure all			appropriate interventions to protect			
		ght to be free from abuse.			resident #84.			
	The facility will ensure							
		d, suspected, or witnessed			Root cause analysis also concluded the	at		
	• •	so read, in part, "Definitions:			the facility miss-interpreted regulatory			
		ion of injury, or punishment			requirements that requires the facility to			
		al harm, pain, or mental			protect each resident while in the facilit	.у,		
	_	f abuse of all residents, ental or physical condition			and reporting any allegation of abuse immediately but no later than two hours			
		, pain, or mental anguish.			after the allegation is made. The facility			
		ent to resident, staff to			also failed to follow the policies and	,		
	resident, or visitor to				procedures to put measures in place to)		
		n-accidental use of physical			protect residents while in the facility ev			
		in bodily injury, physical			when they are under the custody of DS			
		Examples include, but are						
	not limited to hitting, s	slapping, pinching, and			The root cause analysis, concluded that	at,		
	kicking." The policy a	lso read, in part, "The			the systemic failure that resulted onto			
	objective of the abuse	e policy is to comply with the			resident #84 incident on 6/4/2018			
		to abuse and neglect			includes, broken communication proce	SS		
	detection and preven				from admission for necessary informati			
	•	use prevention system can			to include protective orders for residen	t		
	T	duce, and prevent abuse			#84. As a result the resident's alleged			
	_	view of seven components:			perpetrator visited resident #84 multiple			
		revention, identification,			times with no appropriate interventions	το		
		ion, reporting and response."			protect resident #84. The broken	_		
		in part, "Protection: It is our nt(s) will be protected from			communication process resulted from a lack of a systemic process set forth on			
		s). 4. Patient protection			how protective orders was to be			
		diately removing the patient			communicated by the admission Direct	or		
		alleged abuser during the			to the rest of the IDT.			
		lleged abuser is not an						
		are taken to provide a safe,			Although the facility received the			
		for the patient. Actions may			documentation on admission on			
	include: patient room				4/25/2018, and was notified by the DS	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING				
	201/1252 05 01/1251 155	349213	D. WING _		TDEET ADDRESS SITV STATE TIP SODE	06/	08/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLII	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
				L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 607	Continued From page	e 24	F	307			
	schedule change, vis	itor restrictions, reporting to			social worker of the protective orders of	f	
	other agencies or law				this resident, there is no indication that		
	J				facility put forth measures to protect		
	Review of Resident #	84's hospital discharge			Resident #84 from his wife. Admission		
	summary dated 4/25/	18 read, in part, "Problems:			Director failed to communicate the		
	(2) closed fracture of	pubic ramus; (3) fracture of			pertinent information to the		
		osed (forearm); (4) nasal			interdisciplinary team necessary to ins		
	fracture; (5) assault;				resident #84 was protected while in the	;	
	Suspected abuse by	pt.'s (Resident #84) wife."			facility from his wife.		
	Review of the order of	of protection (known as a			On 6/4/2018 the resident's spouse was	3	
	Petition for Ex Parte				witnessed by the facility Activity Aide, &		
	provided to the facility	y on 4/25/18 by the			Central Supply Aide #1 in the room wit		
	Department of Social	Services (DSS), Adult			the Resident #84. Activity Aide and		
	Protective Services (A	APS)read, in part, "The			Central Supply Aide stated they witnes	sed	
		er (DSS Director of the			resident's spouse kicking resident's leg		
		ough his representative (APS			and stepping on his feet. Resident and		
		SW #1) having sufficient			spouse were immediately separated by	/	
	_	the respondent (Resident			the Central Supply Aide. A Complete		
		tective services alleges: 3.			Head to toe body assessment was		
		ident #84) is a disabled			completed by the Registered nurse	ont.	
	on the following spec	of protective services based			Supervisor #1. No injuries noted, resident denied any signs and symptoms of pair		
		is concerned the wife will			discomforts. Initial report for the allege		
	•	Resident #84) from the			abuse was completed and sent on	u	
	hospital/rehab (rehab	•			6/4/2018, DSS social worker and the		
	Troopitali Torias (Torias	madon).			attending Physician notified.		
	Review of Resident #	84's medical record			, , , , , , , , , , , , , , , , , , , ,		
		nitted from the hospital to the			IMMEDIATE ACTION TAKEN		
		ith admitting diagnoses			The Chief Clinical officer from the		
	including: Colles' frac	ture of right radius			Management and consulting company		
		nasal bones, fracture of			that manages the center, re-educated	the	
	right pubis, history of				Center Executive Director and the		
	unspecified dementia				Director of Nursing 6/7/2018 on the cel	nter	
	-	ed fracture of head of right			Abuse Prohibition and Investigation		
	radius, and cognitive	communication deficit.			policies and procedures, and emphasiz		
	A F -1 NADO /84' '	Data Oat a ta 1			the importance of screening, identificat		
		um Data Set-a tool used for) dated 5/2/18 revealed			protecting and reporting to the regulator required agencies immediately but no	ory	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345213	B. WING		00	C 5/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		5/00/2010
				1995 EAST CORNELIUS HARNETT BOU		
UNIVERSA	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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From page	e 25	F 6	07		
	Resident #84 was ad acute care hospital. Frequired extensive to activities of daily living	mitted 4/25/18 from an He was cognitively intact and total assistance for all g. He had 1 upper limb (arm) e diagnoses included other		later than two hours from the allegation is made. The education emphasized on the importance ensuring residents are screen potential abuse and measures forth to protect them while restacility.	ation also se of ned for s are put	
	which read, "Staff war room at 4:42 PM when his hands in the air at spouse was noted kind stepping on his feet. It bruising was evident, for safety and police or responded. The reside escorted from the buit until further notice." An incident report dat incident type was an occurred in the reside the incident read, "St resident's room at 4:45.	ote dated 6/4/18 at 7:27 PM s walking past resident's en they noted resident with and yelling. The resident's cking him on the legs and Resident denied pain and no Resident was supervised were notified and lent's wife spouse was lding and is not to return ted 6/4/18 indicated the allegation of abuse, which ent's room. A narrative of		The Chief Clinical officer from Management and consulting of that manages the center, reefacility management team that the department supervisors of center's Abuse Prohibition and Investigation policies and procemphasized on the importance screening patients and employ hire, protecting resident(s), and any allegation of abuse or New Direct supervisor and the Exercited Director in a timely manner as the Regulatory required agency immediately but no later than forming suspicion, witness the and/or after a resident, another and/or family member alleged	company educated t consist of n the d cedures, and ee of yees before nd reporting glect to their ecutive s well as to cies 2 hours after e abuse er staff	
	resident's spouse wa legs and stepping on pain and no bruising supervised for safety responded. The resid escorted from the bui until further notice." A statement provided Witness #1 read, "I w being physically abus	s noted kicking him on the his feet. Resident denied was evident. Resident was and police were notified and lent's wife spouse was lding and is not to return on 6/4/18 to the facility by itnessed (Resident #84) sed by his relative. I was II Resident #84 resided on)		On 6/04/2018 at approximatel the Central supplies aide separesident #84 from his wife by out of the room to the hallway supplies aide remained with roon the hallway, and notified ADDirector of nursing who was so the proximity at the nurse's standon walked towards the respective of the central supplies a over supervision and protectic	arated pushing him r. The central esident #84 ssistant standing in ation #2. sident nager #1 who aide and took	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C 06/08/2018	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP COI 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546		0.000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From page	e 26	F 6	607			
F 607	when I noticed (Residuands held high. (Rehis wife was physical legs and stomping or happened approximal.) An interview was conwith Witness #1 (Cerstated on 06/04/18 a. Resident #84 resided loudly and saw his hastated he was in his subserved kicking his She also stated, "She stated she intervened he was alright, but restated she removed and brought him to than danother staff me Director) stayed with also stated, "This is here. I think he was here second time becarbused him. This is helieve he's under protated the wife visited second admission, but this admission. A statement provided Witness #2 read, "I, (resident room (Resident of the wife visited and told (nurse) about the w	dent #84) yelling with his sident #84) relative whom is ally abusing him by kicking his in his feet. This incident ately at 4:42 PM." Inducted 6/5/18 at 11:50 AM intral Supply Clerk) She is she walked down the hall id on she heard him speaking ands up and shaking. She wheelchair and his wife was alegs and stomping his feet. It was abusing him." She id and asked Resident #84 if accived no response. She Resident #84 from the room the common area where she mber (Medical Records him until police arrived. She his second or third admission there under a protective order ause his wife physically his third admission and I rotective custody now." She id frequently during the frequently during the frequently during the frequently walked by well and saw him and other. Ask her to step out		facility abuse prohibition procresident #84, per the facility and procedures. Unit Manag completed a head to toe ass the resident and noted no inj Resident denied pain or disconding the cords supervisor who was the nurse station #1. Medical walked to the resident's room and met Unit Manager #1 in Medical records aide assiste manager #1 while the Unit massessing the patient. Unit Mand Medical Records supervitransferred resident #84 to the and moved the resident to the Medical Records supervisor with resident #84 until the powith a brief period when she by the transportation aide when the resident when Medical Records supervisor departed. Likewise, the ADON who left Manager #1 with resident#84 the Executive Director's officinotification. On 06/04/2018 to initial report was sent to the of Health and Human Servic resident #84's witnessed abus pouse. These reports were and submitted by the Director The Five day report was con 6/7/2018 after a detail investi	abuse policy per #1 pessment of puries. comforts. d a Medical standing at all records aide immediately the room. ad Unit manager was Manager #1 visor me wheel chair me dining area. remained police arrived was relieved mo stayed with electric stayed with the cords. It Unit 4 walked to be for the 24 hour Department per mes related to use by the completed or of Nursing. Inpleted on significant police on the completed or of pursing.		
	with Witness #2 (Acti 06/04/18 she walked	ivities Aide). She stated on by Resident #84's room and 84 and his wife hitting each		conducted by the Center Exe Director, Director of Social S Director of Nursing. The incident	ecutive Services and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 06/08/2018
	ROVIDER OR SUPPLIER AL HEALTH CARE LILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 607	often but I had never before. When he was hall she stayed with admission she was (Witness #1 and Wi we took him out of thim in the TV room, (Medical Records D Witness #2 was not restrictions for Resident date of admission (A related to safety me initiated until after thon 06/04/18. An interview was cowith APS SW#1. She hospital in April rela 3rd admission to the for multiple fractures they (APS) suspected She stated, "The fact his admission in April his wife to physically Admission's Coordin his admission. I sign protective order in padmission to (facility against medical advito do the same thing admission) but she protective order. So improved tremendor have concrete evide with her. He was re-	have seen his wife visit quite or seen a physical interaction as on the rehab (rehabilitation) him all the time, but this n't here so much. When we tness #2) saw her hitting him he room immediately. We put she followed, and had irrector) stay with them."	F 60	6/4/2018 against resident #84 was substantiated based on findings of trinvestigation conducted by the Facili Department of Social Services, and Harnett county Police Department. Resident #84's spouse is ordered by court not to visit or be in contact with resident effective 6/5/2018. The photograph of the alleged perpetrato (resident#84 wife) is currently posted the front desk, and at each nurse's s for easy identification and notification effective 6/6/18. The photograph is located on the pertinent location whe employees can identify resident #84' wife. Facility Executive Director, Director of Nursing, and Social worker from Department of Social Services met be on 6/5/2018 to discuss the incident the happened on 6/4/2018. The team discussed the possible actions necesto protect the resident from the spoud Multiple ideas were discussed, such room change, identify the resident we different name, or transfer resident # another location that the spouse will be aware of. On 6/5/2018, the facility well as the DSS social worker reached conclusion that, the best course of at that will protect resident #84 from his spouse, while maintaining his dignity self-determination, and reduce risk for deterioration from this event is to referesident #84 to another part of the faresident #84 to another part of the faresid	tty, the the the ar dat tation in the re all is so of soriefly that ssary see. as sith a set to not a seed a ction is contact of the re all is seed a ction i

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING			(X3) DATE SURVEY COMPLETED				
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		345213	B. WING			06/	08/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	his wife was physical to the facility at the til was not to be left alo (AC #1) told me they meet in common area open, he was put in a Administrator's office approximately 100 fe office) so it would be was going on, and he room with an alert an SW #1 also stated, "(know that woman is I disagree, but we neer room assignment and were put into place be time. So the facility with situation. When I ask happened they told in all the time. Now we a Domestic Violence police are pressing a be arrested this after. A copy of the DVPO was put in place, aga 6/5/18 at 3:08 PM and Defendant (wife) has intentionally caused in placed me in fear of in June 2018- An aid at commotion coming frem #84) room, then observable placed himself from the slapping him, punching	cility and hospital speculated ally abusing him. I explained me of his last admission he ne with her for his protection. would only be allowed to as, his door was to be kept a room up front near the end (his room was beet from the Administrator's easy to hear if something end oriented roommate." APS (The AC #1) said to me, 'You hurting him.' I told her I didn't ended proof of abuse. His did those protective measures before he was admitted last was well aware of the end them today what the they couldn't monitor him are in the process of getting Protective Order, the (local) ssault charges, and she will	F	607	protection, per facility abuse prohibition process by the facility Director of Nursi Executive Director and Admission Director. This measure is in alignment with the facility abuse policy and procedure. Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was change Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was initiated on 6/5/2018 in which an employee observe the resident at all tir while in the facility. One on one supervision was discontinu on 6/27/2018, after the facility Quality Assurance and Improvement Committed determine that resident #84 is safe and protected from his wife with the other measures in place such as locking the means of egress, resident relocation to another room and change resident sname. IDENTIFICATION OF OTHERS 100% audit of all residents clinical documentation within the last 30 days of completed by the Director of Nursing, Assistant Director of Nursing and/or Nursing	ng, d. o mes ued ee l	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 06/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.00.2010
				1995 EAST CORNELIUS HARNETT BOULEVAR	RD
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG	,	:Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 607	Continued From pag	e 29	F 607	7	
	(Harnett County Dep	artment of Social Services)		and/or Elder Justice Act. The audit	
	to not allow any supe	ervised contact between		revealed two other documented alle	egation
	Plaintiff & Defendant			of abuse, and/or neglect document	ed in
				resident medical records. This audi	
	· •	Prevention, intervention,		completed on 6/6/18 & 6/7/18. Find	_
		igation policy dated 11/2016		this audit is documented on clinical	
		17 read, in part, "The center		records audit tool located at the fac	ility
	has developed a sys	· · · · · · · · · · · · · · · · · · ·		compliance binder.	
	1	ncluded screening and		4000/	
		ying, preventing, and		100% audit was completed by the 0	
		t or suspected incident of		executive Director for all allegation	
	1	The Abuse Policy further tion- Patient protection		abuse and/or neglect submitted in to past from 1/24/2018 to 6/7/2018	ne
		ediately removing the patient		determine if the alleged perpetrator	- Wae
		alleged abuser. If the		suspended during investigation to p	
	I .	an employee, actions may		the resident, 24 hours completed w	
		change, patient daily		hours of the allegation and 5 days	2
	schedule change, vis			completed and submitted to the sta	ite
	31,			agency as required by regulation a	
	An interview was cor	nducted on 6/5/18 at 3:55 PM		Elder Justice Act in a timely manne	
	with AC #1. She state	ed she had no recall of any		audit revealed 5 of 5 completed	
	safety discussions w	ith APS SW #1, just that he		abuse/neglect reports indicated the	:
	, ,	under APS for "some type of		alleged perpetrator was suspended	
		n." She stated Resident #84		pending investigation per abuse	
		tember 2017 and signed out		prohibition policy and procedure, he	
	, •	ce by his wife in October of		all 5 of 5 initial 24 hour reports were	e not
		nitted 3/8/18 by APS SW #1		submitted within two hours of the	
		e 4/5/18. He was admitted a		allegation. 2 months noted with det	ail
	_	V #1 on 4/25/18. She said		investigation and the Alleged	
		of domestic violence but both		Perpetrator(s) were suspended. Th	is audit
	Resident #84 and his	s wite denied it.		was completed on 6/7/2018.	
	An additional intervie	w was conducted with AC #1		On 06/06/2018, 100% interviews w	as
		I. She stated there were no		completed by Director of Rehabilita	tion
	plans in place for Re	sident #84's safety when he		Center, Business office Manager, A	Activity
	was admitted on 4/25	5/18 because APS had not		Director, Medical Records Supervis	or and
	I -	to do. She stated she knew		MDS for all current alert and oriente	
	1	n of neglect and abuse, but it		residents in the facility to identify ar	-
	was just a suspicion	and denied any recall of		resident with an allegation of Abuse	<u> </u>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345213	B. WING _			06/	/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page safety details being of the time of his last ad An additional intervie at 3:35 PM with APS #1 stated she had sp Resident #84's admis and explained why R under a protective or being protected. It ha wife was abusing him cognitively intact until always denied abuse the abuser on 6/5/18 the day of admission concerns the wife wanever been able to su discussed putting him safety, on the main h #1) and I agreed to k wife visited. (This occ keeping visits to the could hit him just area as in his room. I with the wife behind corder I gave them stafrom his wife related proof of physical abuse Monday (6/4/18). Not	iscussed with APS SW #1 at mission. w was conducted on 6/6/18 SW #1 and AC #1. APS SW oken to AC #1 on the day of sion to the facility (4/25/18) esident #84 was admitted der and from whom he was d always been a concern his a this admission and had. He admitted his wife was APS SW #1 Stated, "On (AC #1) told me she had a sabusing him, but we had abstantiate the abuse. We in a semi-private room for all for more traffic and (AC eep his door open when the curred) We talked about common area, but realized as easily in the common told them not to allow visits closed doors. The protective ted he was to be protected to neglect, but I needed se and I never had that until		307		tken the ttor ant evere	
	(Minimum Data Set) of stated, "I know APS w #84) was placed here there was a protective	ducted with MDS Nurse #1 on 6/6/18 at 11:20 AM. She was involved when (Resident e (4/25/18), but I didn't know e order in place until after /18. I just did a care plan for			mistreatment, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made to the administrator of the facility and to other officials to include; the State Survey Agency, adult protective services, the state Ombudsmen in accordance with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING				08/ 2018	
NAME OF D	ROVIDER OR SUPPLIER	0.02.0	1	-	STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	06/2016	
NAME OF T	NOVIDER OR SOLT EIER				, , ,			
UNIVERSA	AL HEALTH CARE LILLII	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD			
			LILLINGTON, NC 27546		ILLINGTON, NC 27546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE				
F 607	Continued From page	e 31	F6	307				
		ducted on 6/6/18 at 12:50			State law through established facilities			
		rator and Director of Nursing			policies and procedures.			
		heir expectations were all			policies and procedures.			
		rotected at all times from			Effective 6/7/2018, The facility will repo	ort		
	-	behavior could not be			the results of all investigations to the	,,,		
		nistrator stated systems were			administrator or his or her designated			
		d protect residents (rounds,			representative and to other officials in			
		f were in serviced on abuse			accordance with State law, including to	,		
	at the time of hire and			the State Survey Agency, within 5 work				
		strator stated, "I don't feel			days of the incident, and if the alleged			
	our systems failed (R	lesident #84) because we			violation is verified appropriate correcti	ve		
	couldn't predict the w	rife's behavior. There's a			action must be taken.			
	possibility she wasn't							
	from. If I had concrete	e evidence it was her we			Effective 6/7/2018, the facility			
	would have had inter-	ventions in place. I had no			interdisciplinary team to include Execu	tive		
	suspicion he was bei	ng abused."			Director, Director of Nursing, Director of	of		
					Social services and at least three other	•		
	An additional intervie	w was conducted with the			department supervisors will attend a			
		18 at 4:00 PM. He stated AC			monthly mandatory training that will be			
		him of the APS protective			conducted by contracted management			
	order at the time of a	dmission on 4/25/18.			and consulting company that oversees			
					facility. This training will put an emphas	sis		
		iducted on 6/6/18 at 9:15 AM			on all seven components of abuse			
		ords Director. She stated the			prohibition to include screening, trainin			
		l on abuse annually and as			prevention, identification, investigation,			
		ig done was the resident in			protection, reporting and responses. The			
	_	and brought to safety. They			training will take place monthly for next	•		
	•	until told by administration to			twelve months or until the pattern of			
		ated, at the time of Resident			compliance is maintained.			
		e facility on 4/25/18, the			F" 1: 0/7/2040 II 0 1 D: 1			
	•	lace included to keep him in			Effective 6/7/2018, the Center Director			
		ic (it was), his door and			Human Services, and/or employee dire	CT		
	•	en when his wife visited			supervisor and/or designated staff	. h		
		were kept in the common			member will conduct interviews for each			
	-	ssible. She stated there was			current employee at least once a year.	ĺ		
		on he was being abused by			The interview will be intended to	n of		
		. She also stated when she on the day of the assault			determine the employee understanding the Center Abuse policies and	j UI		
		ght he said yes and, "She			Procedures. The interview process will	he		
	(5, 1, 15) II 115 Was all 1	J IS Said 700 aria, Orio	1			~~		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
1995 EAST CORNELIUS HARNETT BOULEVARD	
UNIVERSAL HEALTH CARE LILLINGTON LILLINGTON, NC 27546	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
didn't mean to hurt me." The Medical Records Director also stated the facility had kept Resident #84's door and curtain open whenever his wife visited him since his 2nd admission. An interview was conducted on 6/6/18 at 9:30 AM with the facility physician (MD). He stated he was not aware resident #84 was here under APS protective order, but he was notified of the resident's assault on Tuesday (6/5/18) morning. He also stated, "If the facility was aware he was here under APS protection they never should have let the wife visit him alone under any circumstances. Today he is remarkably alert and oriented. He told me his wife in no way abused him, but the court order he came in with is very clear. He should not have been left alone with any visitors, except (the APS SW #1). It was the facility's responsibility to protect this man from being abused. Even if they could not prevent her from visiting him, they never should have been present during all visits. I was notified Tuesday morning that his wife was seen abusing him. I was told the facility assessed him for injuries, and I saw him today." An interview was conducted with Resident #84's roommate on 6/6/18 at 11:30 AM. He stated, "I was in the room when his wife was shoving and hitting him. I saw her hit him before too. When she hit him before I told the Nursing Assistants (NAYs), but she still came in closed the door and curtain all the time. When she's in here, and I'm in here the door is supposed to be open. I don't like what she did to him." The roommate was not able to state which NA's he told or when he told them about what he saw.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				08/ 2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010	
					1995 EAST CORNELIUS HARNETT BOULEVARD			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page	∋ 33	F 6	607				
F 607	The Administrator, Di Corporate Consultant immediate jeopardy of 6/7/18 at 10:48 PM the following credible alle immediate jeopardy redible alle immediate jeopardy resident statistical form a spouse. On 4/resident #84 for rehal placement. Resident named "Ex parte order Clerk of Superior Couprotective order was the time of admission assigned Social work Social Services. The information that the "oservices is concerned physical abuse and ne "Without a protective Services is concerned respondent from the late of the services on the artification, protective sulted from the broif from resident's admissionecessary information.	rector of Nursing, and a were notified of the on 6/6/18 at 2:55 PM. On the facility provided the egation of compliance and the emoval: Impliance resulted from the power than the abuse policy and the protecting one resident appected domestic abuse 25/2018 the facility admitted boilitation and long term care #84 had a protective order the filled in Harnett County purt on 4/24/2018. The presented to the facility at a on 4/25/2018 by the er from the Department of protective order included department of Social downth the possibility of eglect", it also added that order department of Social downth the wife will remove thospital/rehab." Poliance resulted from the ement abuse policies and the ear of proper screening, on and reporting that the communication process	F	807	protective orders received on admission or readmission by the admission direct or designated person during the admission process, will be placed in the medical file under the advance directive tab for easy identification and accessib by the nursing staff. Effective 6/7/2018; received protective orders will be added to resident's care plan by the Admitting nurse and/or Nursing supervisor and nursing aide care guide for accessibility by both license nurses and nurse aides. If the protective order includes guidelines such as supervised visits, no visitation, or not allowed on the premises such measure will be added to resident's face sheet a appropriate information posted such as the perpetrator picture and/or description a readily accessible location in the facility. Facility Director of Nursing (DON), Assistant Director of Nursing and/or Urmanager will complete 100% education on the location of protective orders in each resident's medical charts and the location of intervention necessary to protect the resident with protective order to include adding the protective order intervention to resident's care plan and to nursing a care guide for accessibility by both lice	or e e e illity are es and s on hit n ers.		
		sited resident #84 multiple riate interventions to protect			nurses and nurse aides. Guidelines sur as supervised visits, no visitation, or no allowed on the premises will also be covered in this education. The education	ot		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		345213	B. WING _		06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
				1995 EAST CORNELIUS HARNETT	BOULEVARD	
UNIVERSA	AL HEALTH CARE LII	LLINGTON		LILLINGTON, NC 27546		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	CORRECTION (X5)	
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 607	Continued From page	age 34	F 6	607		
		sis also concluded that the		will also emphasize on the	e process that	
	facility miss-interpo	reted regulatory requirements		such information will be a	dded to	
	that requires the fa	acility to protect each resident		resident's face sheet and	appropriate	
		, and reporting any allegation of		information posted such a		
		but no later than two hours		perpetrator picture and/or		
		is made. The facility also		be a readily accessible lo	cation in the	
		policies and procedures to put		facility.		
		to protect residents while in		This education will be pro-		
	•	nen they are under the custody		licensed nurses, nursing a		
	of DSS.			include full time, part time		
				licensed nursing staff. Thi		
		alysis, concluded that, the		be completed by 6/7/2018		
	•	at resulted onto resident #84		not educated by 6/7/2018 will not be allowed to work until educated. This		
		18 includes, broken				
		ocess from admission for		education will also be add		
		tion to include protective orders as a result the resident's alleged		hire orientation process for licensed nurses and nursi		
		resident #84 multiple times		effective 6/7/2018, and wi	-	
	' '	e interventions to protect		provided annually.	ii aiso be	
		broken communication process		provided armidally.		
		ck of a systemic process set		Effective 6/7/2018, the ce	nter nursing	
		ctive orders was to be		administrative team, which		
		the admission Director to the		Nurse supervisors, Unit M		
	rest of the IDT.			SDC, added reviewing of	9	
				orders to an existing proce		
	Although the facilit	ty received the documentation		clinical documentation for		
		/25/2018, and was notified by		hours, which includes con	npleted skin	
	the DSS social wo	rker of the protective orders of		assessments, incident rep	orts for the last	
	this resident, there	is no indication that the facility		24 hours, and Physician of	rders written in	
	put forth measures	s to protect Resident #84 from		the last 24 hours. By addi	ng the review of	
	his wife. Admission	n Director failed to		DSS protective orders to t	his process, it	
		pertinent information to the		will ensure that any reside		
		am necessary to insure		history of allegation of abu		
		protected while in the facility		and/or injuries of unknowr		
	from his wife.			appropriate measures in p	•	
				the resident from the alleg		
		esident's spouse was witnessed		effective 6/7/2018. This pr		
		rity Aide, & Central Supply Aide		place daily Monday through		
	#1 in the room with	n the Resident #84. Activity		effective 6/7/2018. The re	sult of this	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C 06/08/2018
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVAR LILLINGTON, NC 27546	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 607	Continued From page	pply Aide stated they	F 60	systemic process will be documented	
	and stepping on his for spouse were immedia	spouse kicking resident's leg eet. Resident and the ately separated by the A Complete Head to toe		the clinical meeting form maintained "Daily Clinical meeting binder." Effective 6/7/2018, the week end	in the
	body assessment wa Registered nurse Sup			Registered Nurse supervisor and/or designated licensed nurse will revie clinical documentation for the last 24	w
		s. Initial report for the alleged d and sent on 6/4/2018, DSS attending Physician		hours, completed skin assessments incident reports for the last 24 hours. Physician orders written in the last 2 hours to ensure that any allegation abuse, neglect and/or injuries of unless.	s, and 24 of
	and consulting compa	I TAKEN icer from the Management any that manages the he Center Executive Director		sources reported/documented is investigated thoroughly, the alleged perpetrator is suspended pending investigation, and ensure the event	
	and the Director of No center Abuse Prohibit policies and procedur	ursing 6/7/2018 on the		reported to the facility Executive Dir This process will also incorporate reviewing of any DSS protective ord ensure the facility put measures in p	ector. ders to
	and reporting to the r immediately but no la time the allegation is	egulatory required agencies tter than two hours from the made. The education also		to address such orders. This system process will take place every Saturd and Sunday. Any negative findings	nic day will be
	residents are screene	nportance of ensuring ed for potential abuse and th to protect them while		documented on the week end super report form and maintained in the da clinical meeting binder, effective 6/7/2018 the Admission Di	aily 7/2018.
	and consulting compa center, re-educated f	icer from the Management any that manages the acility management team partment supervisors on the		(AD) will print any protective order for referral to the facility before bed is compared to the AD will then provide copies of the AD will then provide copies of the protective order to the facility Executive order to the	or any offered. he
	center's Abuse Prohil policies and procedul importance of screen	pition and Investigation res, and emphasized on the ing patients and employees g resident(s), and reporting		Director, Director of Nursing, Director social services and/or designated licenurse. The IDT team will then review referrals with DSS protective orders	or of censed w all
	any allegation of abu	se or Neglect to their Direct xecutive Director in a timely		to admitting resident to the facility to ensure measures are put in place to	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		E SURVEY MPLETED
		345213	B. WING			C 6/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	0/00/2010
	10115211 011 001 1 2.2.1			1995 EAST CORNELIUS HARNETT BO		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546	JLLVAND	
				·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 607	Continued From page	e 36	F 60	07		
	manner as well as to	the Regulatory required		protect the resident when add	mitted to the	
		y but no later than 2 hours		facility.		
		on, witness the abuse and/or				
		her staff and/or family		Effective 6/7/2018 the facility	Executive	
	member alleged abus			Director, Director of Nursing,		
				Director of social services wil	l discuss	
	On 6/04/2018 at appr	roximately 5:00PM the		new admits and re-admits to	the facility	
		separated resident #84		during their daily department		
		ing him out of the room to		meeting to validate that any a		
	•	tral supplies aide remained		readmitted resident with prote		
		the hallway, and notified		has measures in place to pro		
		nursing who was standing in		resident against the alleged p	erpetrators.	
	_	urse's station #2. ADON		Effective C/7/2019 and allege	d	
	Unit Manager #1 who	esident accompanied by the		Effective 6/7/2018 any allege with restraining orders for vis		
	_	ok over supervision and		be allowed to visit the facility.		
		abuse prohibition process		facility exit doors are locked a		
		he facility abuse policy and		be accessed using an approx	-	
		nager #1 completed a head		Visitors will utilize the facility		
	=	the resident and noted no		entrance to enter the premise		
	injuries. Resident der	nied pain or discomforts.		6/7/18. All the facility exit doc		
	-	•		using a magnetized lock that	releases in	
	Central supplies aide	notified a Medical records		case of fire. In case of any ot	her	
	supervisor who was s	standing at the nurse station		emergency, each locked facil		
		aide walked to the resident's		is equipped with an emergen	•	
		d met Unit Manager #1 in		override switch located besid		
		cords aide assisted Unit		door to allow the door to dem		
	manager #1 while the			open from the inside. The ma	-	
		t. Unit Manager #1 and		system is also equipped with		
	•	ervisor transferred resident		override switch located at each		
		ir and moved the resident to		station. This is in compliance		
	_	ical Records supervisor		Carolina life safety code. Sign		
		nt #84 until the police arrived nen she was relieved by the		posted on all exit doors to dir the main entrance, effective (
	-	ho stayed with the resident		une main entrance, effective (טו וווע.	
	-	ds supervisor departed.		Facility Executive Director, D	irector of	
	When wedical record	ao dapoi vidoi departed.		Nursing (DON), Assistant Dir		
	Likewise, the ADON	who left Unit Manager #1		Nursing and/or Director of So		
	with resident#84 walk			will complete 100% re-educa		

	DF DEFICIENCIES CORRECTION			TE SURVEY MPLETED		
		345213	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	0.102.10		STREET ADDRESS, CITY, STATE, ZIP CODE	•	6/08/2018
NAME OF FI	NOVIDER OR SUFFLIER					
UNIVERSA	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BOU	LEVARD	
				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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From page	e 37	F 60	07		
F 607	Director's office for not the 24 hour initial rep Department of Health related to resident #8 spouse. These report submitted by the Director of Submitted by the Director of Nursin against resident #84 findings of the investi Facility, Department of Harnett county Police Resident #84's spous to visit or be in contact 6/5/2018. Facility has confirmation of action spouse. Facility will k confirmation is obtain to come to the facility. The photograph of the (resident#84 wife) is desk, and at each nuidentification and noti The photograph is location where all em #84's wife. Facility Executive Director of Nursin and Social worker from Services met briefly of Services met briefly of submitted to the submitted submitted in the submitted submit	ort was sent to the and Human Services 4's witnessed abuse by the swere completed and ctor of Nursing. The Five eted on 6/7/2018 after a as conducted by the Center irector of Social Services ag. The incident on 6/4/2018 was substantiated based on gation conducted by the of Social Services, and Department. The is ordered by the court not be with the resident effective yet to receive a staken legally against the eep resident on 1 on 1 until ed of the spouse's inability. The alleged perpetrator currently posted at the front rese's station for easy fication effective 6/6/18. Stated on the pertinent ployees can identify resident effector, Director of Nursing, and Department of Social on 6/5/2018 to discuss the	F 60	location of protective orders in resident's medical charts and importance of implementing at to ensure the resident's protect facility abuse prohibition proceeducation will be provided for nurses, to include full time, pa as needed licensed nursing steducation will be completed by Any employee not educated by will not be allowed to work unto This education will also be adding hire orientation process for licensed nurses effective 6/7/2 will also be provided annually. MONITORING PROCESS Effective 6/7/2018, Executive or Director of Social Services all alleged violation to ensure a investigation is completed and the state agency and other off required by regulation and/or fact. Any issues identified during monitoring process will be adding promptly. Findings from this manitoring process will be documented on prohibition tool and filed in daily binder after proper follow ups. This monitoring process will ta daily to include Saturdays and for 2weeks, weekly x 2 more worthly x 3 months or until the compliance is maintained.	the opproaches stion, per ess. This all licensed rt time and aff. This y 6/7/2018 il educated. ded on the or all new 2018, and Director and will review a thorough a reported to icials as Elder Justice on this liressed in abuse ly meeting are done. ke place Sundays weeks, then	
	discussed the possib protect the resident fr ideas were discussed	ed on 6/4/2018. The team the actions necessary to the spouse. Multiple I, such as room change, the different name, or		Effective 6/7/2018, the facility a quality assurance and perform improvement meeting monthly agent from the contracted mar	mance with an	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION (X3) DATE SUR COMPLETE		
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		345213	B. WING			06/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIMINEDO	AL HEALTH CARELILL	NCTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		L	ILLINGTON, NC 27546		
(X4) ID 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	spouse will not be aw facility as well as the a conclusion that, the will protect resident # maintaining his dignit reduce risk for deterior relocate resident #84 facility. Resident #84 6/5/2018 to an alias the facility abuse prohibit Director of Nursing, Endmission Director. The with the facility abuse Resident #84 was related facility as changulated on every 15 m 6/4/2018 to 9am. One initiated on 6/5/2018 observe the resident facility. One on one of facility receives confinition with a completed by the Director of Nursing and determine if there is a resident medical recof abuse, neglect, or any, determine wheth investigation reports reported to the state	to another location that the vare of. On 6/5/2018, the DSS social worker reached best course of action that 84 from his spouse, while cy, self-determination, and coration from this event is to to another part of the 1's name was changed on to ensure his protection, per cition process by the facility executive Director and This measure is in alignment to policy and procedure. Inducted to another room in 18 and the posted name in 19 and 19 a	F	607	and consulting company that oversees company to ensure that the facility systematically identify and address are related to resident's abuse and neglect and ensuring the abuse policies and procedures is implemented. This will ta place for the next twelve months or unt the facility shows the pattern of compliance. Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or Stoevelopment Coordinator, will monitor compliance with resident protection, perfacility abuse prohibition process, thorough investigation, injuries of unknown sources and resident neglect conducting clinical meeting daily. This meeting will allow the team to review allegation of abuse, incidents or accident that occurred from the prior clinical meeting. Any DSS protective orders and any documented information that indicated suspicion of abuse will be reviewed to ensure measures are in place to protect the resident. Any issues identified during this monitoring process will be address promptly. Findings from this meeting we documented on a daily clinical report form and filed in the clinical meeting binder after proper follow up is done. To monitoring process will take place daily 4 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern compliance is maintained. Effective 6/7/2018, Director of Nursing report findings of this monitoring process.	as like like taff by ll ents ad ate ct ng ed ill rt his r for of	
	a conclusion that, the will protect resident # maintaining his dignit reduce risk for deterior relocate resident #84 facility. Resident #84 6/5/2018 to an alias the facility abuse prohibit Director of Nursing, Endmission Director. It with the facility abuse Resident #84 was related facility on 6/5/2018 to facility was changulated on every 15 m 6/4/2018 to 9am. One initiated on 6/5/2018 observe the resident facility. One on one of facility receives confiniting in a resident medical recompleted by the Director of Nursing and determine if there is a resident medical recompleted to the state reported to the state.	e best course of action that 84 from his spouse, while by, self-determination, and boration from this event is to to another part of the 's name was changed on to ensure his protection, per tion process by the facility executive Director and This measure is in alignment to policy and procedure. It cated to another room in 18 and the posted name in typed. Resident #84 was hinutes watch from 7pm on the on one supervision was in which an employee that all times while in the that will continue until the transition that resident #84's FOTHERS dents clinical the last 30 days was the last 30 days was the correction of Nursing, Assistant and/or Nurse Supervisor to the last 30 days was the last 30 da			related to resident's abuse and neglect and ensuring the abuse policies and procedures is implemented. This will ta place for the next twelve months or unt the facility shows the pattern of compliance. Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or S' Development Coordinator, will monitor compliance with resident protection, perfacility abuse prohibition process, thorough investigation, injuries of unknown sources and resident neglect conducting clinical meeting daily. This meeting will allow the team to review at allegation of abuse, incidents or accided that occurred from the prior clinical meeting. Any DSS protective orders an any documented information that indicas suspicion of abuse will be reviewed to ensure measures are in place to protect the resident. Any issues identified during this monitoring process will be address promptly. Findings from this meeting we documented on a daily clinical report form and filed in the clinical meeting binder after proper follow up is done. To monitoring process will take place daily 4 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern compliance is maintained. Effective 6/7/2018, Director of Nursing	ke iil taff by II II II II II II II II II	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345213	B. WING			C 6/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		0/00/2010
				1995 EAST CORNELIUS HARNETT BO	III FVARD	
UNIVERS	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546	OLL WILL	
(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) COMPLETION DATE
F 607	Continued From page	e 39	F 60	07		
	allegation of abuse, a in resident medical recompleted on 6/6/18 audit is documented located at the facility 100% audit was comexecutive Director for and/or neglect submit 1/24/2018 to 6/7/2012 perpetrator was suspto protect the resident 2 hours of the allegat and submitted to the regulation and Elder manner. The audit reabuse/neglect reports perpetrator was suspper abuse prohibition however all 5 of 5 init submitted within two months noted with de Alleged Perpetrator(saudit was completed On 06/06/2018, 100% by Director of Rehabit office Manager, Activ Records Supervisor and oriented resident with ar Neglect. Two other resident #3 voiced an eglect. Alleged perpsuspended while the by the facility Execution Nursing. 24 hour reports 100% and	and/or neglect documented ecords. This audit was & 6/7/18. Findings of this on clinical records audit tool compliance binder. pleted by the Center rall allegation of abuse tted in the past from 8 determine if the alleged ended during investigation and 5 days completed within ion and 5 days completed state agency as required by Justice Act in a timely vealed 5 of 5 completed indicated the alleged ended pending investigation policy and procedure, and 24 hour reports were not hours of the allegation. 2 etail investigation and the so were suspended. This on 6/7/2018.		Performance Improvement Cany additional monitoring or of this plan monthly x 3 month the pattern of compliance is a The QAPI committee can month to ensure the facility remains substantial compliance. RESPONSIBLE PARTY Effective 6/7/2018, the center Director and the Director of Nobe ultimately responsible to a implementation of this plan of for this alleged noncompliant the facility remains in substate compliance.	modification ths, or until maintained. odify this plan in er Executive Nursing will ensure of correction ce to ensure	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	ľ	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C 06/08/2018	
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546			·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT		
F 607	and #3, will be inform actions taken when the by the Center Execut of Social Services. The Director of Social of Nursing, Unit mansor Director of Rehabilitar responsible parties for able to answer quest to mental capacity demember voiced any aneglect. SYSTEMIC CHANGE Effective 6/7/2018, all abuse, neglect, exploincluding injuries of unimmediately, but not allegation is made to facility and to other of Survey Agency, adults at the Ombudsmen in through established for procedures. Effective 6/7/2018, Tresults of all investigation in accordance the State Survey Agency and if the appropriate corrective Effective 6/7/2018, the team to include Executive Effective Effecti	f the allegation. Resident #2 ned of the findings and he investigation is completed tive Director and/or Director all services, Assistant Director ager, Admission Director and ation Services interviewed the for residents who were not ions during this interview due efficit on 6/7/18. No family allegation of abuse and/or ES Il alleged violations involving bitation or mistreatment, inknown source, are reported later than 2 hours after the the administrator of the fficials to include; the State t protective services, the accordance with State law	F	507			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	LETED
		345213	B. WING _			C 08/2018
	ROVIDER OR SUPPLIER	NGTON		1995 I	ET ADDRESS, CITY, STATE, ZIP CODE EAST CORNELIUS HARNETT BOULEVARD NGTON, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 607	monthly mandatory tr by contracted manag company that overse will put an emphasis abuse prohibition to in prevention, identificat reporting and respon- place monthly for new pattern of compliance Effective 6/7/2018, th Services, and/or emp and/or designated sta interviews for each co once a year. The interviews for each co once a year. The interview process will annual employee eva	ant supervisors will attend a aining that will be conducted ement and consulting es the facility. This training on all seven components of include screening, training, ion, investigation, protection, ion, investigation, investigation, protection, investigation, investigation, investigation, protection, investigation,	F	607		
	Director of Social Set Recreational Services member at least once allegation of Abuse a will be documented of assessment tool. Any and/or neglect will be Executive Director primit will be suspended perfacility, and reported requirements.	s and/or designated staff e every month to identify any nd/or Neglect. This interview				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _		C 06/08/2018	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
F 607	the responsible partiable to answer quest to mental capacity de interview will be doct assessment tool. Any and/or neglect will be Executive Director provided in the suspended person of the protective orders recovered requirements. Effective 6/7/2018 a protective orders recovered person of the protective orders recovered person of the will be placed in the advance directive tal accessibility by the number of the protective orders recovered and person of the protective orders in the protective orders in the protective orders in the will be added to resident or the will be added to resident or the protective orders in the protective orders in the control of the protective orders in the pr	es for residents who are not cons during the interview due efficit effective 6/7/18. This umented on the psychosocial y voiced allegation of abuse, e reported to the Center comptly. Alleged perpetrators ending investigation by the according to the regulatory copy of any resident's eived on admission or dmission director or uring the admission process, medical file under the ofor easy identification and ursing staff. eccived protective orders will 's care plan by the Admitting y supervisor and nursing aide sibility by both license nurses he protective order includes upervised visits, no visitation, e premises such measures dent's face sheet and on posted such as the ind/or description in a readily	F 6	07		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345213	B. WING _			C 6/08/2018	
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 607	plan and to nursing a accessibility by both aides. Guidelines su visitation, or not allow be covered in this ed also emphasize on trinformation will be and appropriate inforperpetrator picture arreadily accessible location will be nurses, nursing assistime and as needed leducation will be conemployee not education will be conemployee not educated allowed to work until also be added on the process for all new lie aides effective 6/7/2018, that administrative team, supervisors, Unit Marreviewing of DSS proprocess of reviewing the last 24 hours, whas sessments, incider hours, and Physician hours. By adding the orders to this process resident with prior his neglect, and/or injurie appropriate measure resident from the alleaf/7/2018. This process	o include adding the ventions to resident's care ide care guide for license nurses and nurse ch as supervised visits, no wed on the premises will also ucation. The education will be process that such ided to resident's face sheet mation posted such as the ind/or description to be a cation in the facility. The provided for all licensed stant to include full time, part icensed nursing staff. This inpleted by 6/7/2018 will not be educated. This education will a new hire orientation censed nurses and nursing to 18, and will also be provided	F 6	07			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI A. BUILDIN		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED C		
		345213	B. WING	·	0	6/08/2018
	ROVIDER OR SUPPLIER AL HEALTH CARE LILL	NGTON	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOUL LILLINGTON, NC 27546	LIUS HARNETT BOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Effective 6/7/2018, the Nurse supervisor and nurse will review clint last 24 hours, compliancident reports for the Physician orders writensure that any alleg and/or injuries of unhareported/documented the alleged perpetration investigation, and enthe facility Executive also incorporate reviorders to ensure the to address such order will take place every negative findings will end supervisor report daily clinical meeting. Effective 6/7/2018 the will print any protection the facility before be provide copies of the facility Executive Dir. Director of social ser licensed nurse. The	c process will be clinical meeting form aily Clinical meeting binder." The week end Registered door designated licensed ical documentation for the eted skin assessments, and ten in the last 24 hours to gation of abuse, neglect known sources do is investigated thoroughly, for is suspended pending sure the event is reported to Director. This process will ewing of any DSS protective facility put measures in place ears. This systemic process Saturday and Sunday. Any be documented on the week to form and maintained in the binder, effective 6/7/2018. The Admission Director (AD) we order for any referral to do is offered. The AD will then a protective order to the ector, Director of Nursing, vices and/or designated IDT team will then review all	F 60	7		
	admitting resident to measures are put in when admitted to the Effective 6/7/2018 th Director of Nursing, a	rotective orders prior to the facility to ensure place to protect the resident e facility. e facility Executive Director, and/or Director of social new admits and re-admits to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED	
		345213	B. WING _			C 06/08/2018	
	ROVIDER OR SUPPLIER	NGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULI LILLINGTON, NC 27546		ODE	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From page	e 45	F	607			
	meeting to validate the readmitted resident was measures in place to the alleged perpetrate. Effective 6/7/2018 are restraining orders for to visit the facility. All	with protective orders has protect the resident against ors. by alleged perpetrator with visitation will not be allowed the facility exit doors are					
	approved card. Visito entrance to enter the All the facility exit do magnetized lock that case of any other em exit door is equipped	be accessed using an ors will utilize the facility main premises, effective 6/7/18. ors are locked using a releases in case of fire. In lergency, each locked facility with an emergency release ed beside each exit door to					
	inside. The magnetic equipped with a mas each nurse's station. North Carolina life sa	ter override switch located at This is in compliance with fety code. Signs have been ors to direct visitors to the					
	(DON), Assistant Director of Social Sere-education on the lineach resident's me importance of implemensure the resident's prohibition process. provided for all licensime, part time and a staff. This education 6/7/2018. Any emplo 6/7/2018 will not be a	nenting approaches to protection, per facility abuse This education will be sed nurses, to include full as needed licensed nursing will be completed by yee not educated by					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C 6/08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		00/03/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From pag	e 46	F 6	07			
		ion process for all new ctive 6/7/2018, and will also					
	Director of Social Se violation to ensure a completed and repor other officials as requested. An amonitoring process were with the social series of the soci	executive Director and or rvices will review all alleged thorough investigation is ted to the state agency and uired by regulation and/or y issues identified during this will be addressed promptly. Conitoring process will be see prohibition tool and filed in after proper follow ups are g process will take place rdays and Sundays for more weeks, then monthly x pattern of compliance is					
	quality assurance an meeting monthly with contracted managem that oversees the confacility systematically related to resident's a ensuring the abuse properties implemented. This w	ment and consulting company mpany to ensure that the ridentify and address areas abuse and neglect and policies and procedures is ill take place for the next till the facility shows the					
	Director of Nursing, a Coordinator, will mor protection, per facility thorough investigation	pirector of Nursing, Assistant and/or Staff Development nitor compliance with resident y abuse prohibition process, on, injuries of unknown t neglect by conducting					

	TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345213	B. WING _		,	C 06/08/2018	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 607	team to review all all or accidents that occ meeting. Any DSS produced information abuse will be reviewed place to protect their during this monitoring promptly. Findings from documented on a dafiled in the clinical metallic follow up is done. The take place daily for 4 weeks, then monthly pattern of compliance. Effective 6/7/2018, Daring from this monitoring or modifical months, or until the promotion of the plan to ensure the factom liance. RESPONSIBLE PARE Effective 6/7/2018, the plan to ensure the factom for this ensure the facility recompliance. The credible allegation of the compliance. The credible allegation interviews, in-serviced interviews, in-serviced interviews, in-serviced interviews.	This meeting will allow the egation of abuse, incidents urred from the prior clinical rotective orders and any tion that indicate suspicion of ed to ensure measures are in esident. Any issues identified g process will be addressed om this meeting will be filly clinical report form and seting binder after proper is monitoring process will weeks, weekly x 2 more x 3 months or until the e is maintained. Sirector of Nursing will report oring process to the facility and Performance attee for any additional reation of this plan monthly x 3 reattern of compliance is electronal compliance in substantial. ETY The center Executive Director cursing will be ultimately eximplementation of this plan alleged noncompliance to mains in substantial.	F 6	07			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				R WING		С	
		345213	B. WING			06/	08/2018
NAME OF PROVIDER OR SUPPLI	ER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSAL HEALTH CARE	LILLI	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
				L	ILLINGTON, NC 27546		
PREFIX (EACH DEF	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
The in services #84's new alias action was to boon the facility pfor reporting all observations in Resident #84, refrom the facility photograph of Fevery nursing swas initiated 6/risk for injury and abuse." The state safety from his were not limited identify by a diffection on national interventions, in behavior, and a Reporting of All CFR(s): 483.12 S483.12(c) In refreshed to the serious bodily in the events that abuse and do resident in the serious and the serious abuse and the serious actions and the serious actions and the s	staff in include, new the taker operties the taker operation of the taker operation, and the taker operation operation, and the taker operation operation, and the taker operation operation operation operation operation operation.	services, and observations. ded information r/t Resident room number, and what in if his wife was observed y, and the 2 hour time frame ins of abuse. Other d one on one (1:1) staff with ored (locked) entry and exits in entrance, and a ent #84's wife posted at and ante room. A care plan ind focused on "Safety: At cial isolation r/t spousal coals included maintained interventions included, but elocation to another room, name, 1:1 supervision, staff hange, room change, safety ring for changes in mood or roved visitor list. Violations		607			7/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345213	B. WING		0.0	C 06/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER	1 1 1		STREET ADDRESS, CITY, STATE, ZIP CODE		0/00/2010	
				1995 EAST CORNELIUS HARNETT BOU			
UNIVERSA	AL HEALTH CARE LILLII	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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	Continued From page	e 49	F 60	9			
	adult protective service for jurisdiction in long	the State Survey Agency and ces where state law provides i-term care facilities) in e law through established					
	designated represent accordance with Stat Survey Agency, withi incident, and if the all appropriate corrective This REQUIREMENT by:	administrator or his or her tative and to other officials in e law, including to the State in 5 working days of the leged violation is verified e action must be taken.					
	by: Based on observation, record review, facility staff, Nurse Practitioner and Medical Director interviews, the facility failed to submit a 24-hour and 5-day report to the State Agency for 1 of 1 residents who was observed with a bruise of unknown origin to the left eye (Resident #19). Findings included:			F609 ROOT CAUSE This alleged noncompliance w from the Center's Director of M misinterpretation of regulatory requirements related to thorou investigation of an injury of un source. The DON stated that	lursing ghly known		
	Record review reveal	led Resident #19 was y on 3/4/2015 with diagnoses nson's Disease and		the bruise on resident #19 and the location and the type of inj concluded that the bruise was from resident hitting her face a bedside table. DON added that consider the injury as unknown	I based on ury he resulted against the it he did not		
	(MDS) dated 3/14/20 was severely cognitive extensive to total ass for all activities of dai the resident displayed. Review of an incident 7:00AM by Nurse #4	erly Minimum Data Set 18 revealed Resident #19 vely impaired and required istance of 1 staff member ly living. The MDS indicated d no rejection of care. t report dated 5/6/2018 at revealed Resident #19 was notic/bruised area under the		was able to conclude how the happen. Root cause analysis a concluded that the DON reach conclusion without thoroughly investigating the causative fact did not interview other employ resident involved and/or any of member who noticed the injury perspective on how the injury happened. On the interview of	injury also ued the tors as he ees, a ther staff y to gain the might have		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C 6/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	0/00/2010	
				1995 EAST CORNELIUS HARNETT BO			
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	Continued From page	e 50	F 6	09			
	left eye. The report re			6/8/2018 at 9:48am with the	state survey		
		imeters (cm) in length by 4		agency staff while on site; "T			
		e was no laceration noted.		indicated there was a	10 0011		
		ed that due to the resident's		misunderstanding/miscommu	ınication		
		as likely self-inflicted with		about the bedside table". DO			
		nich was at eye level. The		not report the injury of unknown			
		the immediate actions taken		before completing the investi			
		was completed, the bruise		causative factors; something			
	was noted, vital signs were taken and the physician and responsible party were notified.			have been done after the rep			
				injury of unknown source to t			
	. ,	, ,		Agency, Adult Protective Ser			
	A review of an Incide	nt 24 hour follow up report		other officials as required by			
	with Resident #19's n	name indicated the		within two hours of the occur	rence. Chief		
	immediate post-incide	ent actions taken were the		Clinical Officer from the Cons	sulting and		
	bed was moved away	y from the bedside table and		Management Company contr	acted by the		
	the room was rearran	nged. The report indicated		facility re-educated the Cente	er Executive		
		d the location of the bruise		director and the Director of N	-		
		e bedside table, it was		7/2/2018 on reporting expect			
		nt hit her head against the		is an injury of unknown origin	noted for		
		caused the bruise. There		any resident in the facility.			
	_	ture documented on the		IMMEDIATE ACTION			
	follow up report.			On 6/4/2018, the 24 hour rep			
		5/0/0040		report were sent to the Depar			
	_	5/6/2018 at 6:31PM for		Health and Human Services,			
		viewed. The note was signed		#19s injury of unknown source			
		e revealed the resident had		These reports were complete			
		er left eye and her providers		submitted by the Director of N	-		
		were informed. The note		further actions taken for resid			
	there were no witness	as "asking around" and		100% audit of all current resi			
		further indicated the resident ragitated and the resident		documentation within the last completed by the Director of	•		
	was "getting around"	~		Assistant Director of Nursing			
	was yeuny around	by wileciciali.		Supervisor to determine if the			
	Physician's orders we	ere reviewed and revealed		injuries of unknown source de	•		
	_	7/2018 for Resident #19.		any residents medical record			
		iscontinue aspirin and restart		determine whether an initial;		 	
		portable x-ray of bilateral		two hours and 5 days investig	•		
	-	socket) for hematoma. The		were completed and reported	-		
	Table and Diditions	ANDROLL IN HOLHARDING, THE	1	TO WOLL COMPLETED AND TENUTER			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010	
				1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
F 609	Continued From page	e 51	F 609	9		
	#1.	y Nurse Practitioner (NP)		agency and other officials as required regulation and/or Elder Justice Act. The audit revealed no other incident of injustice.	ne	
		sident #19 dated 5/7/2018 at		of unknown source documented in		
	•	was reviewed. The note		residents medical records. This audit		
		was awake and alert with		completed on 06/07/2018. Findings of		
		e. The note indicated the		audit is documented on clinical record		
	_	NP#1 earlier in the day and		audit tool located at the facility complia	ance	
	_	The note further indicated		binder.	a ator	
		the x-ray and it was not		100% audit was completed by the Dire of Nursing of all incidents reports	ector	
	completed.			completed within the last 30 days to		
	An observation of Pe	sident #19 was completed		identify any injuries of unknown source		
	on 6/5/2018 at 4:40 F	•		and ensure that a proper investigation		
		elchair at the nursing station.		was completed and a an initial report		
		I kempt with no visible		within two hours as well as 5 days rep	orts	
	injuries noted. There			are completed and submitted to the st		
	observed under her le			agency as required by regulation and		
		•		Elder Justice Act. The audit revealed in	no	
	An interview was con	ducted with the facility		other incident of injury of unknown sou	ırce	
	Medical Director on 6	/6/2018 at 9:38 AM. The		noted. This audit was completed on		
	Medical Director state	ed his expectation was the		6/7/2018. Findings of this audit is		
		ate and follow policy for		documented on incident reports audit		
	reporting injuries of u	nknown origin.		located at the facility compliance binde	er.	
				100% skin assessments of all active		
		ducted with Nurse #1 on		residents completed by the Director of	•	
		I. Nurse #1 stated she		Nursing, Assistant Director of Nursing		
		sing to Resident #19's left		and/or Unit Manager to identify any ot		
	_	ne bruising as crescent		resident with an injury of unknown sou		
		e and blueish/black in color.		The audit revealed no other incidents		
		ne first saw the bruise when on 5/7/2018. Nurse #1 said		injury of unknown source noted. This a	auuit	
	•	ng nurse what caused the		was completed on 6/6/18. SYSTEMIC CHANGES		
		o one knew. She stated the		Effective 7/10/2018, Facility will report	anv	
		I an x-ray was ordered.		injury of unknown source immediately		
		he resident was in bed it		m=not later than two hours after the in		
		position and the bedside		being noted to the facility Executive	Jan y	
	•	de of the bed. She stated		Director and to other state officials		
		uld not lower more than		including the State Survey Agency and	d to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			D. WING			С	
		345213	B. WING _		0	6/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
LIMIVEDO	AL HEALTH CARE LILLI	NCTON		1995 EAST CORNELIUS HARNETT BO	ULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE			
F 609	09 Continued From page 52		F 60	09			
L 008	approximately 30 inclaresident would not be table if she were in both never saw the bedside resident. An interview was cond 6/6/2018 at 11:18 Alwas the nurse who old Resident #19's left ey Incident Report on 5/when she entered the resident was sitting in bed and the bedside of the resident. Nurse remember if the resident was using the knurse #4 stated she the resident's left eye before. Nurse #4 repart appearing and bluish indicated she assess there were no open a bleeding. Nurse #4 rephysician on call (she physician), notified the Director of indicated Resident #7 times but the resident morning she discover stated the bedside table at eye level and did not the bedside table at exercise the nursing assis	these from the floor and the eable to hit her eye on the ed. Nurse #1 indicated she let able at eye level with the ducted with Nurse #4 on I. Nurse #4 confirmed she beserved the bruise to we and completed the 6/2018. Nurse #4 indicated eresident's room, the in her wheelchair beside the table was positioned in front ered table was positioned in front ered was eating breakfast or bedside table for activities. It is saw the bruised area under er which was not there the day borted the bruise was new worklack in color. Nurse #4 ed the resident's eye and areas and it was not exported she called the eresponsible party and off Nursing (DON). Nurse #4 ed the bruise. Nurse #4 ed the bruise. Nurse #4 ble was not at the resident's recall a time she observed eye level of Resident #19. asked the "localized people tants" who were working	F 60	the Adult Protective Services accordance with State law. Effective 7/10/2018, the cent administrative team, which in ADON, Unit Manager, Nurse Unit Managers, and/or SDC details any noted injury on coassessment reports and/or into ensure that such injuries his source and if not, ensure the procedure for reporting and is followed based on the faci Policy and Procedures. This thorough review will be added existing process of reviewing documentation for the last 24 which includes completed sk assessments, incident report 24 hours, and Physician order the last 24 hours. This procedure daily Monday through effective 7/10/2018. The resistency process will be doct the clinical meeting form ma "Daily Clinical meeting form ma "Daily Clinical meeting binded Effective 7/10/2018, the week Registered Nurse supervisor designated licensed nurse with details any noted injury on coassessment reports and/or into ensure that such injuries his source and if not, ensure the procedure for reporting and is followed based on the faci Policy and Procedures. This	ter nursing includes DON, is supervisors, will review in completed skin incident report in as a known is proper investigating sellity Abuse process of its don an incident report in as a known in a golinical in the incident report in a ses will take in the incident report in a self in and/or will review in completed skin incident report in as a known in a proper investigating sellity Abuse		
	resident's bruised eye Nurse #4 stated since	ey knew what caused the e and no one knew anything. e no one knew what to the reasonable conclusion		thorough review will be addeduced existing process of reviewing documentation for the last 24 which includes completed skews.	g clinical 4 hours,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 6/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP COD		0/00/2010	
				1995 EAST CORNELIUS HARNETT BO	ULEVARD		
UNIVERS	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	Continued From page 53		F 60	09			
F 009	the resident hit her en Nurse #4 stated the resident to pick up something on the corner of the sindicated she told the cause of the resident. A telephone interview Practitioner (NP) #1 NP#1 reported she with morning of 6/7/2018 in her wheelchair at stated she immediate under the resident's light what happened (NP# asked). NP#1 indicate and since no one knesshe ordered x-rays to fractures. NP#1 state responsible party aboresponsible party aboresponsible party aboresponsible party repurised easily. NP#1 Resident #19 several issues associated with An interview was connursing (DON) on 6/1 indicated there was a misunderstanding/mi bedside table. The DResident #19 hit her not the bedside table low position, the resident to report it to indicated if he had be reason to report it to indicated if he had be	ye on the bedside table. resident probably bent down off the floor and hit her eye bedside table. Nurse #4 a DON her conclusion of the 's bruised eye. If was conducted with Nurse on 6/7/2018 at 12:44 PM. If was in the facility on the and saw Resident #19 sitting he nurse's station. NP#1 all policed the bruised area aft eye and asked nursing and not recall who she and the bruise was significant and the source of the injury of ensure there were no and she recalled talking to the bout the bruised area and the corted the resident always said she followed up with a times and there were no and the bruise. If we contains the source of all	F 60	assessments, incident report 24 hours, and Physician order the last 24 hours. This syster will take place every Saturda Sunday. Any negative finding documented on the week encreport form and maintained in clinical meeting binder, effect 7/10/2018. Director of Nursing (DON), A Director of Nursing (ADON) a Development Coordinator (Sicomplete 100% re-education facility's abuse/neglect policy procedures including notifical protocols. This education will on reporting any injury of unkimmediately but not later than to the facility Executive Directother state officials including Survey Agency and to the Ad Services in the accordance with the education will be provided employees, to include full time and as needed staff. This education will also be accompleted by 7/10/2018. A employee not educated by 7/10/2018. A employee seffective 7/10/2018. A employees effective 7/10/2018. A employees effective 7/10/2018, Director Assistant Director of Nursing Development Coordinator, with compliance with investigation reporting of injuries of unknown compliance with investigation reporting of unknown compliance with investigation reporting of unknown compliance with	ers written in mic process y and gs will be d supervisor in the daily tive ssistant and/or Staff DC) will on the y and tion emphasize known source in two hours tor and to the State fult Protective with State law. Bed for all lee, part time fucation will Any (10/2018 will educated. Edded on new all new las, and will lilly. of Nursing, and/or Staff ill monitor in and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345213	B. WING _			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP	CODE	1 00/00/2010	
				1995 EAST CORNELIUS HARNETT			
UNIVERSAL HEALTH CARE LILLINGTON		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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI		
F 609	9 Continued From page 54		F 6	09			
F 609	5-day report and prov State Agency. An interview was con Officer (CCO) on 6/8/ interview with the DO expectation was the f investigate injuries of complete the required	ducted with the Chief Clinic 2018 at 9:48 AM during the N. The CCO stated the acility would thoroughly unknown origin and documentation per policy ort the resident's injury of	F 6	This meeting will allow the the daily clinical meeting of ensure completion and prothrough, incidents or accide from the prior clinical meeting any injury of unknown sour investigated and reported policy. The nursing admin will also review completion assessments from prior date any documented injury of was followed through pertissues identified during the process will be addressed. Findings from this meeting documented on a daily clinand filled in clinical meeting proper follow ups are done monitoring process will tall (M-F) for 2weeks, weekly weeks, then monthly x 3 in the pattern of compliance. Effective 7/10/2018, Direct will report findings of this in process to the facility Qual and Performance Improved Committee for any addition or modification of this plant three months, or until the compliance is maintained. committee can modify this the facility remains in subscompliance. RESPONSIBLE PARTY Effective 7/10/18, the cent Director and the Director of be ultimately responsible implementation of this plant implementation implementation implementation of this plant implementation	checklist to oper follow dents occurre ting to ensure urce was note per abuse istrative team of skin ay and ensure unknown sou policy. Any is monitoring I promptly. I gwill be nical report for g binder after e. This ke place daily x 2 more months or unt is maintained tor of Nursing monitoring ality Assurancement nal monitoring in monthly for pattern of the QAPI is plan to ensure the stantial ter Executive of Nursing will to ensure the stantial ter Executive of Nursing will to ensure	d e e e d n in e urce orm f d d e urce I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY
		345213	B. WING			С	
		345213	B. WING			06/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
ONIVERO	AL HEALIN OAKE LILLII	to roll		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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page	e 55	F	609	for this alleged noncompliance to ensure the facility remains in substantial compliance.		
F 610 SS=D	Investigate/Prevent/C CFR(s): 483.12(c)(2)-	Correct Alleged Violation (4)	F	610			7/10/18
		se to allegations of abuse, or mistreatment, the facility					
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged hly investigated.					
		t further potential abuse, or mistreatment while the gress.					
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the eged violation is verified a action must be taken.					
	staff, Nurse Practition interviews, the facility injury of unknown orig was observed with a (Resident #19). Findings included: Record review reveal	ed Resident #19 was v on 3/4/2015 with diagnoses			F610 ROOT CAUSE: This alleged noncompliance was result from the Center's Director of Nursing misinterpretation of regulatory requirements related to thoroughly investigation of an injury of unknown source. The DON stated that he noted the bruise on resident #19 and based of the location and the type of injury he concluded that the bruise was resulted from resident hitting her face against the	on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						С	
		345213	B. WING		o	6/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	•		
				1995 EAST CORNELIUS HARNETT BO	ULEVARD		
UNIVERSA	AL HEALTH CARE LI	LLINGTON		LILLINGTON, NC 27546			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION DATE	
F 610	Continued From p	nage 56	F 6	10			
	Dementia.	age oo			hat ha did not		
	Dementia.			bedside table. DON added the consider the injury as unknown			
	Review of the Ou	arterly Minimum Data Set		was able to conclude how th			
		/2018 revealed Resident #19		happen. Root cause analysis			
	' '	nitively impaired and required		concluded that the DON read			
		assistance of 1 staff member		conclusion without thoroughl			
		daily living. The MDS indicated		investigating the causative fa	•		
		ayed no rejection of care and		did not interview other emplo			
		ot directed towards others.		resident involved and/or any			
				member who noticed the inju	ıry to gain the		
		dent report dated 5/6/2018 at		perspective on how the injury			
		#4 revealed Resident #19 was		happened. On the interview	conducted on		
		hymotic/bruised area under the		6/8/2018 at 9:48am with the			
		rt revealed the area was		agency staff while on site; "T	he DON		
		entimeters (cm) in length by 4		indicated there was a			
		nere was no laceration noted.		misunderstanding/miscomm			
		ented that due to the resident's		about the bedside table". DC			
		e was likely self-inflicted with		not report the injury of unknown			
		which was at eye level. The		before completing the invest	-		
		ed the immediate actions taken ent was completed, the bruise		causative factors; something have been done after the rep			
		gns were taken and the		injury of unknown source to			
		ponsible party were notified.		Agency, Adult Protective Sei			
	priysician and ics	porisible party were notified.		other officials as required by			
	A review of an Inc	ident 24 hour follow up report		within two hours of the occur			
		's name indicated the		Clinical Officer from the Con-			
		cident actions taken were the		Management Company cont	•		
		way from the bedside table and		facility re-educated the Cent			
		rranged. The report indicated		director and the Director of N			
	based on the size	and the location of the bruise		7/2/2018 on reporting expec	tation if there		
	and the location of	f the bedside table, it was		is an injury of unknown origin	n noted for		
		ident hit her head against the		any resident in the facility.			
		ch caused the bruise. There		IMMEDIATE ACTION:			
	1	gnature documented on the		On 6/4/2018, the 24 hour rep			
	follow up report.			report were sent to the Depa			
				Health and Human Services			
	_	ted 5/6/2018 at 6:31PM for		#19s injury of unknown sour			
		reviewed. The note was signed		These reports were complete			
	Dy Nurse #4. The	note revealed the resident had		submitted by the Director of	Nursing. No		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C 06/08/2018
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010
				1995 EAST CORNELIUS HARNETT BOULEVAR	₹D
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 610	Continued From pag	e 57	F 610		
		er left eye and her providers		further actions taken for resident #1	9.
		y were informed. The note		IDENTIFICATION OF OTHERS:	
		as "asking around" and		100% audit of all current residents of	clinical
	there were no witnes	, , ,		documentation within the last 30 da	•
		further indicated the resident		completed by the Director of Nursin	-
		r agitated and the resident		Assistant Director of Nursing and/or	
	was "getting around"	by wheelchair.		Supervisor to determine if there is a	·
	DI			injuries of unknown source docume	
	_	ere reviewed and revealed		any residents medical records, and	-
		/7/2018 for Resident #19.		determine whether an initial; report	Within
		iscontinue aspirin and restart		two hours and 5 days thorough	od and
		, portable x-ray of bilateral socket) for hematoma. The		investigation reports were complete reported to the state agency and ot	
		by Nurse Practitioner (NP)		officials as required by regulation a	
	#1.	y range i ractitioner (ivi)		Elder Justice Act. The audit reveale	
	" 1.			other incident of injury of unknown	
	A nursing note for Re	esident #19 dated 5/7/2018 at		documented in residents medical re	
	_	I was reviewed. The note		This audit was completed on 06/07/	
	· •	t was awake and alert with		Findings of this audit is documented	
	bruising to her left ey	e. The note indicated the		clinical records audit tool located at	
		/ NP#1 earlier in the day and		facility compliance binder.	
	x-rays were ordered.	The note further indicated		100% audit was completed by the D	Director
	the resident resisted	the x-ray and it was not		of Nursing of all incidents reports	
	completed.			completed within the last 30 days to	
				identify any injuries of unknown sou	
		esident #19 was completed		and ensure that a proper investigati	
		PM. The resident was		was completed and a an initial repo	
		elchair at the nursing station.		within two hours as well as 5 days r	•
		Il kempt with no visible		are completed and submitted to the	
	injuries noted. There			agency as required by regulation ar	
	observed under her l	еп еуе.		Elder Justice Act. The audit reveale	
	A m imtomio	almata al mithe the a fee silite :		other incident of injury of unknown s	
		nducted with the facility		noted. This audit was completed on	
		6/6/2018 at 9:38 AM. The		6/7/2018. Findings of this audit is	dit tool
		ed his expectation was the		documented on incident reports aud located at the facility compliance bit	
	-	hly investigate any injuries of Medical Director indicated		100% skin assessments of all active	
	_	s with no explanation was		residents completed by the Director	
		ng to him and immediate		Nursing, Assistant Director of Nursi	
	particularly conceilli	ig to tillit and inititediate	1	indiany, Assistant Director of Nulsi	ng

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			750.25			С	
		345213	B. WING		۰ ا	06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	1 0.02.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL		0/00/2010	
NAME OF T	TOVIDER OR OUT FEER			1995 EAST CORNELIUS HARNETT BO			
UNIVERSA	AL HEALTH CARE LIL	LINGTON			ULEVARD		
				LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 610	Continued From pa	age 58	F 6	10			
	investigation should			and/or Unit Manager to ident	ify any other		
	investigation should	d be conducted.		resident with an injury of unk			
	An interview was o	onducted with Nurse #1 on		The audit revealed no other i			
		AM. Nurse #1 stated she		injury of unknown source not			
		ruising to Resident #19's left		was completed on 6/6/18.	ou. Tino dadic		
		I the bruising as crescent		SYSTEMIC CHANGES			
	-	eye and blueish/black in color.		Effective 7/10/2018, Facility v	will thoroughly		
		she first saw the bruise when		investigate any injury of unkn			
		rk on 5/7/2018. Nurse #1 said		immediately but not later than			
	she asked the off going nurse what caused the bruise and was told no one knew. She stated the			after the injury being noted to	the facility		
				Executive Director and to oth	er state		
	off going nurse stat	ed an x-ray was ordered.		officials including the State S	urvey Agency		
		n the resident was in bed it		and to the Adult Protective So	ervices in the		
	-	ow position and the bedside		accordance with State law.			
		side of the bed. She stated		Effective 7/10/2018, the cent	-		
		ould not lower more than		administrative team, which in			
		nches from the floor and the		ADON, Unit Manager, Nurse	•		
		be able to hit her eye on the bed. Nurse #1 indicated she		Unit Managers, and/or SDC			
				details any noted injury on co	•		
	resident.	side table at eye level with the		assessment reports and/or in to ensure that such injuries h	•		
	resident.			source and if not, ensure the			
	An interview was o	onducted with Nurse #4 on		procedure for reporting and in			
		AM. Nurse #4 confirmed she		is followed based on the facil			
		observed the bruise to		Policy and Procedures. This	•		
		eye and completed the		thorough review will be adde			
		5/6/2018. Nurse #4 indicated		existing process of reviewing			
		the resident's room, the		documentation for the last 24			
		in her wheelchair beside the		which includes completed ski	in		
	bed and the bedsid	le table was positioned in front		assessments, incident report	s for the last		
	of the resident. Nur	se #4 reported she did not		24 hours, and Physician orde			
		sident was eating breakfast or		the last 24 hours. This proces			
		e bedside table for activities.		place daily Monday through F	•		
		e saw the bruised area under		effective 7/10/2018. The resu			
		ye which was not there the day		systemic process will be doci			
		eported the bruise was new		the clinical meeting form mai			
		sh/black in color. Nurse #4		"Daily Clinical meeting binder			
		ssed the resident's eye and		Effective 7/10/2018, the weel			
	there were no oper	n areas and it was not		Registered Nurse supervisor	and/or		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG _		С	
		345213	B. WING			06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page bleeding. Nurse #4 re physician on call, not and notified the Direct #4 indicated Residentimes but the resident morning she discover stated the bedside tale eye level and did not the bedside table at experience with the resident if the resident's bruised eye Nurse #4 stated she alike the nursing assis with the resident if the resident's bruised eye Nurse #4 stated since happened she came the resident hit her eye Nurse #4 stated the resident hit her eye not be corner of the beindicated she told the cause of the resident stated she did not see investigation and relation. A telephone interview Practitioner (NP) #1 on NP#1 reported she with the cause of the resident stated she did not see investigation and relations.	e 59 eported she called the ified the responsible party stor of Nursing (DON). Nurse t #19 could be very active at t was not agitated the red the bruise. Nurse #4 ble was not at the resident's recall a time she observed eye level of Resident #19. asked the "localized people tants" who were working ey knew what caused the e and no one knew anything. It is no one knew what to the reasonable conclusion eye on the bedside table. esident probably bent down off the floor and hit her eye predside table. Nurse #4 to DON her conclusion of the the store of the store the		610		n kin ort en eg e e e e e e e e e e e e e e e e e	DATE
	stated she immediate under the resident's le what happened (NP# asked). NP#1 indicate and since no one kne she ordered x-rays to fractures. NP#1 state	he nurse's station. NP#1 ely noticed the bruised area eft eye and asked nursing eld did not recall who she ed the bruise was significant ew the source of the injury of ensure there were no d she recalled talking to the but the bruised area and the			or injury of unknown source per the facility's abuse/neglect policy and procedures. This education will also be added on not hires orientation process for all any new Executive Director, Director of Nursing and Social Services Director effective 7/10/2018, and will also be provided annually.		
		orted the resident always			Director of Nursing (DON), Assistant		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345213	B. WING _			C 6/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	0/00/2010
				1995 EAST CORNELIUS HARNETT BO		
UNIVERSA	AL HEALTH CARE LIL	LINGTON		LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 610	Continued From pa	age 60 #1 said she followed up with	F 6	10 Director of Nursing (ADON)	and/or Staff	
	Resident #19 seve issues associated whe did not know if investigation but fe enough to warrant	ral times and there were no with the bruise. NP #1 stated the facility completed an It the injury was significant an investigation.		Development Coordinator (S complete 100% re-education facility's abuse/neglect police procedures including notifical protocols, and investigation This education will emphasis	SDC) will n on the sy and ation procedures. ze on	
	An interview was conducted with the Director of Nursing (DON) on 6/8/2018 at 9:48 AM. The DON indicated there was a misunderstanding/miscommunication about the bedside table. The DON stated he understood Resident #19 hit her eye on the nightstand and not the bedside table and if the bed was in the low position, the resident could have hit her eye on the nightstand. The DON stated the nurse's conclusion seemed logical so he did not see a reason to investigate it any further. The DON indicated if he had been aware it was the bedside table not the nightstand he would have initiated an investigation. An interview was conducted with the Chief Clinic Officer (CCO) on 6/8/2018 at 9:48 AM during the interview with the DON. The CCO stated the expectation was the facility would thoroughly investigate injuries of unknown origin. The CCO stated an investigation for Resident 19's injury of unknown origin would be conducted.			reporting any injury of unknown immediately but not later that to the facility Executive Dire other state officials including Survey Agency and to the A Services in the accordance. This education will be provide employees, to include full tire and as needed staff. This education by 7/10/2018. employee not educated by 7/10/2018.		
				This education will also be a hires orientation process for employees effective 7/10/20 also be provided semi-annu MONITORING PROCESS Effective 7/10/2018, Directo Assistant Director of Nursing Development Coordinator, we compliance with investigation reporting of injuries of unknown by conducting clinical meeting. This meeting will allow the totally clinical meeting characteristics of the daily clinical meeting characteristics. The prior clinical meeting any injury of unknown source investigated and reported peopolicy. The nursing administ will also review completion of	r all new on the state of the s	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345213	B. WING				C
NAME OF D		340210	3	C-	TREET ARRESCO CITY STATE ZIR CORE	1 06/	08/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		1995 EAST CORNELIUS HARNETT BOULEVA 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	÷ 61	F	610	assessments from prior day and ensurany documented injury of unknown souwas followed through per policy. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report for and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or untit the pattern of compliance is maintained. Effective 7/10/2018, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement. Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/18, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation in substantial compliance.	orm il il g g Irre	
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	ents	F	641	Compliance Date 7/10/2018		7/10/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	NO _		, ا	C
		345213	B. WING				08/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILL	INGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
	I			L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From pag	ge 62	F	641			
	§483.20(g) Accuracy						
		st accurately reflect the					
	resident's status.						
		T is not met as evidenced					
	by:	one record review and staff			 F641:		
		ons, record review and staff / failed to accurately code the			ROOT CAUSE		
	1	a Set) to reflect the behaviors			MDS nurse #1, Social Worker #1, Direct	ctor	
	exhibited by 1 of 2 residents (Resident #23)				of Nursing, and the facility Executive		
	reviewed for wander	ing behaviors.			Director discussed on 6/11/18 to identif	·y	
					the root cause of this alleged		
	The findings include	:			noncompliance. The root cause analys		
	Resident #23 was a	dmitted 12/28/17 with			concluded that, Social worker #1 failed accurately code MDS assessment to	ιο	
		ded Dementia and Cognitive			reflect the behaviors exhibited by resid	ent	
	Communication Defi				#23 reviewed for wandering behaviors was an oversight of documented note t		
	A review of a social	work note dated 1/3/18 read			detailed the wandering behaviors.		
	in part: "walks and w	anders inside the facility".					
	A review of the resid	lent's most recent			IMMEDIATE ACTION TAKEN		
		S dated 1/4/18 was coded as			The comprehensive MDS assessment	for	
		sment. The assessment			resident #23 Assessment Reference D		
		elopement alarm was used			(ARD) 1/4/2018 was modified by MDS		
	daily. Wandering w	as not coded on the			Nurse #1 on 6/8/2018 to reflect wander	ing	
	assessment.				behaviors per RAI guidelines.		
	A review of another	MDS for the resident dated			The quarterly MDS assessment for		
	4/2/18 was coded as	s a quarterly assessment.			resident #23 ARD 04/02/18 was modifi	ed	
		realed a wander/elopement			by MDS nurse #1 on 6/8/2018 to reflec		
		y. Wandering was not coded			Wandering behavior per RAI guidelines	; in	
	on the assessment.				section E of MDS.		
	On 6/5/18 at 11:16 A	AM was observed traveling					
		of the facility. On 6/7/18 at			IDENTIFICATION OF OTHERS		
		as observed as he attempted			100% audit for current wandering		
		area. He was redirected by			behavior residents most recent MDS	_	
	starr and went back	aff and went back down the hall.			assessment was completed by the MD		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	()	X3) DATE SI COMPLE	
		345213	B. WING _			C 06/08	8/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
		NOTON		1995 EAST CORNELIUS HARNETT BOULE	VARD		
UNIVERSA	AL 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 OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	E	(X5) COMPLETION DATE
F 641	Continued From page	e 63	F 6	41			
F 641	During an interview of #6 stated that Reside in the facility. She rethe facility doors but it in the facility doors but in t	on 6/7/18 at 1:50 PM, Nurse on the #23 frequently wandered apported that he will approach is easily redirected. ducted with Nursing 8 at 2:19 PM. She reported quently goes to the building 8 that Resident #23 will easily redirected. ducted with the MDS 8 at 12:31 PM. During this the assessments completed should have reflected the should have reflected the should have reflected the iors. The MDS Nurse did 1/2/18 assessment that did fors. with the Director of Nursing M he stated it is his MDS was completed with the Administrator on	F 6	other resident with wandering be the lookback period was coded appropriately per RAI guidelines E of MDS 3.0. The results of the indicated 2 other residents with behaviors was coded inaccurate guidelines in section E of MDS 3 nurse #1 modified the assessme both identified residents to reflect wandering behaviors per RAI guidelines of this audit is documen "MDS accuracy audit tool locate facility compliance binder. SYSTEMIC CHANGES Effective 7/10/2018, MDS nurse social worker who complete sect MDS 3.0 is required to review the documentation completed within days of MDS Assessment Refer Date (ARD) to determine support documentation for accurate codi MDS section E. Any documented observation, or documented interest also be coded based on RAI guidelines wandering behaviors will accurately in MDS 3.0 per RAI guidelines. This education coding requirements and support code approach coding requirements and support code approach coding requirements and support coding requirements and support coding requirements and support code approach coding requirements and support code approach cod	s in section audit wandering wandering wands for extended in the wands of the second o	on ng AI S vill ed s.	
				documentation for each item coo MDS. This education was provid Social worker #1 who is respons complete section E of MDS 3.0.	ded in ded to sible to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				C 08/2018	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	e 64	F	Effer Accombined National Action (CD) provided Direction MO Effer MD: MD: #1 to code The week find Effer report to the Perilany of the until main modern main main modern main modern main main main main main main main mai	ective 7/10/2018; The education on surate coding of MDS is added to not as orientation education for MDS ases, Director of Social Services, evities Director, and Dietary Manage DM). This education will also be wided annually for MDS nurses, ector of Social Services, Activities ector, and the Dietary Manager. NITORING PROCESS ective 7/10/2018, prior to submissions Social Services and the Dietary Manager. NITORING PROCESS ective 7/10/2018, prior to submissions Social Services action E of Social Services and social work are ensured that wander behaviors is educurately per RAI guidelines. The ensure that wander behaviors is estable to ensure that wander behaviors is estable to ensure the submission of this monitoring process and the ensured that wander behaviors is estable to ensure the facility Quality Assurance and formance Improvement Committee and additional monitoring or modification is plan monthly for three months, of the pattern of compliance is not an ensure the facility entire plan to ensure the facility entire plan to ensure implementation of this plan to ensure implementation entire plan of correction for this alleged accompliance to ensure the facility entire plan of correction for this alleged accompliance to ensure the facility accompliance.	ew er n, eer or 4 l sss for on or		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG		COMPLETED	
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F 641			F 6	remains in substantial compliar Compliance	nce.		
F 676 SS=D	Activities Daily Living CFR(s): 483.24(a)(1)		F6	76		7/10/18	
	resident's needs and provide the necessary ensure that a residen daily living do not dim of the individual's clin that such diminution vincludes the facility ensurement and services or her ability to carry living, including those of this section	dent and consistent with the choices, the facility must y care and services to t's abilities in activities of sinish unless circumstances ical condition demonstrate was unavoidable. This insuring that: ent is given the appropriate es to maintain or improve his out the activities of daily especified in paragraph (b)					
		ide care and services in graph (a) for the following g:					
	grooming, and oral ca						
	§483.24(b)(2) Mobility including walking,	y-transfer and ambulation,					
	§483.24(b)(3) Elimina	ation-toileting,					
	§483.24(b)(4) Dining- snacks,	eating, including meals and					
	§483.24(b)(5) Comm	unication, including					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345213	B. WING			06/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILL	INGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
				L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	This REQUIREMEN by: Based on observation review, the facility fare resident with shaving sampled residents whom of oversight, ending one staff (Resident #46 was addiagnoses including pulmonary disease, Parkinson's disease disorder. Resident #46 was as Data Set on 4/19/18 a moderate impairment mood issues. He need of oversight, encours staff for personal hys He needed limited as bathing. A care plan dated 4/ with my care r/t (relaweakness, dementia "I will participate in napproaches included as much as possible subtask if rest periodProvide assist as read the participate in the provide assist as read the participate in the	communication systems. T is not met as evidenced on, staff interview and record iled to assist and supervise a g and nail care for 1 of 1 who needed supervision in the accouragement and cuing from #46). Findings included:	F	676	F676: ROOT CAUSE Director of Nursing, and the facility Executive Director discussed on 6/08/1 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged non-compliance resulted from failure by an employee to assist and cue residen #46 with shaving and nail care. Reside needed supervision in the form of oversight, encouragement and cuing frestaff. The root cause analysis added the the alleged noncompliance was caused the employees' culture within the facility that include, but not limited to, lack of residents' centered care delivery cultur lack of good customer service, and lack consistent staffing who provide care for residents in the facility to assure care is delivered to residents in the facility at a times. IMMEDIATE ACTION On 06/08/2018, Nurse Aide #3 and Director of Nursing (DON) provided naic care and set-up, oversight, and cuing for resident #46 to shave and complete ADL's. Resident #46 was able to shave himself after set up assistance and supervision. IDENTIFICATION OF OTHERS	y t t om nat d by y e, k of s III	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	· /	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	700/2010
	10 115211 011 001 1 21211			1995 EAST CORNELIUS HARNETT BOULEVA	A D D	
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546	1110	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 676	Continued From page	e 67	F 67	76		
	were noted. Personal hygiene cor documentation for Ma	reviewed. No behaviors npleted care task ay and June 2018 was nclude notes about provision		100% audit of all current residents facility was completed by the Dire Nursing, Assistant Director of Nur and/or Unit Manager on 6/27/2018 6/28/2018 to identify any other reswith any ADL care needs to include	ctor of sing 3 & sident	
	of nail care or shaving Resident #46 was init	g. ially observed on 6/08/18 at		care and facial hair removal/shavi other residents were identifies with for nail care and five residents we	ng. Six h need	
	8:50 AM lying in a bed positioned in a low level. He had one inch long hair growth on side burns and at least 1/4 inch long beard on the rest of his face. He said, "I don't like my face like this. I			with need for cutting facial hair. Assistance with nail care and shaving/removal of facial hair for i residents provided by Director of I	Nursing,	
	1/4 inch long on both some nails. Resident	rnails were observed to be hands with jagged edges on #46 was observed again at in the chair next to his bed.		Assistant Director of Nursing and/ Manager on 6/28/2018. Findings of audit is documented on the "ADL Assistance audit tool" maintained	of this	
	His facial hair and na He was observed a the said there was a shaw	ils were the same as before. hird time at 11:07 AM. He ving kit in his cabinet. He		facility compliance binder. SYSTEMATIC CHANGES Effective 7/10/2018; residents wil	I receive	
	facial hair and nails w	ince he was admitted. His vere the same as before. d shaving cream were on ared bathroom.		assistance with activities of Daily (ADL) to include assistance with r and assistance with shaving at the minimum during scheduled shower	nail care e	
		Aide #3 on 6/8/18 at 11:35 es for himself. I ask if he is		and as needed. The ADL assistant include nail care and assistance with shaving will be provided by certifications.	vith	
	the second shift show he came, the beard w	e washes himself. He is on ver list." She added, "When vas long. He said he could		nursing assistance with an oversit licensed nurses, based on each replan of care.	esident's	
		e never used the electric disposable razors. We are ngernails."		Effective 07/10/2018, the facility w provide proper set-up, oversight, of and nail care to all current resider need supervision, to ensure hygical	cuing nts that	
	of a black razor bag in 11:37 AM on 6/8/18.	ic razor was observed inside in the resident's closet at At that time, the resident eck was at least 3/4 inch was present for the		mobility, elimination, dining and communication are maintained an diminish unless circumstances of individual's clinical condition demothat such diminution is unavoidable.	the onstrate	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		PLETED	
		345213	B. WING			l	C 08/2018	
	ROVIDER OR SUPPLIER	NGTON		19	TREET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546	1 00,	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		,		(X5) COMPLETION DATE	
F 676	REGULATORY OR LSC IDENTIFYING INFORMATION)			676	((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
					include full time, part time and as need nursing staffs. This education will provi an emphasis on the importance to prov the appropriate treatment and services maintain or improve resident's ability to carry out the activities of daily living, to include but not limited to; utilizing prop set-up, oversight and cuing for resident and ensuring maintaining abilities to perform ADL's. Nursing staff were also re-educated on how to access each resident plan of care to determine the assistance needed for ADL's. Nurses of	de ride to o er ts		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345213	B. WING		C 06/08/2018			
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION			
F 676	Continued From page	e 69	F 67	duty were re-educated to follow up wit residents on shower days to make sur that nail and facial care was provided, signing the bath/shower sheet after th proper follow through. This education be completed by 07/10/2018, any nurs staff not educated by 07/10/2018 will be allowed to work until educated. Thi education will also be added to new hi process for all new nursing employees effective 07/10/2018 and will be provid annually. MONITORING PROCESS Effective 07/10/2018, the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator complete the random audit of nursing aides and/or nurses providing set-up for residents needing supervision to ensure are was provided correctly. Effective 06/29/2018, will report finding this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 7/10/2018, Director of Nursing Assistant Director of Nursing, Unit manager and/or designated licensed nurse, will monitor compliance with assistance with ADL care for residents who are capable of performing their Allowed as a substantial compliance with assistance with ADL care for residents who are capable of performing their Allowed as a substantial compliance of performing their Allowed are capable of performing their Allowed ar	e and e will sing not s re s ded will or re gs of f until d. olan			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546	06/08/2018
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 676	Continued From page	e 70	F 67	by randomly checking five randomly selected residents in different halls on each shift to ensure ADL assistance is provided to include nail care and shav as appropriate based on each resident plan of care. Any issues identified dur this monitoring process will be address promptly. Findings from this monitoring process will be documented on an "ADD Assistance monitoring tool "and filed in the facility compliance binder after profollow up is done. This monitoring process will take place daily for two weeks, we x 2 more weeks, then monthly x 3 more or until the pattern of compliance is maintained. Effective 7/10/2018, Director of Nursin Assistant Director of Nursing and/or S Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plate to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/2018, the center Execut Director and the Director of Nursing with the pattern of this plan of correction of this alleged noncompliance to ensure implementation of this plan of correction this alleged noncompliance to ensure implementation of this plan of correction this alleged noncompliance to ensure implementation in substantial compliance.	ing it's ing sed ing sed ing per sess sekly iths g, taff he for on il d. olan

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		345213	B. WING		O6/0	8/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.0	5.25.6
				1995 EAST CORNELIUS HARNETT BOULEVARD	ETT BOULEVARD	
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		LILLINGTON, NC 27546		
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F 676	Continued From page	2 71	F 676	6		
F 677 SS=D	ADL Care Provided for CFR(s): 483.24(a)(2)	or Dependent Residents	F 677	Compliance date 7/10/2018	7	7/10/18
	out activities of daily I services to maintain of personal and oral hyg. This REQUIREMENT by: Based on record revi interviews the facility care for 3 of 3 depend 48, #59 & #62) review living. The findings included 1) Resident #48 was 2/01/17 with diagnose and cerebral infarct wright dominant side. A review of the most (MDS), a quarterly rehe was cognitively imextensive to total assidaily living (ADLs). Hand be understood. It a staff for bathing. A record review of the revealed Resident #4 assistance with bathindue to hemiplegia and	ew, observations and staff failed to provide finger nail dent residents (Resident # //ed for activities of daily admitted to the facility on es which included dementia ith hemiplegia affecting the recent Minimum Data Set view dated 4/23/18, revealed		F677 ROOT CAUSE Director of Nursing, and the facility Executive Director discussed on 6/08/1 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged non-compliance resulted from failure by an employee to provide nail care to 3 of identified residents; resident #48, #59, #62. Resident #48, #59, &62 are unab to carry out the activities of Daily living their own, specifically nail care. The roo cause analysis added that the alleged noncompliance was caused by the employees' culture within the facility the include, but not limited to, lack of residents' centered care delivery cultur lack of good customer service, and lack consistent staffing who provide care for residents in the facility to assure care is delivered to residents in the facility at a times. IMMEDIATE ACTION On 06/08/2018, Director of Nursing	y of 3 & ole on ot at re, k of r	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	700/2010	
	10115211 011 001 1 2.2.1			1995 EAST CORNELIUS HARNETT BOUL	EVARD		
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(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	e 72	F 67	77			
		n on 5/4/18 at 11:47 AM served to have black debris on both hands.		(DON), Assistant director of Nu and/or Unit manager provided of residents #48, #59 & #62. IDENTIFICATION OF OTHERS	nail care for		
	Resident #48 was ob wheelchair in the hall the dining room for lu	while being transported to nch. His fingernails were ontinued to have black debris		100% audit of all current reside facility was completed by the D Nursing, Assistant Director of N and/or Unit Manager on 6/25/26/2018 to identify any other with any ADL care needs to inc	ents in the hirector of Nursing 018 & resident lude nails		
	During an observation on 6/6/18 at 9:01 AM Resident #48 was in bed. He stated he had not had a bath yet. His finger nails remained dirty. On 6/6/18 at 5:08 PM Nursing Assistant #4 was interviewed. She stated cleaning fingernails was part of any bath and not just part of the twice per week shower. During an interview with the Director of Nursing on 6/8/18 at 1:00 PM he stated cleaning fingernails was part of the daily bath and nails should be cleaned whenever they have debris under them.			care. Six other residents were i with need for nail care. Nail car identified residents provided by Nursing, Assistant Director of N and/or Unit Manager on 6/28/2	re for Director of Nursing		
				Findings of this audit is docume the "ADL care audit tool" maintafacility compliance binder. SYSTEMATIC CHANGES Effective 7/10/2018; residents	ented on ained in the		
				the necessary to maintain good to include but not limited to, nai during daily ADL care. The ADL include nail care will be provide certified nursing assistance with oversite of the licensed nurses,	d grooming il care _ care to ed by h an		
	On 6/8/17 at 1:14 PM have black debris cal	I his fingernails continued to ked under the nails.		each resident's plan of care. Effective 7/10/2018, facility will consistent assignment for licen	establish		
	fingernails of Resider black debris under hi She stated they need would do it immediate 2) Resident #59 was 7/30/12. Her diagnos	I Nurse #4 observed the nt #48. She observed the s fingernails on both hands. led to be cleaned and she ely. admitted to the facility on ses included profound s, blindness in both eyes,		and nursing aides. This will aid improving residents' centered of delivery and customer centered Staff members will be familiar versidents under their care as the each resident needs will be antinclude ADLs care specifically reffective 6/7/18 the facility will interdisciplinary weekly team be	e on care d approach. with the ne result ticipated to care. conduct an		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			7. BOILD	_		، ا	С	
		345213	B. WING				08/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010	
					995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLII	NGTON			ILLINGTON, NC 27546			
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F 677	Continued From page	e 73	F	677				
					supervisors to discuss culture change			
	I .	al Minimum Data Set (MDS)			initiatives to be implemented in the faci	lity.		
	dated 4/27/18 revealed	-			These meetings will be held without			
	, , ,	required extensive to total			affecting resident care activities. These	;		
		tivities of daily living (ADLs)			meetings are intended to improve			
		ge of motion on both sides			employee culture in the facility and her			
	of both the upper and	nower extremities.			improve quality of care to all our reside Effective 6/7/2018 the facility established			
	The care plan dated	4/28/17 stated Resident #59			an Employee Appreciation Committee	s u		
	T	re related to immobility of			(EAC) chaired by the Director of Huma	n		
	both upper extremitie				Resources. Initial members of this	"		
		staff for all care needs with			committee were selected by the facility			
	· ·	eive nail care on shower			Executive Director and Director of Nurs			
	days.				Services. Members include the Activity	-		
	An observation on 6/5	5/18 at 5:03 PM revealed her			Director, Director of Social Services,			
	fingernails had back of	debris under them.			Nurse Aide #1, Dietary Aide #1 and			
					Laundry aide #1. This committee will m	eet		
		1 Nursing Assistant (NA) #4			monthly to discuss ways to improve			
		stated cleaning fingernails			employees' morale in order to reduce s			
	1	of the daily bath and not just			turnover and improve work place cultur	e		
	1 -	nower on the scheduled			effective 6/7/2018.			
	shower days.				Effective 07/10/2018, the facility will			
	0:- 0/7/40 -1 44 00 41	M D = -:-			provide proper set-up, oversight, cuing			
	On 6/7/18 at 11:22 Al				and nail care to all current residents the	JŁ		
		nair. NA #5 was in the room			need supervision, to ensure hygiene,			
		iven Resident #59 at bath ne fingernails was part of the			mobility, elimination, dining and communication are maintained and do	not		
		he nails and reported they			diminish unless circumstances of the	ΠΟι		
	I .	d trimming. She said she			individual's clinical condition demonstra	ate		
	_	nt #59 's nails today during			that such diminution is unavoidable			
		ean and trim them later in			On 7/02/2018; Chief Clinical officer from	n		
		the end of her shift. She did			the consulting and Management			
		did not clean the nails during			Company contracted by the facility revi	sed		
	the resident's bath.	<u> </u>			a "bath/shower form" to include area fo			
					documentation for nail care. Facility			
	During an interview w	vith the Director of Nursing			nursing staff will utilize the revised sho	wer		
	on 6/8/18 at 1:00 PM	he stated cleaning			sheet effective 7/10/2018.			
		of the daily bath and nails			Effective 7/10/2018; certified nursing a			
	should be cleaned wh	nenever they have debris			on duty will notify a licensed nurse on o	lutv		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 06/08/2018		
NAME OF P	ROVIDER OR SUPPLIER	0.02.0		STREET ADDRESS, CITY, STATE, ZIP CODE		6/06/2016	
TVAIVIL OF T	TO VIDER OR OUT FILE						
UNIVERSA	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOU	LEVARD		
				LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	e 74	F 67	7			
	under them.			of any refusal of care specifica	ally related		
				to nail care promptly when it o	•		
	3) Resident #62 was	readmitted to the facility on		Licensed nurse will discuss wi			
		es which included heart		resident to validate the refusal	I. Licensed		
		contractures of both knees.		will sign the Bath/shower form	s for		
				individual residents who is sch	neduled for		
	A review of the quarte	erly Minimum Data Set		bath/shower with the reason for	or refusal		
	(MDS) dated 4/30/18	revealed Resident #62 was		added on the form. Completed	d		
	severely cognitively in	mpaired and required		bath/shower forms will be mai	ntained in		
	extensive to total ass			the residents' shower books m			
	•	ch required the assistance of		each nursing station effective			
	2 staff.			Director of Nursing, Assistant			
	.	0/5/40 4 0 00 514		Nursing and/or Staff developm			
		n on 6/5/18 at 2:30 PM		coordinator will complete 1009			
		served in the day room		re-education to all current nurs	-		
		air. An observation of his		include full time, part time and			
	_	here was debris under his t obvious under the thumb		nursing staffs. This education	-		
	nails on both hands.	l obvious under the thumb		an emphasis on the important the appropriate treatment and	-		
	nails on both hands.			maintain or improve resident's			
	On 6/6/18 at 5:08 PM	1 Nursing Assistant (NA) #4		carry out the activities of daily	-		
		e stated cleaning fingernails		include but not limited to; utilize	-		
		of the daily bath and not just		set-up, oversight and cuing for			
	completed with the tv			and ensuring maintaining abili			
				perform ADL's. Nursing staff w			
	On 6/8/18 at 9:43 AM	1 Resident #62 was up in a		re-educated on how to access	each		
	wheelchair in his rooi	m. An observation of his		resident plan of care to detern	nine the		
	nails revealed the thu	umb nails on both hands		assistance/services needed for	or ADL's.		
	were long and contai	ned dark debris under the		Nurses on duty were re-educa	ated to follow		
	nails.			up with residents on shower d			
				sure that nail and facial care v			
		M an additional observation		provided, and signing the bath			
	_	Resident #62 revealed his		sheet after the proper follow the	•		
	_	to contain dark debris under		education will be completed by	-		
	the thumb nails.			07/10/2018, any nursing staff			
				educated by 07/10/2018 will n			
		vith the Director of Nursing		allowed to work until educated			
	on 6/8/18 at 1:00 PM			education will also be added to			
	tingernails was part o	of the daily bath and nails		process for all new nursing en	npioyees		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.02.0		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	06/2016
TO AVIL OF T	NOVIBER OR COLL ELER				995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	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 PREFI) TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 677	F 677 Continued From page 75		F 6	677			
	should be cleaned when under them.	nenever they have debris			effective 07/10/2018 and will be provide annually.	ed	
					MONITORING PROCESS Effective 07/10/2018, the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator complete the random audit of nursing aides and/or nurses providing set-up for residents needing supervision to ensur care was provided correctly. Effective 06/29/2018, will report finding this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or use the pattern of compliance is maintained. The QAPI committee can modify this plat to ensure the facility remains in	or re us of until d.	
					Effective 7/10/2018, Director of Nursing Assistant Director of Nursing, Unit manager and/or designated licensed nurse, will monitor compliance with AD care for residents who are unable to perform their ADL by randomly checkin five randomly selected residents in different halls on each shift to ensure A care is provided to include nail care as appropriate based on each resident's p of care. Any issues identified during th monitoring process will be addressed promptly. Findings from this monitoring process will be documented on an "AD Care monitoring tool "and filed in the facility compliance binder after proper	L ng NDL plan nis	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEY. LILLINGTON, NC 27546			00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page	76	F6	677	follow up is done. This monitoring proceduil take place daily for two weeks, were x 2 more weeks, then monthly x 3 monor until the pattern of compliance is maintained. Effective 7/10/2018, Director of Nursing Assistant Director of Nursing and/or State Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plate on the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/2018, the center Execution Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	ekly ths g, aff for on I. an		
F 690 SS=D	Bowel/Bladder Incont CFR(s): 483.25(e)(1)-		F 6	590 	Compliance date 7/10/2018		7/10/18	
	admission receives se							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345213	B. WING _		C 06/08/2018	
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEV LILLINGTON, NC 27546	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 690	not possible to main §483.25(e)(2)For a rincontinence, based comprehensive asseensure that- (i) A resident who erindwelling catheter is resident's clinical continence to the exident who erindwelling catheter of is assessed for removed as possible unless the demonstrates that cound (iii) A resident who is receives appropriate prevent urinary tract continence to the exidence to the exidence to the exidence of the	mes such that continence is tain. resident with urinary on the resident's essment, the facility must here the facility without an sonot catheterized unless the indition demonstrates that necessary; here the facility with an or subsequently receives one loval of the catheter as soon he resident's clinical condition at heterization is necessary; is incontinent of bladder the treatment and services to infections and to restore tent possible. resident with fecal on the resident's essment, the facility must not who is incontinent of bowel the treatment and services to mal bowel function as This not met as evidenced ons, resident and staff of review the facility failed to from coming in contact with sidents (Resident #16) or care.	F 6	F690 ROOT CAUSE Director of Nursing, Dietary Mana Staff Development Coordinator, Unit Manager and the facility Exe Director discussed on 6/08/18 to the root cause of this alleged	ADON, ecutive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245242	B WING	B. WING			С		
		345213	B. WING_			0	6/08/2018		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
UNIVERSA	AL HEALTH CARE LILLI	NGTON		19	995 EAST CORNELIUS HARNETT BOULEVARD				
				LI	ILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 690	Continued From page	e 78	F	690					
	2/15/17. His diagnose	es included right lower leg			noncompliance. Root cause analysis				
	amputation, contracti	ures of the right and left			conducted revealed, the alleged				
	knees, dementia and	stage 4 pressure ulcer.			noncompliance resulted from Nurse Aid	de			
					#6 not properly securing privacy,				
		erly Minimum Data Set			concluding that the facility failed to kee	ра			
		revealed Resident #16 was			catheter privacy bag from coming in				
	cognitively intact with no behaviors. He required				contact with the floor.				
		sistance with all activities of							
		cept he was independent			IMMAEDIATE A OTIONI				
	with eating. He had a	n indwelling urinary catheter.			IMMEDIATE ACTION	_			
	The care plan dated	1/12/19 addragad			On 6/08/18, DON adjusted catheter ba under resident # 16 wheelchair to prev				
		indwelling catheter which			from coming in contact with floor.	CIIL			
		acy bag, observe for signs			nom coming in contact with hoor.				
		nary tract infections and to			IDENTIFICATION OF OTHERS				
	follow orders for cath	-			This deficiency practice has the potent	ial			
					of affecting all resident that have Foley				
	During an interview w	vith Resident #16 on 6/5/18			catheters.				
	at 12:42 PM his urina	ary catheter privacy bag was							
	observed touching th	e floor.			On 6/08/2018 facility wide audit was				
					conducted by the Director of Nursing,				
		n on 6/6/18 at 8:55 PM			Assistant Director of Nursing and/or Ur	nit			
		If-propelling his wheelchair in			manager for all residents with Foley				
		r bag was observed strapped			catheters to ensure the catheter privac	-			
		with the bottom of the			bags are being properly secured above				
	conection bag cover	dragging on the floor.			the ground but below resident's bladde Eight other residents were identified wi				
	On 6/7/18 at 2:47 PM	A Pesident #16 was			Foley catheters in place. All eight	uı			
		s wheelchair in the court			resident's catheters were properly				
	_	heter privacy bag was			secured and not touching the floor.				
	observed touching th				Findings of this audit is documented or	1			
					the "Foley Catheter Audit Tool"				
	During an interview w	vith Resident #16 on 6/7/18			maintained in the facility compliance				
	_	he was not aware the			binder.				
	privacy bag was touc	ching the concrete because							
	he could not see it.				SYSTEMATIC CHANGES				
					Effective 7/10/2018; any resident with	а			
		Nursing Assistant (NA) #6 catheter privacy bag and			Foley Catheter will have a privacy bag located below the bladder and secured	to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING				08/2018
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEY LILLINGTON, NC 27546			00/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	stated Resident #16 t should remain below not be in contact with was tied to the wheel touch the floor. She s to secure the urinary not touch the floor. On 6/8/18 at 2:30 PM resident's urinary catl	the catheter collection bag the bladder level but should the floor. She stated if it chair correctly it would not said the NA was responsible catheter privacy bag so it did	F	690	ensure it doesn't touch the ground. Director of Nursing, Assistant Director of Nursing and/or Staff development coordinator will complete 100% re-education to all current nursing staff include full time, part time and as need nursing staffs. This education will provi an emphasis on ensuring any resident with a Foley Catheter has a privacy bar place below the bladder and secured above the ground. This education will be completed by 07/10/2018, any nursing staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to new hir process for all new nursing employees effective 07/10/2018 and will be provide annually. MONITORING PROCESS Effective 07/10/2018, the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator observe all current resident with cathet ensure the catheter bags are placed below the bladder and secured above the floor/ground for each resident with a Focatheter. Any issues identified during the monitoring process will be addressed promptly. Findings from this monitoring process will be documented on the "Focatheter Monitoring tool" and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily for two weeks, were x 2 more weeks, then monthly x 3 monor until the pattern of compliance is	, to ed de g in e e ed will ers he bley his ley e ess ekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				C 08/2018	
	ROVIDER OR SUPPLIER	IGTON		19	REET ADDRESS, CITY, STATE, ZIP CODE 095 EAST CORNELIUS HARNETT BOULEVARD 01LLINGTON, NC 27546	<u> </u>	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 690	Continued From page	80	F	690	maintained. Effective 7/10/2018, Director of Nursing Assistant Director of Nursing and/or St. Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plate on the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/2018, the center Execution Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance date 7/10/2018	aff ne for on I d. lan ve		
F 692 SS=D	CFR(s): 483.25(g)(1)- §483.25(g) Assisted r (Includes naso-gastric both percutaneous er percutaneous endosc enteral fluids). Based comprehensive asses ensure that a residen §483.25(g)(1) Maintal	autrition and hydration. and gastrostomy tubes, doscopic gastrostomy and opic jejunostomy, and on a resident's sment, the facility must	F	692			7/10/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345213	B. WING _			06/	08/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADI	DRESS, CITY, STATE, ZIP CODE	1 00/	30,2010		
				1995 EAST	CORNELIUS HARNETT BOULEVARD				
UNIVERSA	AL HEALTH CARE LILLII	NGTON			ON, 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 APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 692	Continued From page	e 81	F 6	92					
	balance, unless the re	t range and electrolyte esident's clinical condition s is not possible or resident otherwise;							
	§483.25(g)(2) Is offer maintain proper hydra	ed sufficient fluid intake to ation and health;							
	there is a nutritional p provider orders a the This REQUIREMENT	ed a therapeutic diet when problem and the health care rapeutic diet.							
	by: Based on record review, staff interview, observation, the facility failed to provide a therapeutic diet consistent with renal diet restrictions for 1 of 1 resident who was prescribed a renal diet (Resident #90). Findings included:			Directo Regist Execu to ider	T CAUSE or of Nursing, Dietary Manager, tered Dietitian, and the facility tive Director discussed on 6/08/20 tify the root cause of this alleged mpliance. Root cause analysis				
	diagnoses, in part, indialysis and hyperten #90's medical record to receive a renal reg phosphorus, potassiu included dialysis on T	ent #90 was admitted on 5/8/18. His oses, in part, included end stage renal is and hypertension. Review of Resident medical record revealed he had a diet order eive a renal regular diet. A renal diet limits phorus, potassium and sodium. His orders ed dialysis on Tuesday, Thursday and day. He was ordered calcium acetate with		condu nonco trainin the res therap restric	mpliance resulted from inadequage/ mpliance resulted from inadequage/ g/understanding of dietary staff, sult the facility failed to provide a eutic diet consistent with renal d tions for resident #90, who is ibed a renal diet.	as			
	helps prevent people retaining too much ph	ate is a medication that with kidney disease from nosphate, which could cause and calcium deposits in		that th the tra reside items	oot cause analysis also conclude e lack of effective communicationy-line caused the error for a not therapeutic diet to be served withat resident #90 should have not based on physician order.	n in vith			
	5/15/18 using the Mir diagnoses included e diabetes mellitus. He therapeutic diet and o	nd stage renal disease and was determined to need a lialysis treatments. He had		Reside	DIATE ACTION ent #90 was assessed by the				
no long or short term memory problems.			Directo	or of Nursing on 6/8/2018 to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDIN	NG	
		245242	B. WING		C
		345213	B. WING _		06/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
UNIVERS	AL HEALTH CARE LIL	LINGTON		1995 EAST CORNELIUS HARNETT	BOULEVARD
ONIVERO	AL IILALIII OAKE LIL	LINGTON		LILLINGTON, NC 27546	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION DATE
F 692	Continued From no	999		200	
F 092	Continued From pa	ige 62	F 6	692	
	D : 1 1 1/100	1717		determine if resident had	* '
		care planned (date of care		resulted from receiving ite	
	' '	al decline and weight and fluid		trays on 6/6/2018 and 6/7	
		end stage renal disease and		not compatible with the or	
	receiving hemodialy	ysis.		therapeutic diet. Resident	
	Poviou of the facilit	ty's menu for 6/6/18, revealed		signs or symptoms of any Resident #90's attending	
		g a renal diet was to receive		notified that resident #90	
		e or noodles, green beans,		items on the meal tray for	
		ne, white cake, fruit punch,		breakfast on 6/6/2018 and	
	_	. According to the USDA Food		consecutively that were n	
		pases ½ cup of rice contains 28		with resident's ordered th	
	· ·	ootassium and ½ cup of green		No new orders were rece	•
	beans does not cor			notification took place on	
				IDENTIFICATION OF OT	
	On 6/6/18 at 4:43 F	PM, Resident #90 received his		All residents on therapeut	tic diet have the
	supper meal which	consisted of; baked chicken,		potential to be affected by	y this alleged
	cubed potatoes, su	ccotash (corn and lima		deficient practice.	
		margarine, white cake, tea			
		ets. According to the USDA		On 6/27/2018 & 6/28/201	·
		Databases ½ cup of potatoes		Managers, Completed fac	
		potassium and ½ cup of		residents with therapeution	
		112 mg of phosphorus. The		that diets ordered matche	
	•	n the resident's meal tray		system 5 other residents	
	specified he was or	n a renai diet.		diet orders not matching t	
	0= 0/07/40 =+ 0:00	AM Decident #00 received		Dietary Manager correcte	
		AM, Resident #90 received which consisted of; cranberry		diet orders in the tray car	-
				7/2/2018. Findings of this	
		white toast, grits, sweetener, packet, creamer and jelly.		documented on the "Dieta Report" and maintained in	
		SDA Food Composition		compliance binder.	i tile lacility
		cket of salt contains 290 mg of		Compliance billuer.	
	sodium.	oner of sair contains 200 mg of		On 6/27/2017 dietary mar	nager observed
	Godium.			the tray card process duri	<u> </u>
	Interview on 6/8/18	at 9:01 AM, with cook #1		meal to identify if any other	
		on renal diets should not be		therapeutic diet received	
	served salt packets			not compatible with their	
				physician ordered diet. N	· · · · · · · · · · · · · · · · · · ·
	A telephone intervie	ew with the registered dietitian		was identified as receivin	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				C 08/2018	
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		199	REET ADDRESS, CITY, STATE, ZIP CODE 95 EAST CORNELIUS HARNETT BOULEVARD LLINGTON, NC 27546	1 00/	00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 692	on 6/8/18 from 11:40 would have expected potatoes. She did no instead for green beat Interview with the Directive of the between 02:09 - 2:21	AM- 12:02 PM revealed she rice to be served instead of t comment on succotash	F		tray not compatible with the ordered diese SYSTEMATIC CHANGES Effective 7/10/2018 the facility will prove the physician and will not include items not compatible with each resident's diet. The will be accomplished through systemic modification of dietary meal preparation on tray line. This modification will include changes from the point of calling a diet order, plating food and receiving the tray at the end of the line as outlined below. Effective 7/10/2018 the tray line will consist of the minimum of three dietary employees. The first employee will be responsible to call the diet order from a tray card. This employee will read the needed information from both individual resident's tray card and from the menu spreadsheet. Information such as; diet texture, therapeutic restriction, food allergies, resident dislikes, and/or items not allowed on the try based on the therapeutic restriction will be verbally reand mentioned by the first dietary employee at the beginning of the tray lift The second dietary employee will be responsible to plate the food based on information read by the first employee. The third employee will be responsible receive and verify the accuracy of the tray based on information read by the first employee. The third employee will be responsible receive and verify the accuracy of the tray based on information on the tray card. Effective 7/10/2018, dietary Manager we complete 100% audit pf all residents in the facility once every month by comparing physician orders and each	ed his his de ay to ray		

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		345213	B. WING		C 06/08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		
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F 692	Continued From page	e 84	F 69	resident's diet on tray card to ensure in discrepancies are noted on the diet. A identified discrepancy will be corrected promptly by the Dietary manager. Employed 100% education of all curred dietary staff, to include full time, part tiand as needed nursing staff, will be completed by Dietary Managers and/or Registered Dietitian. This education will be completed by 06/29/2018, any staff not educated by 06/29/2018 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 06/29/2018 and with be provided annually. Dietary Manager and/or Registered Dietician will complete 100% re-educated all current dietary staff, to include fut time, part time and as needed dietary staffs. This education will focus on the new tray line process to include the thremployees on the line duties and responsibilities and will also provide all emphasis on ensuring any resident witherapeutic diet receive accurate meal items on the tray card comparable with resident's diet orders. The education also focus on common items not including each commonly ordered therapeutic diets in the facility. This education will be completed by 07/10/2018, any dietary staff not educated by 07/10/2018 will not be allowed to word until educated. This education will also added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the new hire process for all not be added to the	nt me r ill This o vill tion Il the a n will ded c ated ork b be	

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F 692	Continued From page	e 85	F	592	dietary employees effective 07/10/2018 and will be provided annually. MONITORING PROCESS Effective 07/10/2018, the Dietary Managers and Registered Dietitian will complete audit of one meal a day to assure dietary staff preparing, serving, and/or calling tray line, to ensure all tra match the diet requested per tray ticket Findings from this monitoring process vibe documented on "Tray/Dietary Monitoring Tool" maintained in the facilic compliance binder. This monitoring process will take place daily for two weeks, weekly for two more weeks, the monthly for three months or until the pattern of compliance is maintained. Effective 7/10/2018, Dietary Manager and/or Executive director will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plate to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/2018, the center Executive Director, Dietary Manager and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility	ys t. will ity en for on I d. lan	

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F 692	Continued From page	e 86	F (692	remains in substantial compliance.		
F 698 SS=D	Dialysis CFR(s): 483.25(l)		F (F 698		7/	7/10/18
	require dialysis receive with professional star comprehensive personal star comprehens	ew, staff interview, dialysis servation, the facility failed to dialysis at the scheduled int who received in the facility failed in the facility failed in the facility failed in the facility failed in dialysis center and a long facility in services, schizophrenia, heart fail and movement fail orders included dialysis and Saturday.			F698: ROOT CAUSE Director of Nursing, Medical Records Director, Transportation Aide, and the facility Executive Director discussed on 6/07/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the allege noncompliance resulted from a good fa attempt by the facility staff to accommodate a second resident who h a scheduled appointment outside facilit transportation limitation zone, without considering the negative outcome of st to resident #90 who had a regularly scheduled dialysis. IMMEDIATE ACTION Resident #90 was reassess by the Director of Nursing on 6/8/2018 to iden any signs or symptoms of any distress caused by the extended period of time spent at the Dialysis center. Resident shown no signs or symptoms of any distress.	ed hith nad ties uch	

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F 698	Continued From page 87 period.		F 698				
	hemodialysis and alto decreased mobility. Resident #90 was int	re planned on 5/15/18 for eration in comfort related to		IDENTIFICATION OF OTHERS On 6/29/2018 Medical Records, Double of Nursing, Transported, and Executive Director completed 100% audit of residents transported to outside appointment to for the last 2 monting of the last 2 m	cutive all ths to		
	PM. He said he went to dialysis via ambulance. He said he went on Mondays, Wednesdays and Fridays at 4:00 PM. These statements could not be corroborated with the physician's orders or scheduling book. He said he had no concerns with dialysis treatments and had not missed any treatments.			identify any other resident who was transported to their appointment of than plan (target 30 minutes or more than plan (target 30 minutes or more the appointment time with the proper reason). No other resident identified as being sent to the appointment 30 minutes or earlier the appointment time. Findings of	earlier ore out before		
	station indicated Res appointments were o	ok located at the nurse's ident #90's dialysis n Tuesday, Thursday and portation was planned for		audit is documented on the "trans audit tool" maintained in the facilit compliance binder.	portation		
A nurse's note dated 6/6/18 indicated the center faxed a note indicating Resident #9 complained about left groin pain and he re examination. On 6/07/18 at 09:30 AM Nurse #2 said Reference #90 went to dialysis at 9:20 AM.		ndicating Resident #90 t groin pain and he refused AM Nurse #2 said Resident		SYSTEMATIC CHANGES Effective 07/10/2018, the facility wensure a proper transport for residuallysis at the scheduled time, reswill be scheduled to arrive at the appointment location no more that minutes before the appointment uspecified otherwise.	dent to sidents n 30		
	clinic on 6/07/18 at 1 #90's scheduled time he usually completed. He said he arrived at dialysis nurse stated lobby and explained treatment today. He off lots of reasons for	lysis nurse at the dialysis 1:56 AM revealed Resident was at 12:30 PM. He said the treatment at 4:30 PM. 10:00 AM today. The Resident #90 was in the Resident #90 refused said Resident #90 rambled his refusal to get into the dialysis nurse said he was		Effective 07/10/2018; to accommon other residents with the outside the medical appointment scheduled a same time or close by together, the will schedule transportation with a contracted non-emergency transportation to the appointment earlier minutes before the scheduled appointment.	ne facility It the The facility The facility The portation The facility The facilit		

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F 698	Continued From page	e 88	F 69	8		
		reported the refusal to the				
		aid it was the first time he		Effective 07/10/2018 Medical Record		
	_	llyzed. He had confusion.		Transportation Aide will maintain a da		
	He said the dialysis of			log of all residents appointments to	,	
		d would reschedule the		include dialysis residents.		
	appointment.			Medical Records Director and		
				Transportation aide and the Director	of	
		edical Records Manager on		Nursing will receive education on pro	per	
		evealed she was responsible		planning and scheduling for dialysis		
		ortation. She said Resident		residents and other medical appointn		
		or dialysis at noon. She said		to ensure residents will arrive to their	1	
		left the nursing home		appointment within 30 minutes of the		
	around 11:00 - 11:30 AM. The Medical Records			scheduled appointment unless specif	iea	
		ansportation Aide called her lled the Transportation Aide		otherwise. This education will be conducted by the facility Executive		
		00 refused to get in the chair.		Director and will be completed by		
	and said resident #3	o relased to get in the oriali.		07/10/2018, any staff not educated by	y	
	Telephone interview	with the Transportation Aide		07/10/2018 will not be allowed to wor	·k	
	on 6/7/18 at 12:19 PM	M revealed the reason why		until educated. This education was a	so	
	-	lanned was because she did		added to new hire process for all new	<i>i</i>	
		00 to be late for dialysis. She		Medical record staff, transportation		
		eeded to transport another		employees and/or Director of Nursing		
		urgery appointment out of		effective 07/10/2018 and will be prov	ided	
		ticipated. The Medical		annually.		
	_	ded, "We did our best to				
		missed dialysis today, they		MONITORING PROCESS		
	will try to schedule hi	ill tolliollow.		Effective 07/10/2018, the Director of		
	Interview with Nurse	#2 on 6/7/18 at 12:21 PM		Nursing and Executive Director will		
		00 did not want to go to		complete the transportation audits for	r all	
		o coach him. He said the		residents with scheduled appointmen		
		nt to go was because he		ensure planning and schedules for ea		
	thought he went yest	_		resident with a medical appointment		
	-	-		assures each resident arrived at the		
	On 6/7/18 at 4:38 PM	1, Resident #90 was		appointment no earlier than 30 minut	es	
		led back into the nursing		before the appointment time. Any ne	gative	
	home. Approximately	y seven hours had elapsed		findings identified during this monitor	ing	
	since he left at 9:20 A	AM.		process will be addressed promptly.		
				Findings from this monitoring process	s will	

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F 698	Continued From page	e 89	F 6	98		
	confirmed Resident # 6/7/18. He arrived at 10:00 AM. They left to surgery and she whis dialysis treatment nursing home at 4:36 On 6/8/18 at 8:10 AM Manager said Reside his dialysis appointment he would be taken at Interview with the Direction of acceptable to sendialysis. He said he would be taken at the said he would said to sendialysis.	the Medical Records nt #90 was rescheduled for ent today at noon and that around 11:00 AM. ector of Nurses on 06/08/18 d 2:21 PM revealed it was d Resident #90 too early for was aware of the issue grievance from dialysis		be documented on the "Tr audit tool" and filed in the compliance binder after pris done. This monitoring p place daily for two weeks more weeks, then monthly until the pattern of compliant maintained. Effective 07/10/2018, Director with of this monitoring process Quality Assurance and Pele Improvement Committee additional monitoring or monthis plan monthly for three the pattern of compliance. The QAPI committee can to ensure the facility remains substantial compliance.	facility roper follow usercess will take, weekly x 2 y x 3 months ance is ector of Nursing II report finding to the facility erformance for any modification of a months, or userce modify this p	ng, ngs until
F 745 SS=D	CFR(s): 483.40(d) §483.40(d) The facilit medically-related soc	y Related Social Service y must provide ial services to attain or practicable physical, mental	F 7	RESPONSIBLE PARTY Effective 06/29/2018, the Director and the Director of be ultimately responsible implementation of this plate for this alleged noncomplitate facility remains in subscompliance. Compliance date 7/10/20	of Nursing wil to ensure n of correctio ance to ensu stantial	n

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F 745	Continued From page	∍ 90	F 7	45			
	This REQUIREMENT by:	Il-being of each resident. is not met as evidenced		DOOT CALLET			
		ns, record review and staff failed to send a resident for		ROOT CAUSE			
	_	c evaluation for 1 of 1		Director of Nursing, Social V	Norker and		
		psychiatric evaluations		the facility Executive Director			
	(Resident #64).	p-,		on 6/08/18 to identify the roo			
	,			this alleged noncompliance.			
	Findings included:			analysis conducted revealed noncompliance resulted from			
	Review of the medica	al record of Resident #64		communication failure between			
		admitted to the facility on		staff who receive orders for	psychiatric		
	06/17/2017 (initial ad			services to the facility Socia			
		uded Diabetes Mellitus,		schedule the psychiatric ser			
		renia, and Mood Disorder.		site or off site, as the result failed to arrange services fo	r resident #64		
		nt's annual Minimum Data		as ordered by physician in o			
		08/2018 indicated she had		on 4/11/2018. Other factors	•		
	no cognitive impairme			this alleged noncompliance having reliable contracted p	sychiatric		
	Review of the resider	· · · · · · · · · · · · · · · · · · ·		services to provide services	on site for our		
		the resident received		residents.			
		ions for Schizophrenia, uct Disorder. Listed as part					
	•	'Notify MD (Medical Doctor)		IMMEDIATE ACTION			
		psyche (psychiatric) services		Resident #64 attending phys	sician was		
		v up with recommendations		notified of the attempts by the			
	as ordered".	v up with recommendations		send a resident fr outside ps	-		
				appointment. The earliest av	-		
	Review of the resider	nt's medical record indicated		appointment will be in Augus			
		medications which included		Attending physician for resid			
		ions since 01/01/2018. The		approved for resident's psyc			
	resident's prescribed	antipsychotic mediation was		appointment to be schedule	d on the next		
		milligrams intramuscular		available appointment. Resi			
		ks for psychotic behavior		signs or symptoms of any di	stress.		
		n 02/28/2018. The resident					
	refused the medication			IDENTIFICATION OF OTHE			
	03/23/2018, 04/06/20	118, took the medicine on		100% audit of all current res	idents in the		

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F 745	Continued From page	e 91	F 7	45			
F 745	04/20/2018, took the refused it on 05/18/2 on 06/01/2018. The rumerous refusals of well as routine insulir through 06/05/2018. Review of a nursing po4/11/2018 at 9:08 A Director of Nursing (Inoted to routinely refusant had recent be outbursts. Medical Dwe send resident out evaluation due to refusant and assist as Review of the record psychiatric evaluation psychiatric evaluation psychiatric evaluation outse on 11/08/2017 The Corporate Clinical interviewed on 06/08 stated the facility conservices ended but woccurred. He also stated they had not visual interview with the state of the services with the state of the services with the se	medication on 05/04/2018, 2018 and took the medication ecord also indicated if finger stick blood sugars as a refusals from 01/01/2018 progress note dated M and written by the facility DON) indicated "Resident use medications. Resident ehavior incidents or proctor notified and suggested for psyche (psychiatric) usal of Risperdal eation). Will continue to a indicated." revealed no orders for a and no documentation of a notice visit related to the note of ord also indicated the mented psychiatric visit was in a continue of the date this eated the facility had a new miatric service, but at this sited the facility DON on	F 7	facility completed by the facility Worker, MDS nurse and Direct Nursing on 6/28/2018 to identified with resident with orders for psychiatry services that were not carried other resident identified with porders written in the last 30 dapsychiatry service that remain outstanding. 100% audit of all current residentified by the facility worker, MDS nurse and Direct Nursing on 6/28/2018 to identified the resident who may benefit from services. Attending physician of the resident who may benefit services and refer appropriate SYSTEMATIC CHANGES Effective 07/10/2018, License receive an order for psychiatry will document the order in the electronic health record softw the facility under the "physicial Section of the software. Effective 07/10/2018, Facility worker and/or Medical Record will receive notification of the by accessing the licensed elehealth record software used to daily (Monday through Friday)	ctor of tify any other niatry I out. No ohysician ays for ns dents in the ty Social ctor of tify any other n psychiatric was notified efit from rals given as ed nurse who y services e licensed are used by an order" social ds Manager new orders ectronic by the facility) and obtain		
	contacted the Medica 04/11/2018, and the I resident out for a psy	M, the DON stated he al Director (MD) on MD ordered to send the rche evaluation. The DON tice was to write a telephone		the orders written by licensed previous week day and arrang the services as appropriate at based on the physician order.	ge/schedule nd timely		

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F 745	Continued From page order and communications worker (SW) who the The DON looked throrecord and stated he order, and he may no reiterated he should he in an interview with the (SW) on 06/08/2018 all psychiatric referral point, she interviewed made the appropriate stated she received in related to the 04/11/2. In an interview with the (MD) on 06/08/2018, gave an order for a reevaluation, he expect the order. He also stated harm as a result of no evaluation. Resident #64 was obstimes during the 5 day interviewed about variher refusal of medications and said could not recall the lapsychiatric services.	the this to the facility Social in made the appointments. The sught the resident's clinical could not find the telephone in the third that also have done it but also have done it but also have done this. The facility Social Worker is 2:30 PM, the SW stated is came to her, and at that if the referred resident and appointment. The SW also is or eferrals for Resident #64 in the phone referral. The facility Medical Director is the MD stated when he is ferral for a psychiatric for the facility to carry out fated the resident suffered no out receiving the psychiatric is served every day at random and investigation. She was incusted the facility to carry out for the facility in the psychiatric is served every day at random and investigation. She was incusted the facility in the psychiatric in the facility in the psychiatric is served every day at random and investigation. She was incusted the facility in the psychiatric in the facility in t	F 7	445		up nee18. of nd on iny nic al n ee ed e n nic will		
	medications.				Social workers, Medical Records Mana and Director of nurses effective 07/10/2018 and will be provided annual			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(XX	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVI CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 745	Continued From pag	e 93	F7	MONITORING PROCE Effective 07/10/2018, S Director of Nursing, As Nursing and/or Staff D Coordinator will monitor arranging/coordinating services as ordered by reviewing physician or documentation from pr ensure any psychiatric documented appropria electronic health record the facility and followed appropriately by the facility and followed appropriately by the facility and followed appropriately by the facility in the facility of the facility of the facility in the facility of the facility of the facility completed through Friday. Any negative findings in monitoring process will be documented for the facility compliance of the facility of the	Social Worker, seistant Director of revelopment or compliance with a psychiatrist or physician by ders, and clinical revious day to referrals are ately in the licensed d software used by d through cility Social worker as Manager. This d daily Monday didentified during this libe addressed on the audit tool" and filed on the audit tool" and filed on the audit tool and filed on the facility and areport findings of s to the facility and areport findings of s to the facility and are for any	5		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345213	B. WING		· · · · · · · · · · · · · · · · · · ·	06/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLI	NGTON			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 PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 745 F 761 SS=D	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the capplicable. §483.45(h) Storage of §483.45(h)(1) In accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accessed \$483.45(h)(2) The faci locked, permanently a storage of controlled	d Biologicals (1)(2) of Drugs and Biologicals s used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when of Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized		745	this plan monthly for three months, or use the pattern of compliance is maintained. The QAPI committee can modify this plate on the facility remains in substantial compliance. Effective 07/10/2018, the center Execur Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance date 7/10/2018.	I. an tive I	7/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING			1	08/2018
NAME OF P	ROVIDER OR SUPPLIER	0.02.0		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 06/	00/2010
TO WILL OF TH	NOVIBER OR OUT FEER				95 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILL	NGTON	LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From pag	e 95	F	761			
F 761	Control Act of 1976 a abuse, except when package drug distrib quantity stored is min be readily detected. This REQUIREMEN' by: Based on observation record review the face expired medication for refrigerators observed. A review of the undanged medication Storage in "When the original some container or vial is in or vial will be dated in expiration date. 1) To opened' sticker on the date opened and the policy also included, be removed from act the facility, regardless. On 6/7/18 at 9:04 AND Prep Room was revisible to the Magic Mouthwash we expiration date of 6/8 adhesive label on the handwritten expiration.	and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can T is not met as evidenced ons, staff interviews and cility failed to remove an rom 1 of 2 medication and for medication storage. Ited facility policy titled, nother facility included, and of a manufacturer's itially broken, the container of the product has a shortened the nurse shall place a 'date are medication and enter the enterned medication and estroyed in the soft amount remaining." If the 500 hall Medication dewed for medication storage, are was an opened bottle of the amount and enterned the manufacturer's form of the bottle with a soft date of 5/30/18.	F?	761	F761 ROOT CAUSE This alleged noncompliance resulted for the facility failure to have a system of ensuring expired medication are remove from circulation from both medication rooms and medication carts, before the date of expiration. IMMEDIATE ACTION TAKEN No Residents were named in this alleganoncompliance. On 6/7/2018 nurse #5 removed and discarded the identified Magic Mouth Wash identified from 500 hall medication prep room. An identified opened bottle Magic Mouthwash with a manufacturer expiration date of 6/5/2018 and hand written expiration date of 5/30/2018, in 500 hall medication prep room were discarded by the Licensed nurse #5 on 6/7/2018.	ed on of	
	#5 stated she had do Medication Prep roo were no expired med	on 6/7/18 at 11:58 AM, Nurse one an audit in that m on 6/5/18 to be sure there dications. Nurse #5 stated the gic Mouthwash was not in the			IDENTIFICATION OF OTHERS All residents who receives medication have the potential to be affected by this alleged non- compliance.	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			1	08/ 2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010	
				19	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLIN	IGTON		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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 761	Continued From page 96		F	761				
F 761	refrigerator when she it might have been in on the hall at the time Medication room. On 6/7/18 at 4:39 PM (DON) stated there she medication in the Medication rooms. The #5 was responsible for rooms and the bottle	did the audit. She indicated the possession of a nurse she was reviewing the the Director of Nursing mould be no expired dication carts or the le DON specified that Nurse or checking the medication		761	On 06/08/18, the Director of Nursing, Assistant Director of Nursing, Nurse Supervisor checked all medication storage rooms and medication carts to ensure expired medication observed in the medication rooms and/or medication carts. SYSTEMIC CHANGES Effective 7/10/2018 an incoming nurse review the medication cart to ensure all open medication bottles for Magic mouwash are dated when opened, and not expired at the beginning of the shift. The process will incorporate all other medications will short term expiration dates to ensure no expired medication stored in the carts. Effective 7/10/2018; licensed nurses or Medication aides on duty during the nighing form of the carts. Effective 7/10/2018; licensed nurses or Medication refrigerators to ensure any medication prep room to include medication refrigerators to ensure any medication with expiration date falling of the next three days of the inspection is removed from circulation to prevent expired medication being circulated. Director of Nursing, Assistant Director of Nursing and/or Staff development coordinator will complete 100% re-education to all current licensed nursing Medication aides, to include full timpart time and as needed nursing staffs. This education will include the process checking expiration dates of medication.	will I I I I I I I I I I I I I I I I I I		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 06/08/2018
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	·	010012010
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From pag	e 97	F 76	the medication carts at the beging the shift and the responsibilities overnight employees to inspect medication prep rooms and merefrigerators for any expired methose with expiration within three This education will be complete 07/10/2018, any licensed nurse Medication Aide not educated be 07/10/2018 will not be allowed to until educated. This education wadded to new hire process for a licensed nurses and Medication effective 07/10/2018 and will be annually. MONITORING PROCESS Effective 07/10/2018; The Direct Nursing, Assistant Director of Nand/or Nursing Supervisor will be responsible for checking medication and medication rooms to identified expired medication or medication expiration within 72 hours of obtained ensure that medication with expiration are dated, when operating process will be address or medication Storage audit tool at the facility compliance binder affollow up is done. This monitoring will take place daily (Monday the Friday) for two weeks, weekly xweeks, then monthly x 3 months.	dication or edication or editor of edit	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				08/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVAN LILLINGTON, NC 27546			06/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Qualified Dietary Staf CFR(s): 483.60(a)(1)(§483.60(a) Staffing	f		761	the pattern of compliance is maintained. Effective 07/10/2018, Director of Nursir and/or Assistant Director of nursing will report findings of this monitoring procest to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly for three months, of until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 07/10/2018, the center Execut Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance date 7/10/2018.	ng, I ss for on or tive I	7/10/18
	The facility must emp appropriate competer out the functions of th taking into considerat individual plans of car						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345213	B. WING			C 06/08/2018		
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOUI 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) COMPLETION DATE		
F 801	full-time, part-time, or qualified dietitian or contrition professional (i) Holds a bachelor's a regionally accredite United States (or an existed with completion of the aprogram in nutrition an appropriate nation recognized for this puting (ii) Has completed at supervised dietetics pure supervision of a register professional. (iii) Is licensed or certain nutrition professional services are performed provide for licensure will be deemed to have or she is recognized the Commission on Exaccessor organization requirements of paracteristic section. (iv) For dietitians hire November 28, 2016, no later than 5 years as required by state I \$483.60(a)(2) If a qualified nut employed full-time, the person to serve as the nutrition services who (i) For designations in the person to serve as the nutrition services who (ii) For designations in the person to serve as the nutrition services who (iii) For designations in the person to serve as the nutrition services who (iiii) For designations in the person to serve as the nutrition services who (iiiii) For designations in the person to serve as the nutrition services who (iiiiii) For designations in the person to serve as the nutrition services who (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	fied dietitian or other rition professional either on a consultant basis. A other clinically qualified is one who- or higher degree granted by ad college or university in the equivalent foreign degree) a cademic requirements of or dietetics accredited by all accreditation organization arpose. Least 900 hours of oractice under the other dietetian or nutrition or by the State in which the ed. In a State that does not or certification, the individual or met this requirement if he as a "registered dietitian" by dietetic Registration or its on, or meets the graphs (a)(1)(i) and (ii) of dor contracted with prior to meets these requirements after November 28, 2016 or aw. Calified dietitian or other rition professional is not the facility must designate a de director of food and	F 8	01				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345213	B. WING _		,	C 06/08/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	70/00/2010		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOU LILLINGTON, NC 27546	LEVARD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 801	year after November after November 28, 2 (A) A certified dietary (B) A certified food set (C) Has similar nation service management certifying body; or D) Has an associate' service management course study includes management, from a higher learning; and (ii) In States that hav food service manage meets State requiren managers or dietary (iii) Receives frequent from a qualified dietit qualified nutrition proof This REQUIREMENT by: Based on observation Registered Dietitian, Administrator, the fact dietitian on a full-time employed dietary ma complete the certified requirements. Finding The Dietary Manager	r 28, 2016, or no later than 1 28, 2016 for designations 2016, is: manager; or ervice manager; or hal certification for food and safety from a national s or higher degree in food or in hospitality, if the s food service or restaurant an accredited institution of the established standards for rs or dietary managers, hents for food service managers, and titly scheduled consultations tian or other clinically fessional. It is not met as evidenced an and interview with the Dietary Manager and cility failed to employ a the basis while the newly mager was working to didetary manager ags included: The was met on 06/07/18 at	F 8	F801 ROOT CAUSE The facility executive director Clinical officer met on 6/8/201 the root cause of this alleged noncompliance. The root caus concluded that this alleged noncompliance was resulted f Center's Executive Director	8 to discuss se analysis from the			
	badge was observed Manager. The DM sa 5/8/18. He said, "I an July". He said he wo	the Dietary Manager's (DM) to be Certified Dietary aid he was employed on m going to be certified in uld take the exam at that gistered Dietitian (RD) was		Misinterpretation of the revised requirements related to qualification requirements for food services that was in effective November The root cause analysis concludered though the Dietary Managemployed by the center's Exercise Director on 5/8/2018 has the account of the revised requirements.	cation s Director r 28, 2017. uded that ager cutive			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING				C 08/2018
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVA LILLINGTON, NC 27546			00/2010
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F 801	AM and 12:02 PM. S consulting at this nurs six years. She said s She said she needed the new building and nursing home tried to manager (CDM). The the interdisciplinary c confirmed awareness manager was not cer there was an allowan. An interview with the conducted on 6/8/18 administrator said the the facility. He said s	wed on 6/8/18 between 11:40 the said she had been sing home for approximately he comes one time a week. more help keeping up with that is part of the reason the get a certified dietary e CDM would participate on are plan team. She that the current dietary tified. She said she thought ce of time to get certified. administrator was from 2:47 - 3:10 PM. The e RD did not work full-time at she works about 8 hours per ed the dietary manager and	F	801	competencies and skills sets to carry of the functions of the food and nutrition services, however he does not have professional qualification required per regulatory requirements. The Executive Director stated that he understood that since the facility was employing mentioned Dietary Manager the second Manager to lead the dietary department, he considered that the first designated manager who has worked if the facility for six years as dietary manager, (who was reassigned as the food service Director to manage the department as the second the manage head cook), would have still counted as qualified personnel per regulation. Chie Clinical Officer from the Consulting and Management Company contracted by the facility re-educated the Center Executive director and the Facility Human Resources Director on 7/2/2018 on the regulatory requirements related to qualified nutrition professional. IMMEDIATE ACTION On 7/3/2018, the center Executive Director change the Dietary Manager's duties. The second Dietary Manager #1 who was in charge of the dietary department for six years before 5/8/20 will oversee all dietary food services effective 7/3/2018. IDENTIFICATION OF OTHERS 100% of all current employees in the facility who hold any position that requiprofessional qualification per regulation audited by the facility Human Resource Director and/or facility Executive Director ensure each employee possess	as / t n r & a ef I the /e	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	COMPLETED	
		345213	B. WING		C 06/08/2018
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVAR LILLINGTON, NC 27546	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 801	Continued From page	e 102	F 80	required qualification per regulatory requirements. No other employee identified without appropriate qualif This audit was completed on 7/2/20 and 7/3/2018. Findings of this audit documented in the employees' qualification audit tool maintained in facility compliance binder SYSTEMIC CHANGES Effective 7/10/2018, the facility will employ individuals with proper qualification as required by regulati provide services in the facility. On 7/3/2018, Chief Clinical officer developed a spreadsheet with all professional positions at the facility required qualification as required by regulation. The spreadsheet is provide facility Human Resources and Executive Director. Effective 7/10/2018, the facility will the developed spreadsheet with all professional positions at the facility reference guide before offering employment to any potential new hensure that the required qualification regulation are met. Chief Clinical Officer from the Consand Management Company contrathe facility re-educated the Center Executive director and the Facility Resources Director on 7/3/2018 on necessary steps to be taken to vericandidate professional qualification offering employment. This education also be added to the new hire proceany new Executive Director and/or	rication. D18 t is n the only on to with y yided to Facility utilize as the ire to on per sulting cted by Human fy each n before on will ess for

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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		345213	B. WING			06/	08/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLIN	IGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
				L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 801	CFR(s): 483.60(a)(3)(§483.60(a) Staffing The facility must emp appropriate competer out the functions of th taking into considerat individual plans of car	oport Personnel (b) loy sufficient staff with the ncies and skills sets to carry e food and nutrition service, ion resident assessments, re and the number, acuity facility's resident population e facility assessment		801	resources Director effective 07/10/2018 and will be provided annually. MONITORING PROCESS Chief Clinical officer from the Management and Consulting company designated consultant will review all nethires qualification before hiring for the next 3 months to ensure facility only employ qualified employees per regulation. Executive Director will sign off on any rhire as an approval after verification of qualification take place, for every new for the next 6 months or until the patter of compliance is maintained. RESPONSIBLE PARTY Effective 7/10/2018, the center Executi Director, and the Director of Human Resources will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliant to ensure the facility remains in substantial compliance.	or ew nire nn ve e f	7/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	· /	(X3) DATE SURVEY COMPLETED		
		345213	B. WING _			C 06/08/2018		
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		7070072010		
				1995 EAST CORNELIUS HARNETT BOU	LEVARD			
UNIVERSA	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 CORRECTION		(X5) COMPLETION DATE		
F 802	Continued From page	e 104	F8	02				
	personnel to safely a functions of the food §483.60(b) A member Services staff must properties interdisciplinary team (2)(ii). This REQUIREMENT by: Based on observation of the kitchen's dishind dietary support person carrying out the funct staff were not propert kitchen's dishind machinal cleaned and sanitized the potential to effect received meals at the Findings included: An observation of starkitchen's dishind machine indicated the specifications listed of machine indicated the at a minimum temper Fahrenheit. Dietary A pushing racks into the tank was observed or interdisciplinary and suppose the specifications of the specifications listed of machine indicated the at a minimum temper Fahrenheit. Dietary A pushing racks into the tank was observed or interdisciplinary and suppose the specifications of the specifications listed of machine indicated the at a minimum temper Fahrenheit. Dietary A pushing racks into the tank was observed or interdisciplinary teams of the specifications of the speci	ride sufficient support and effectively carry out the and nutrition service. It of the Food and Nutrition articipate on the as required in § 483.21(b) It is not met as evidenced and, staff interview and review machine service report, the annel were not effectively ions of dishwashing. Dietary y trained on how to use the are to ensure that it properly didishes. This problem had 93 of 104 residents who are nursing home. If washing dishes in the are was initially conducted on Staff was observed using a nk hot water sanitizing dish dishes. The machine's and the front of the dish are final rinse should operate rature of 180 degrees and (DA) #1 was observed as machine. The machine's werflowing with suds. The		F802 ROOT CAUSE Director of Nursing, Dietary M Registered Dietitian, and the f Executive Director discussed to identify the root cause of the noncompliance. Root cause a conducted revealed, the allegenoncompliance resulted from training/understanding of dieta concluding that the facility failed dietary support personnel train necessary to effectively carry functions of the food and nutri specifically related to cleaning sanitizing dishes using a high machine. IMMEDIATE ACTION On 6/7/2018, food crumbs obsthe table where clean dishes or racks from the dish machine a ants on top of the dish machine	acility on 6/07/18 is alleged nalysis ed inadequate ary staff, ed to provide ning out the tion service, and temperature served on come out on and dead ne were			
	the machine and star	I) instructed DA #1 to drain t again. ade in the kitchen on 6/7/18		cleaned by the Dietary Manage On 6/7/2018; Dietary Manage re-educated dietary aide #1 or minimum acceptable tempera	r n the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF B	20/4252 02 0/425/452	345213	B. WING _		TDEET ADDRESS OFFI OTATE TIP CODE	06/	/08/2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSA	AL HEALTH CARE LILLI	INGTON			995 EAST CORNELIUS HARNETT BOULEVARD			
				L	ILLINGTON, NC 27546			
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F 802	Continued From pag	e 105	F 8	302				
	from 9:58 AM until 10	0:59 AM. Food crumbs were			required for a rinsing cycle.			
	observed on the tabl	e where clean dishes came						
	out on racks from the	e dish machine. Dead ants			On 6/7/2018 Maintenance director			
	'	sh machine tank. The dish			educated the Dietary Manager, the coo	ρk,		
		isplayed P1 and a wrench			Dietary aide #3 of the meaning of a			
		he P1 meant phase 1. The			wrench sign and P1 after being advise			
		ne first time she had ever			by the service company of the meaning	j		
	seen the wrench on			On 6/7/2018: Dieton, Manager				
		not familiar with that. f washing several racks of			On 6/7/2018; Dietary Manager discontinued the use of the dish machi	no		
	dishes in the dish ma	<u> </u>			once notified by the Maintenance Direct			
		temperatures viewed on the			that the dish machine was not function			
		reached temperatures of			properly, and the rinsing cycle did not	9		
		legrees Fahrenheit. Diet Aide			reach 180 degree.			
		dishes into the machine			On 6/7/2018; Dietary Manager spoke v	vith		
	even though the mad	chine's final rinse cycle was			Resident Council President and receive	ed		
	not operating at a ter	mperature of 180 degrees			approval to utilize paper products until			
		l was present during these			machine is fixed and functioning prope	rly.		
		id it was DA #1's third day of						
		first day working in the dish			On 6/07/18 Dietary Manager prepared			
		served to pull dishes out of			and utilized the 3 sink compartment for			
		hout allowing the machine's			manual wash to ensure that dishes we	re		
		nish. DA #1 removed one achine and inserted another			getting clean, rinsed and sanitized appropriately using appropriate chemic	and .		
		o observed to open the dish			sanitization chemicals.	aı		
		the machine's final rinse			Samuzation chemicals.			
	cycle temperature at				On 6/7/2018 the service company			
		aid, "It's on the right cycle			identified a burned wire that caused the	e.		
	now, because it is no				machine to dysfunction. The company			
		•			repaired the problem and the machine			
	During this observati	on on 6/7/18 from 9:58 AM			was verified to function properly with fir	nal		
	until 10:59 AM, the D	OM called the Maintenance			rinsing circle reading 184 on 6/8/2018			
	` ′	MD said he had a little						
	-	sh machine. He called the			IDENTIFICATION OF OTHERS			
		find out what the P1 and			No resident named in this alleged			
	wrench icon on the r	eadout meant.			noncompliance. Any residents who			
	0 0740 : :055	11 DAWS 5			receives meals from the facility kitchen			
		M, DA#2 confirmed the			has a potential to be affected by this			
	sanitizing temperature for the kitchen's dish	1		I SUBGED DOD- COMBUSICE		1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345213	B. WING		06	6/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
				1995 EAST CORNELIUS HARNETT BO	ULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC 27546			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETION DATE	
F 802 Continued From page		e 106	F 80	02			
	machine's final rinse	cycle should be 180 degrees					
	Fahrenheit. The tem	perature of the machine's		SYSTEMATIC CHANGES			
	final rinse cycle was	noted to only be reaching		Effective 7/10/2018, dietary s	staff will		
	160 degrees Fahrenh	neit and DA#1 continued to		check dish washing machine	temperature		
	insert and remove dis	shes from the dish machine.		for both washing and rinsing	cycle at least		
				three times daily. Findings from			
		t 10:20 AM with DA #3 who		process will be documented			
		rom the dirty dishes said she		machine temperature log ma			
	did not know what the wrench symbol displayed			the dietary department. Any i			
	on the machine's rea	d out meant.		findings to include temperatu			
	0 00/07/40 440 50			180 for the final rinsing cycle			
		AM, the Maintenance		reported to the dietary manage	-		
		ed with another maintenance		remove from being used imm			
		e dish machine. He said the		until resolved. Three compar will be utilized to clean dishe			
		not come out, but told them		will be utilized to clean dishes	s at that time.		
		He said, "P1 means call for cided to use paper products		On 7/2/2019 Dioton, manage	or revised a		
		e confirmed the decision was		On 7/2/2018 Dietary manage cleaning schedule to ensure			
		President of the Resident's		remains clean and sanitized			
	T	ded that no dish machine		This schedule incorporated c			
		ecorded by staff during the		top of the dish machine and	-		
	morning of 6/7/18.	borded by stair during the		used for food preparation. Ef			
				7/10/2018; dietary staff will u			
	The service company	s report was reviewed. The		cleaning schedule.			
	· · ·	pair was made to the dish					
	washer on 6/7/18 ard	ound 5:30 PM. The report		Effective 7/10/2018, Dish ma	chine is		
	indicated a wire was	burned. It was repaired and		added on preventative mainte	enance		
	the machine function	ed correctly when they left.		schedule to be checked once	monthly to		
				ensure proper functionality pe	er		
	On 6/8/18 at 9:21 AM	1, dishwashing was		manufacturer guidelines			
		s no wrench icon on the dish					
		Γhe final rinse temperature		Effective 07/10/2018, the fac			
	of the machine was o			a continuous education progr			
		egrees Fahrenheit. The DM		"safe food handling training"			
		ned to work with high		dietary staff that will cover all			
	•	chines, but not this specific		information required to safely			
	machine.			effectively carry out the funct			
				food and nutrition services. T			
	Interview with the Re	gistered Dietitian on 6/8/18		cover all aspects food handli	ng to include	1	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	P) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED C	
		345213	B. WING _			1	ン 08/2018	
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVAN LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE	
F 802	dishwasher was a hig needed to reach a mi temperature of 180 d sanitize the dishes ar in the machine. She	nd 12:02 PM revealed the gh temperature machine and nimum final rinse	F	disheque Any che Regulation and the edulation and the edulation and the edulation and diet and edulation and edula	n washing, kitchen sanitation, and hipment's functionalities and defects anew dietary support personnel will ecked off by the dietary manager and gistered Dietician before assuming lies in the facility. 20% education of all current dietary standed full time, part time and asseded dietary staff, will complete "Sate dhandling training" that will cover a ressary information required to safe a effectively carry out the functions of food and nutrition services. This recation will be provided and validate the dietary manager and/or Register tician and will also cover all aspects of handling to include dish washing, then sanitation, and equipment's ectionalities and defects. It is education will be completed by 10/2018, any dietary staff not educated. This education will also led to the new hire process for all netary employees effective 07/10/2018 will be provided annually. If will be provided annually. If will be completed by 10/2018, any dietary staff not educated. This education on proper cleaning of dietary in ager will complete in-servicing in a cation on proper cleaning of dietary in ager will complete in-servicing in a cation on proper cleaning of dietary in ager will complete in the process for all not action will be completed by 10/2018, any dietary staff not educated. This education will also all ded to the new hire process for all not action will also led to the new hire process for all not ary employees effective 07/10/2018 will not be allowed to we all educated. This education will also led to the new hire process for all not ary employees effective 07/10/2018 will not be allowed to we all educated. This education will also led to the new hire process for all not ary employees effective 07/10/2018 will not be allowed to we all educated. This education will also led to the new hire process for all not ary employees effective 07/10/2018 will not be allowed to we all educated. This education will also led to the new hire process for all not ary employees effective 07/10/2018 will not be allowed to we all	be d/or taff, fe II ly of ed ork be ew 3		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 802	Continued From page	e 108	F	302	MONITORING PROCESS Effective 7/10/2018, Dietary Manager and/or Registered Dietician will evaluat randomly selected dietary staff to determine their competence level relate to food handling including operating the dish washing machine and kitchen sanitation tasks. This evaluation will be conducted via interviews and return demonstration for the randomly selected dietary staff. Findings from this monitor process will be documented on "Dietary Staff competence audit tool" maintained the facility compliance binder. This monitoring process will take place daily Monday through Friday for two weeks, weekly for two more weeks then month for three months or until the pattern of compliance is maintained. Effective 07/10/2018, the Maintenance Director will inspect the dish machine to ensure it works properly per manufacture recommendation. Findings from this monitoring process will be documented "Dish Machine Inspection tool" maintain in the facility compliance binder. This monitoring process will take place daily Monday through Friday for two weeks, weekly for two more weeks then month for three months or until the pattern of compliance is maintained. Effective 7/10/2018, The Executive Director will conduct Sanitation inspect for the main kitchen to ensure all equipment are clean, sanitized and functioning per manufacturer	ed ed ed ring y d in / nly o urer d on ned		

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	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVAR LILLINGTON, NC 27546		
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F 802	Continued From page	e 109	F 80	recommendation. Findings from this monitoring process will be documer "Kitchen sanitation Audit" maintaine the facility compliance binder. This monitoring process will take place to week for 8 weeks, then monthly for months or until the pattern of complis maintained. Effective 7/10/2018, Registered die will also complete sanitation inspectonce a week on opposite days with administrator for the main kitchen. Findings from this monitoring proce be documented on "Kitchen sanitati Audit" maintained in the facility compliance binder. This monitoring process will take place weekly for 8 weeks, then monthly for three mont until the pattern of compliance is maintained. Effective 7/10/2018, Dietary Manag and/or Executive director will reporfindings of this monitoring process the facility Quality Assurance and Performance Improvement Commit any additional monitoring or modific of this plan monthly x 3 months, or the pattern of compliance is maintain. The QAPI committee can modify this to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/2018, the center Exeroirector, Dietary Manager and the Director of Nursing will be ultimately responsible to ensure implementation.	nted on d in wice a three iance iance itician tion the ss will on hs or er to the tee for ation until ned. s plan cutive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345213	B. WING _			l	08/2018	
	ROVIDER OR SUPPLIER	NGTON		1	TREET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546	1 001	00/2010	
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F 802	Continued From page 110		F 8	802	this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.			
F 803 SS=E	' '		F 8	803			7/10/18	
	§483.60(c) Menus an Menus must-	nd nutritional adequacy.						
	1	ne nutritional needs of nee with established national						
	§483.60(c)(2) Be pre	pared in advance;						
	§483.60(c)(3) Be follo	owed;						
		ne religious, cultural and esident population, as well as						
	§483.60(c)(5) Be upd	lated periodically;						
	§483.60(c)(6) Be revi dietitian or other clinic professional for nutrit	cally qualified nutrition						
	construed to limit the personal dietary choice. This REQUIREMENT by:	Γ is not met as evidenced			ROOT CAUSE			
		d consulting registered ne facility failed to follow the			Director of Nursing, Dietary Manager, Registered Dietitian, and the facility Executive Director discussed on 6/08/1	8		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345213	B. WING			l	08/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
I INIVEDS	AL HEALTH CARE LILL	INGTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILL	INGTON		L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 803	home on 5/8/18. Remedical record reveatives a renal regular. Supper menu for 6/6 renal diet was planning or noodles, gree margarine, white calchoice. On 6/6/18 at 4:43 Phobserved to receive succotash (corn and margarine, white calcon his supper meal to receive the rice or noplanned on the facilial Interview with the corevealed she did not involved with the prefor 6/6/18. A telephone interview on 6/8/18 from 11:40 would have expected potatoes to residents supper meal on 6/6/succotash being serunterview with the Dibetween 02:09 - 2:2 expect potatoes and the renal diet.	s admitted to the nursing eview of Resident #90's aled his current diet order Review of the facility's /18 revealed, a resident on a ed to receive baked chicken,	F	803	to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from inadequa training/understanding of dietary staff, the result the facility failed to provide a therapeutic diet consistent with renal direstrictions for resident #90, and failed follow the lunch menu during a Lunch meal on 6/8/2018. The root cause analysis also concluded that the lack of effective communication the tray-line caused the error for a resident therapeutic diet to be served witems that resident #90 should have no received based on physician order. IMMEDIATE ACTION Resident #90 was assessed by the Director of Nursing on 6/8/2018 to determine if resident had any complicar resulted from receiving items on the metrays on 6/6/2018 and 6/7/2018 that we not compatible with the ordered therapeutic diet. Resident #90 shown riggns or symptoms of any complication. Resident #90 sattending physician we notified that resident #90 received food items on the meal tray for both dinner a breakfast on 6/6/2018 and 6/7/2018 consecutively that were not compatible with resident so ordered therapeutic diet. No new orders were received. The notification took place on 6/9/2018. The facility's lunch menu for 6/8/18, that	te as et to d n in vith t tion eal ere as and	
		otatoes were on the planned			revealed, parsilied potatoes on the	IL	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				08/2018	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	30/2010	
				19	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLIN	IGTON	LILLINGTON, NC 27546		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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 803	for frozen skin on dice potatoes cut into cube and parsley complete the kitchen's lunch tra mashed potatoes were parsilied potatoes. Interview with the coorevealed parsilied pot potatoes. She said, "We've always done cut A telephone interview on 6/8/18 from 11:40 would expect parsley serve the planned me	or parsilied potatoes called ed potatoes or fresh es. Margarine, salt, paprika d the recipe. Observation of my line on 6/8/18 at 10:59 AM et prepared instead of the on 6/8/18 at 10:59 AM atoes were creamed they don't like parsley. They don't like parsley. They with the registered dietitian AM- 12:02 PM revealed she on potatoes and for staff to enu. The registered dietitian of the potatoes would be	F	803	planned menus was reviewed by the dietary manager on 6/8/2018 who cond with the findings that mashed potatoes should have not be prepared instead of parsilied potatoes without Registered dietician approval. No resident named this alleged non-compliance. IDENTIFICATION OF OTHERS All residents on therapeutic diet have the potential to be affected by this alleged deficient practice. On 6/27/2018 & 6/28/2018 Dietary Managers, Completed facility audit on residents with therapeutic diets to ensure that diets ordered matches the tray card system 5 other residents identified with diet orders not matching the tray card. Dietary Manager corrected all identified diet orders in the tray card system on 7/2/2018. Findings of this audit is documented on the Dietary Roster Regard maintained in the facility compliant binder. On 6/28/2018 Dietary Managers, Completed facility audit on residents all menu for meals scheduled for two wee from 6/28/2018 to ensure the facility hall items necessary to prepare the mean per menu. Facility food storage indicate have all necessary items to follow the menu.	of to ne ure ds d d port ce		
					to ensure that diets ordered matches the tray cards system 5 other residents identified with diet orders not matching			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			1	08/2018	
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 803	Continued From page	e 113	F	803	tray card. Dietary Manager corrected a identified diet orders in the tray card system on 7/2/2018. Findings of this a is documented on the Dietary Roster Report and maintained in the facility compliance binder. On 6/27/2017 dietary manager observe the tray card process during the lunch meal to identify if any other resident wit therapeutic diet received items in the trate to compatible with their specific physician ordered diet. No other reside was identified as receiving items on the tray not compatible with the ordered diet. Systematic Changes Effective 7/10/2018 the facility will prove the physician and will not include items not compatible with each resident side. It will be accomplished through systemic modification of dietary meal preparation on tray line. This modification will include changes from the point of calling a diet order, plating food and receiving the tradit the end of the line as outlined below. Effective 7/10/2018 the tray line will consist of the minimum of three dietary employees. The first employee will be responsible to call the diet order from a tray card. This employee will read the needed information from both individual resident stray card and from the mens spreadsheet. Information such as; diet	udit ed th y ent e et. ride t This n de : ay .		

` '		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345213	B. WING		C 06/08/2018		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 803	Continued From page	e 114	F 80	texture, therapeutic restriction, food allergies, resident dislikes, and/or iter not allowed on the try based on the therapeutic restriction will be verbally and mentioned by the first dietary employee at the beginning of the tray The second dietary employee will be responsible to plate the food based o information read by the first employee The third employee will be responsibl receive and verify the accuracy of the based on information on the tray card Effective 7/10/2018, dietary Manager complete 100% audit of all residents the facility once every month by comparing physician orders and each resident sident on tray card to ensure discrepancies are noted on the diet. A identified discrepancy will be correcte promptly by the Dietary manager. Effective 7/10/2018 the facility will premeals based on posted menu and coad idetician if a menu item has to be changed to ensure the substitution contain same nutritive value. Employed 100% education of all curredietary staff, to include full time, part than as needed nursing staff, will be completed by Dietary Managers and/or Registered Dietitian. This education value provide an emphasis on proper diets. education will be completed by 06/29/2018, any staff not educated by 06/29/2018 will not be allowed to wor until educated. This education was all added to new hire process for all new	read r line. n e. e to e tray d. will in n e no Any ed epare nsult ent time or will This		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION S		(X3) DATE SURVEY COMPLETED	
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F 803	Continued From page	e 115	F 80	employees effective 06/29/2018 be provided annually. Dietary Manager and/or Register Dietician will complete 100% rectoral current dietary staff, to inclutime, part time and as needed diestaffs. This education will focus on new tray line process to include the employees on the line duties and responsibilities and will also provemphasis on ensuring any reside therapeutic diet receive accurate items on the tray card comparable resident side to orders. The education of the tray card comparable resident will be completed 07/10/2018, any dietary staff not by 07/10/2018, any dietary staff not by 07/10/2018, any dietary staff not by 07/10/2018 will not be allowed until educated. This education will added to the new hire process for dietary employees effective 07/10/2018, and will be provided annually. MONITORING PROCESS Effective 07/10/2018, the Dietary Managers and Registered Dietitic complete audit of one meal a day assure dietary staff preparing, seand/or calling tray line, to ensure match the diet requested per tray and to ensure meals prepared armatched the facility Menu. Finding this monitoring process will be documented on Tray/Dietary Mon Tool maintained in the facility con	red education ude full etary on the the three d ride an ent with a e meal le with cation will included peutic by educated d to work fill also be or all new 0/2018 an will y to erving, e all trays y ticket, nd served ngs from nitoring		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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				LI	ILLINGTON, NC 27546		
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F 812 SS=F	CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for	core/Prepare/Serve-Sanitary 2) by requirements. be food from sources ed satisfactory by federal, les. bood items obtained directly subject to applicable State		803	binder. This monitoring process will tak place daily for two weeks, weekly for two weeks, then monthly for three months or until the pattern of compliance is maintained. Effective 7/10/2018, Dietary Manager and/or Executive director will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plate to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY: Effective 7/10/2018, the center Execution Director, Dietary Manager and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	ro ce for on I d. dan	7/10/18

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	E SURVEY MPLETED
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AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546	DELVARD	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE
Continued From page	e 117	F 8	12		
facilities from using p gardens, subject to co safe growing and foo- (iii) This provision doe	roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents				
§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and the service company's record, the facility failed to clean and sanitize dishes according to manufacturer's instructions. This problem had the potential to effect 93 of 104 residents who received meals at the nursing home.					
			ROOT CAUSE Director of Nursing, Dietary M Registered Dietitian, and the Executive Director discussed to identify the root cause of the	facility on 6/07/18 nis alleged	
Findings included:			conducted revealed, the alleg	jed	
kitchen's dish machin 06/07/18 at 9:33 AM. hot water sanitizing d front of the machine i should operate at a n degrees Fahrenheit. observed pushing rad	e was initially conducted on A name brand single tank ish machine was used. The ndicated the final rinse ninimum temperature of 180 Dietary Aide (DA) #1 was eks into the machine. The		training/understanding of diet concluding that the facility fail dietary support personnel trainecessary to effectively carry functions of the food and nutrospecifically related to cleaning	ary staff, ed to provide ning out the ition service, g and	
Manager (DM) instruct machine and start ag Observations were muntil 10:59 AM. Food the table where clean from the dish machine	ain. ade on 6/7/18 from 9:58 AM I crumbs were observed on I dishes came out on racks e. Dead ants were on top of		the table where clean dishes racks from the dish machine a ants on top of the dish machine cleaned by the Dietary Manage On 6/7/2018; Dietary Manage	come out on and dead ne were ger. er	
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII SUMMARY ST. (EACH DEFICIENC REGULATORY OR I) Continued From page (ii) This provision doe facilities from using p gardens, subject to co safe growing and food (iii) This provision doe from consuming food standards for food se This REQUIREMENT by: Based on observation service company's reclean and sanitize dismanufacturer's instruthe potential to effect received meals at the Findings included: An observation of stakitchen's dish machino 06/07/18 at 9:33 AM. hot water sanitizing diffront of the machine is should operate at a machine dish machine and start ag Observations were muntil 10:59 AM. Food the table where clean from the dish machine tand the d	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 117 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and the service company's record, the facility failed to clean and sanitize dishes according to manufacturer's instructions. This problem had the potential to effect 93 of 104 residents who received meals at the nursing home.	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 117 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and the service company's record, the facility failed to clean and sanitize dishes according to manufacturer's instructions. This problem had the potential to effect 93 of 104 residents who received meals at the nursing home. Findings included: An observation of staff washing dishes in the kitchen's dish machine was initially conducted on 06/07/18 at 9:33 AM. A name brand single tank hot water sanitizing dish machine was used. The front of the machine indicated the final rinse should operate at a minimum temperature of 180 degrees Fahrenheit. Dietary Aide (DA) #1 was observed pushing racks into the machine. The tank was overflowing with suds. The Dietary Manager (DM) instructed DA #1 to drain the machine and start again. Observations were made on 6/7/18 from 9:58 AM until 10:59 AM. Food crumbs were observed on the table where clean dishes came out on racks from the dish machine. Dead ants were on top of the dish machine tank. The dish machine's	ROVIDER OR SUPPLIER 345213 ROVIDER OR SUPPLIER AL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 117 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. \$483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and the service company's record, the facility failed to clean and sanitize dishes according to manufacturer's instructions. This problem had the potential to effect 93 of 104 residents who received meals at the nursing home. 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The dish machine's	ROWIDER OR SUPPLIER AL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY INST BE PRECEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION) CONTINUED From page 117 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. \$483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and the service company's record, the facility failed to clean and santize dishes according to manufacturer's instructions. This problem had the potential to effect 93 of 104 residents who received meals at the nursing home. 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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		، ا	C
		345213	B. WING			l	08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINIVEDO	NI HEALTH CARELIIII	NCTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 118	F.	812			
		nt phase 1. The cook said	·		required for a rinsing cycle.		
		she had ever seen the			required for a finding cycle.		
		nachine's display and added,			On 6/7/2018 Maintenance director		
		with that. Observations of			educated the Dietary Manager, the coo	k,	
	staff washing several	racks of dishes in the dish			Dietary aide #3 of the meaning of a		
	machine revealed the	e machine's final rinse			wrench sign and P1 after being advised		
	•	on the readout display only			by the service company of the meaning	1	
	-	s of 150, 147, 153, 160					
degrees Fahrenheit. Diet Aide #1 continued to				On 6/7/2018; Dietary Manager			
	feed dishes into the machine even though the machine's final rinse cycle was not operating at a				discontinued the use of the dish machin		
	temperature of 180 degrees Fahrenheit. The DM				once notified by the Maintenance Direct that the dish machine was not function		
		nese observations and said it			properly, and the rinsing cycle did not	rig	
		of employment and her first			reach 180 degree.		
	day working in the dis				On 6/7/2018; Dietary Manager spoke w	/ith	
		es out of the dish machine			Resident Council President and receive		
		nachine's final rinse cycle to			approval to utilize paper products until		
	finish. She removed	one rack from the dish			machine is fixed and functioning prope	rly.	
	machine and inserted	d another rack. DA #1 was					
	also observed to ope	n the dish machine's door			On 6/07/18 Dietary Manager prepared		
		nal rinse cycle temperature			and utilized the 3 sink compartment for		
		Fahrenheit. DA #1 said, "It's			manual wash to ensure that dishes we	e	
		v, because it is not taking			getting clean, rinsed and sanitized		
	forever."				appropriately using appropriate chemic sanitization chemicals.	aı	
	During this observation	on on 6/7/18 from 9:58 AM			Samuzation chemicals.		
	_	M called the Maintenance			On 6/7/2018 the service company		
	'	MD said he had a little			identified a burned wire that caused the	7	
	, ,	sh machine. He called the			machine to dysfunction. The company		
	-	ind out what the P1 and			repaired the problem and the machine		
	wrench icon on the re				was verified to function properly with fir	nal	
	0-0740 44000	M DA#0			rinsing circle reading 184 on 6/8/2018		
		M, DA#2 confirmed the			IDENTIFICATION OF OTHERS		
		e for the kitchen's dish			IDENTIFICATION OF OTHERS		
		cycle should be 180 degrees perature of the machine's			No resident named in this alleged		
		noted to only be reaching			noncompliance. Any residents who receives meals from the facility kitchen		
	· ·	neit and DA#1 continued to			has a potential to be affected by this		
	_	shes from the dish machine.			alleged non- compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C / 08/2018	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	700/2010	
				1995 EAST CORNELIUS HARNETT BOULEV	/APD		
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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 812	Continued From page	e 119	F 81	2			
	was scrapping food f did not know what the on the machine's real On 06/07/18 at 10:59 Director was observed person working on the service people could to clean the probest service." The DM deto serve lunch and he acceptable with the FC Council. The DM additemperatures were remorning of 6/7/18. The dish machine's streviewed. The report made to the dish was PM. The report indiction was repaired and the	AM, the Maintenance of with another maintenance of with another maintenance of dwith another maintenance of dwith another maintenance of dwith another machine. He said the not come out, but told them He said, "P1 means call for cided to use paper products of confirmed the decision was president of the Resident's ded that no dish machine of the corded by staff during the decorded by staff during the decorded a repair was sher on 6/7/18 around 5:30 ated a wire was burned. It		SYSTEMATIC CHANGES Effective 7/10/2018, dietary staff check dish washing machine tem for both washing and rinsing cycl three times daily. Findings from t process will be documented on "o machine temperature log maintai the dietary department. Any negatindings to include temperature least 180 for the final rinsing cycle will reported to the dietary manager or remove from being used immedia until resolved. Three compartmen will be utilized to clean dishes at Con 7/2/2018 Dietary manager receleaning schedule to ensure the remains clean and sanitized at all This schedule incorporated clean top of the dish machine and surfaces of for food preparation. Effecting the process of the dietary staff will utilized to t	nperature e at least his dish ined at ative ess below be and ately, nt sink that time. vised a kitchen Il times. ning on aces ive		
	correctly when they left. On 6/8/18 at 9:21 AM, dishwashing was observed. There was no wrench icon on the dish machine's readout. The final rinse temperature of the machine was observed to reach a temperature of 184 degrees Fahrenheit. The DM said he had been trained to work with high temperature dish machines, but not this specific machine. Interview with the Registered Dietitian on 6/8/18 between 11:40 AM and 12:02 PM revealed the dishwasher was a high temperature machine and needed to reach a minimum final rinse temperature of 180 degrees Fahrenheit to			cleaning schedule. Effective 7/10/2018, Dish machin added on preventative maintenar schedule to be checked once more ensure proper functionality per manufacturer guidelines Effective 07/10/2018, the facility of a continuous education program "safe food handling training" for a dietary staff that will cover all necessification required to safely and effectively carry out the functions food and nutrition services. This cover all aspects food handling to	establish called all facility cessary d s of the cause will		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345213	B. WING			C	
	201/1050 00 01/100/150	343213	15: *******			06/	/08/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLII	NGTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
OITIVE ITO	AL HEALIN GARE EILEN	101011		LI	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	sanitize the dishes ar in the machine. She	e 120 nd equipment being washed said she was responsible for ation and not responsible for	F	812	dish washing, kitchen sanitation, and equipment's functionalities and defects Any new dietary support personnel will checked off by the dietary manager and	be	
					checked off by the dietary manager and Registered Dietician before assuming duties in the facility. 100% education of all current dietary sto include full time, part time and as needed dietary staff, will complete "Saff food handling training" that will cover at necessary information required to safel and effectively carry out the functions of the food and nutrition services. This education will be provided and validate by the dietary manager and/or Register dietician and will also cover all aspects food handling to include dish washing, kitchen sanitation, and equipment's functionalities and defects. This education will be completed by 07/10/2018, any dietary staff not educate by 07/10/2018 will not be allowed to wo until educated. This education will also added to the new hire process for all ned dietary employees effective 07/10/2018 and will be provided annually. Registered Dietician and/or the Dietary Manager will complete in-servicing education on proper cleaning of dietary equipment and overall kitchen. This education will be completed by 07/10/2018, any dietary staff not education will be completed by 07/10/2018, any dietary staff not education will be completed by 07/10/2018, any dietary staff not education will be completed by 07/10/2018, any dietary staff not education will be completed by 07/10/2018, any dietary staff not education will be completed by 07/10/2018, any dietary staff not education will be completed by 07/10/2018, any dietary staff not education will be completed by 07/10/2018, any dietary staff not education will be completed by 07/10/2018, any dietary staff not education will staff not education will educated.	d/or taff, fe II Ily of ed red s ated ork be ew 8	
					education on proper cleaning of dietary equipment and overall kitchen. This education will be completed by	ated ork be ew	

	DF DEFICIENCIES CORRECTION			SURVEY PLETED			
		345213	B. WING			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.102.10		STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 06/	06/2016
TO THE OT T	NOVIDEN ON OUT FREIN				5 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON			LINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page					te 3 ed ed ring y d in nly	
					Effective 7/10/2018, The Executive Director will conduct Sanitation inspect for the main kitchen to ensure all equipment are clean, sanitized and functioning per manufacturer	ion	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 06/08/2018	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVAR LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 812	Continued From page	e 122	F 81	recommendation. Findings from this monitoring process will be documer "Kitchen sanitation Audit" maintaine the facility compliance binder. This monitoring process will take place to week for 8 weeks, then monthly for months or until the pattern of complis maintained. Effective 7/10/2018, Registered die will also complete sanitation inspectonce a week on opposite days with administrator for the main kitchen. Findings from this monitoring proce be documented on "Kitchen sanitati Audit" maintained in the facility compliance binder. This monitoring process will take place weekly for 8 weeks, then monthly for three mont until the pattern of compliance is maintained. Effective 7/10/2018, Dietary Manag and/or Executive director will reporfindings of this monitoring process the facility Quality Assurance and Performance Improvement Commit any additional monitoring or modific of this plan monthly x 3 months, or the pattern of compliance is maintain. The QAPI committee can modify this to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/2018, the center Exeroirector, Dietary Manager and the Director of Nursing will be ultimately responsible to ensure implementation.	nted on d in wice a three iance iance itician tion the ss will on hs or er to the tee for ation until ned. s plan cutive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 06/08/2018	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 812	Continued From page	e 123	F 81	this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	7/40/40	
F 835 SS=J	enables it to use its re efficiently to attain or practicable physical, well-being of each res This REQUIREMENT by: Based on record revi Department of Social	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. is not met as evidenced ew, staff, physician and Services interviews, and	F 83	F835 ROOT CAUSE	7/10/18	
	facility was free from protect 1 of 3 residen physical abused by a witnessed being physin the facility. The fact measures specified b Services Adult Protect prior to Resident #84' protect him from bein Immediate jeopardy befacility administration and management to be from abuse when 2 w #84 seated in his roof female visitor, identific observed hitting, kick	thip to the staff to ensure the abuse and to prevent and ts (Resident #84) from being visitor. Resident #84 was ically abused by his spouse ility failed to implement by the Department of Social tive Services Social Worker is admission to the facility to graphysically abused. The gan on 6/4/18 when the failed to provide oversight ensure the facility was free itnesses observed Resident in a wheelchair and a feed as his wife, was fing and stomping on iate jeopardy was removed ty provided and		This alleged noncompliance resulted the center's failure to be administered manner that use the resources effecti efficiently, and consistently to ensure facility implemented the abuse prohib policies and procedures to protect residents from abuse and/or neglect a ensure the facility attain and maintain regulatory compliance consistently to avoid repeated deficient practices. The analysis conducted also indicated that the facility failure is resulted from high turnover in administrative staff the cause inconsistences on processes at the result quality outcome is diminished. The high turnover rate is concluded to due to the poor work place culture. This alleged noncompliance resulted the center's failure to follow the abuse policy and procedures that led to not protecting one resident with prior history.	tin a vely, the tition and d the at s ed. b be	

			DATE SURVEY COMPLETED					
			A. BOILDII				c l	
		345213	B. WING				06/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	700/2010	
					95 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LI	LLINGTON			ILLINGTON, NC 27546			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 835	Continued From p	page 124	F 8	835				
	Immediate Jeopai	rdy removal. The facility			of suspected domestic abuse from a			
	remains out of co	mpliance at a lower scope and			spouse. On 4/25/2018 the facility admi	tted		
	severity of "D" (no	harm with the potential for			resident #84 for rehabilitation and long			
		al harm that is not immediate			term care placement. Resident #84 ha			
	jeopardy) to ensu	re monitoring systems put in			protective order named "Ex parte order			
	place are effective	e.			filed in Harnett County Clerk of Superior			
					Court on 4/24/2018. The protective ord			
	Findings included	:			was presented to the facility at the time			
	0 D-f T	000: Decedes accord as income			admission on 4/25/2018 by the assigned	∌d		
		600: Based on record review,			Social Worker from the Department of			
		ysician, and Department of			Social Services. The protective order included information that the "department of the control o	ont		
	Social Services staff interviews, the facility failed to protect 1 of 3 residents (Resident #84) from physical abuse when Resident #84 was				of Social services is concerned with the			
					possibility of physical abuse and negle			
		ity staff being hit and kicked by			it also added that "Without a protective			
	his spouse in his	-			order department of Social Services is			
					concerned the wife will remove			
		F-607: Based on record review			respondent from the hospital/rehab."			
		ys, the facility failed implement			This allowed personnliance regulted for	-0-m		
		en the resident, prevent abuse residents (Resident #84) from			This alleged noncompliance resulted fre the facility failure to implement abuse	OIII		
		physical abuse. The facility			policies and procedures on the area of			
		nt measures specified by the			proper screening, identification, protect			
		cial Services Adult Protective			and reporting that resulted from the			
		/orker prior to Resident #84's			broken communication process from			
		5/18 to protect him from being			resident's admission to the facility for			
		. Following the physical assault			necessary information to include			
	Resident #84 was	assessed and did not have any			protective orders for resident #84. As t	he		
	physical injuries a	nd did not require medical			result the resident's alleged perpetrato			
	treatment.				visited resident #84 multiple times with	no		
					appropriate interventions to protect			
		, DON and Corporate			resident #84.			
		notified of the immediate			B			
	, , ,	8 at 2:55 PM. On 6/7/18 at			Root cause analysis also concluded th	at		
		lity provided the following			the facility misinterpreted regulatory	_		
	_	of immediate jeopardy			requirements that requires the facility to			
	removal:				protect each resident while in the facilit	.y,		
	"This alloged per	compliance resulted from the			and reporting any allegation of abuse immediately but no later than two hours	c		
	i i ilis allegeu 11011	compliance resulted horn the	1		minimediately but no later than two flour	ວ	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED C 06/08/2018	
	345213	B. WING				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	06/06/2016	
			1995 EAST CORNELIUS HARNETT BO			
UNIVERSAL HEALTH CARE LIL	LINGTON		LILLINGTON, NC 27546	OLLVAND		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 835 Continued From pa	age 125	F 83	35			
center's failure to be that use the resour consistently to ensiabuse prohibition protect residents from the facility acompliance consist deficient practices. The analysis condition facility failure is restart administrative staff processes as the rediminished. The high to be due to the position of the facility failure to form a spouse. On resident #84 for resident #84 for resident Reside named "Ex parte of Clerk of Superior Clerk of Superio	the administered in a manner of the administered in a manner of the selfectively, efficiently, and the policies and procedures to soom abuse and/or neglect and attain and maintain regulatory tently to avoid repeated functed also indicated that the sulted from the high turnover in a that cause inconsistences on esult quality outcome is gh turnover rate is concluded for work place culture. Impliance resulted from the collow the abuse policy and do not protecting one resident of suspected domestic abuse 4/25/2018 the facility admitted in the sultation and long term care in the superior of the facility at a protective order of the protective order included to the protective order included to the protective order included the department of Social and with the possibility of the great of the wife will remove	F 83	after the allegation is made. also failed to follow the polic procedures to put measures protect residents while in the when they are under the cus. The root cause analysis, cor the systemic failure that resuresident #84 incident on 6/4/includes, broken communication from admission for necessar to include protective orders for #84. As a result the resident perpetrator visited resident #1 times with no appropriate into protect resident #84. The brocommunication process resulack of a systemic process show protective orders was to communicated by the Admisto the rest of the IDT. Although the facility received documentation on admission 4/25/2018, and was notified social worker of the protective this resident, there is no indifacility put forth measures to Resident #84 from his wife. Director failed to communicate pertinent information to the interdisciplinary team necess resident #84 was protected to facility from his wife. On 6/4/2018 the resident's switnessed by the facility Actives witnessed by the facility	ies and in place to a facility even stody of DSS. Included that, ulted onto (2018 ation process by information for resident (2018) at leged		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345213	B. WING			06/	08/2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
				1	1995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLII	NGION		l	LILLINGTON, NC 27546			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 835	Continued From page	e 126	F	835				
	· -	ken communication process			Central Supply Aide stated they witnes	sed		
	from resident's admis	•			resident's spouse kicking resident's leg			
		n to include protective orders			and stepping on his feet. Resident and			
	•	he result the resident's			spouse were immediately separated by			
	alleged perpetrator vi	sited resident #84 multiple			the Central Supply Aide. A Complete			
	times with no appropr	riate interventions to protect			Head to toe body assessment was			
	resident #84.				completed by the Registered nurse			
					Supervisor #1. No injuries noted, resident	ent		
	-	also concluded that the			denied any signs and symptoms of pai			
		regulatory requirements			discomforts. Initial report for the alleged	t		
	that requires the facil			abuse was completed and sent on				
	-	nd reporting any allegation of			6/4/2018, DSS social worker and the			
		ut no later than two hours			attending Physician notified.			
	_	made. The facility also			IMMEDIATE ACTION TAKEN			
	-	licies and procedures to put protect residents while in			IMMEDIATE ACTION TAKEN The Executive Director counselled the			
		they are under the custody			facility Admission Director on 6/7/2018	to		
	of DSS.	They are under the custody			address the communication failure that			
	0. 200.				caused the deficient practice.			
	The root cause analy	sis, concluded that, the			Production of the state of the			
	·	resulted onto resident #84			The New Executive director was hired	on		
	incident on 6/4/2018				2/15/2018 to manage and supervise th	е		
	communication proce	ess from admission for			facility's operation. The Executive direct			
	necessary information	n to include protective orders			is rebuilding the facility management st	aff		
	for resident #84. As a	result the resident's alleged			by hiring qualified personnel to manage	9		
		sident #84 multiple times			the departments in the facility to ensure	9		
		nterventions to protect			and assure quality outcomes. The			
		ken communication process			Executive Director has hired qualified			
		of a systemic process set			Assistant Director of Nursing, Two			
	forth on how protective				Registered nurse Supervisors, Busines	iS		
	-	Admission Director to the			Office Manager, and Director of Food	_		
	rest of the IDT.				Services. The Admistrator is leading th			
	Although the feeilite -	agained the decumentation			team towards systematically identifying			
		eceived the documentation 5/2018, and was notified by			and addressing quality deficits. He has systems and processes in place to	μuι		
					improve facility systems and processes	2		
	the DSS social worker of the protective orders of this resident, there is no indication that the facility put forth measures to protect Resident #84 from			improve facility systems and processes).			
		_			Chief Clinical officer from the			
	his wife. Admission D	- -			Management and consulting company	I		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
						С
		345213	B. WING		06	6/08/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI	DE	
				1995 EAST CORNELIUS HARNETT BO	ULEVARD	
UNIVERSA	AL HEALTH CARE LI	LLINGTON		LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR 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) COMPLETION DATE
F 835	Continued From p	age 127	F 8	335		
F 835	communicate the interdisciplinary te resident #84 was from his wife. On 6/4/2018 the reby the facility Active #1 in the room with Aide and Central Switnessed resident and stepping on his pouse were immediately assessment Registered nurse noted, resident de of pain or discomfabuse was comples ocial worker and notified. IMMEDIATE ACTIVE The Executive Director Admission Director communication fair practice. The New Executive 2/15/2018 to mana operation. The Executive Director accommunication fair practice accommunication fair practice.	pertinent information to the sam necessary to insure protected while in the facility esident's spouse was witnessed vity Aide, & Central Supply Aide h the Resident #84. Activity Supply Aide stated they t's spouse kicking resident's leg is feet. Resident and the ediately separated by the de. A Complete Head to toe was completed by the Supervisor #1. No injuries enied any signs and symptoms orts. Initial report for the alleged eted and sent on 6/4/2018, DSS the attending Physician	F	that manages the center, re- Center Executive Director an Director of Nursing 6/7/2018 Abuse Prohibition and Invest policies and procedures, and the importance of screening, protecting and reporting to th required agencies immediate later than two hours from the allegation is made. The educ emphasized on the importan ensuring residents are scree potential abuse and measure forth to protect them while re facility. The Chief Clinical officer from Management and consulting that manages the center, re- facility management team tha the department supervisors of center's Abuse Prohibition ar Investigation policies and pro emphasized on the importan screening patients and emple hire, protecting resident(s), a any allegation of abuse or Ne Direct supervisor and the Ex Director in a timely manner a the Regulatory required ager immediately but no later than forming suspicion, witness th and/or after a resident, anoth and/or family member allege	and the on the center tigation of the merce tigation of the regulatory ely but not time the cation also on the merce tigation of the	
	leading the team t	Services. The Admistrator is owards systematically dressing quality deficits. He has		the Central Supplies aide sep resident #84 from his wife by out of the room to the hallwa	pushing him	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP COD		00/00/2010	
			1995 EAST CORNELIUS HARNETT BOUI				
UNIVERSA	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 835	Continued From page	e 128	F 83	35			
	put systems and proof facility systems and pro- facility systems and pro- Chief Clinical officer of consulting company to re-educated the Cent the Director of Nursin Abuse Prohibition and procedures, and emp screening, identificati to the regulatory requibit no later than two allegation is made. To emphasized on the in residents are screened	rom the Management and hat manages the center, er Executive Director and g 6/7/2018 on the center d Investigation policies and hasized the importance of on, protecting and reporting hours from the time the		supplies aide remained with ron the hallway, and notified A Director of Nursing (DON) wh standing in the proximity at the station #2. ADON walked tow resident accompanied by the Manager #1 who relieved the Supplies aide and took over sand protection, per facility abortonibition process of resident the facility abuse policy and punit Manager #1 completed a assessment of the resident an injuries. Resident denied pair discomforts.	assistant no was he nurse's hards the Unit Central supervision use ht #84, per procedures. he head to toe and noted no		
	residing in the facility The Chief Clinical offi and consulting compacenter, re-educated fathat consist of the decenter's Abuse Prohit policies and procedur importance of screen before hire, protecting any allegation of abus supervisor and the Exmanner as well as to agencies immediately after forming suspicion after a resident, anoth member alleged abus	cer from the Management any that manages the acility management team partment supervisors on the bition and Investigation res, and emphasized on the ing patients and employees g resident(s), and reporting se or Neglect to their Direct secutive Director in a timely the Regulatory required to but no later than 2 hours on, witness the abuse and/or her staff and/or family		Central Supplies aide notified Records supervisor who was the nurse station #1. Medical aide walked to the resident's immediately and met Unit Mathe room. Medical Records aid Unit manager #1 while the Urwas assessing the patient. Unit #1 and Medical Records supertransferred resident #84 to the and moved the resident to the Medical Records supervisor rwith resident #84 until the pol with a brief period when she by the transportation aide whether resident when Medical Resupervisor departed. Likewise, the ADON who left	standing at Records room nager #1 in ide assisted nit manager nit Manager ervisor e wheel chair e dining area. remained ice arrived was relieved o stayed with ecords		
	Central Supplies aide from his wife by push the hallway. The cent	e separated resident #84 ing him out of the room to rral supplies aide remained the hallway, and notified		Manager #1 with resident#84 the Executive Director's office notification. On 06/04/2018 the initial report was sent to the Executive Directory of the Execut	walked to e for ne 24 hour		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI		2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG _		Ι ,	С
		345213	B. WING			1	08/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		L	ILLINGTON, NC 27546		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 835	Continued From pag	e 129	F	835			
		Nursing (DON) who was			of Health and Human Services related	to	
		mity at the nurse's station #2.			resident #84's witnessed abuse by the		
		ds the resident accompanied			spouse. These reports were completed	1	
		#1 who relieved the Central			and submitted by the Director of Nursir		
	, ,	ok over supervision and			The Five day report was completed on	-	
	l	y abuse prohibition process			6/7/2018 after a detail investigation wa		
		the facility abuse policy and			conducted by the Center Executive		
		nager #1 completed a head			Director, Director of Social Services an	d	
	to toe assessment of	f the resident and noted no			Director of Nursing. The incident on		
	injuries. Resident de	nied pain or discomforts.			6/4/2018 against resident #84 was		
	-				substantiated based on findings of the		
	Central Supplies aide	e notified a Medical Records			investigation conducted by the Facility,		
	supervisor who was	standing at the nurse station			Department of Social Services, and		
	#1. Medical Records	aide walked to the resident's			Harnett county Police Department.		
	room immediately ar	nd met Unit Manager #1 in					
	the room. Medical Re	ecords aide assisted Unit			Resident #84's spouse is ordered by the		
	manager #1 while the	•			court not to visit or be in contact with the		
		t. Unit Manager #1 and			resident effective 6/5/2018. Facility has		
	·	pervisor transferred resident			yet to receive a confirmation of actions		
		ir and moved the resident to			taken legally against the spouse. Facili	ty	
	_	ical Records supervisor			will keep resident on 1 on 1 until		
		ent #84 until the police arrived			confirmation is obtained of the spouse'	5	
		nen she was relieved by the			inability to come to the facility.		
	-	ho stayed with the resident			The photograph of the alleged perpetra	ator	
	When Medical Recor	ds supervisor departed.			(resident#84 wife) is currently posted a		
	Likewise the ADON	who left Unit Manager #1			the front desk, and at each nurse's star		
	with resident#84 wal	_			for easy identification and notification	1011	
		otification. On 06/04/2018			effective 6/6/18. The photograph is		
	the 24 hour initial rep				located on the pertinent location where	all	
		h and Human Services			employees can identify resident #84's		
		34's witnessed abuse by the			wife.		
		ts were completed and					
		ector of Nursing. The Five			Facility Executive Director, Director of		
	_	oleted on 6/7/2018 after a			Nursing, and Social Worker from		
	detail investigation w	as conducted by the Center			Department of Social Services met brie	fly	
	Executive Director, D	xecutive Director, Director of Social Services			on 6/5/2018 to discuss the incident tha	t	
	and Director of Nursi	ing. The incident on 6/4/2018			happened on 6/4/2018. The team		
	against resident #84	was substantiated based on			discussed the nossible actions necess	arv	1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 06/08/2018	
		345213	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/00/2010	
				1995 EAST CORNELIUS HARNETT BOU	LEVARD		
UNIVERSA	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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 835	Continued From page	e 130	F 8	35			
	· -	gation conducted by the		to protect the resident from the	e spouse		
		of Social Services, and		Multiple ideas were discussed	•		
	Harnett county Police			room change, identify the resid			
	,	•		different name, or transfer resi			
	Resident #84's spous	se is ordered by the court not		another location that the spous	se will not		
	to visit or be in contact	ct with the resident effective		be aware of. On 6/5/2018, the	facility as		
	6/5/2018. Facility has			well as the DSS social worker	reached a		
		ns taken legally against the		conclusion that, the best cours			
		eep resident on 1 on 1 until		that will protect resident #84 fr			
		ned of the spouse's inability		spouse, while maintaining his	•		
	to come to the facility	'.		self-determination, and reduce			
	The photograph of th	a alloged perpetrator		deterioration from this event is resident #84 to another part of			
		currently posted at the front		Resident #84's name was cha			
	desk, and at each nu			6/5/2018 to an alias to ensure	•		
		ification effective 6/6/18.		protection, per facility abuse p	-		
		cated on the pertinent		process by the facility Director			
		ployees can identify resident		Executive Director and Admiss			
	#84's wife.			Director. This measure is in all	ignment		
				with the facility abuse policy a	nd		
		ector, Director of Nursing, om Department of Social		procedure.			
		on 6/5/2018 to discuss the		Resident #84 was relocated to			
		ed on 6/4/2018. The team		room in the facility on 6/5/2018			
	•	le actions necessary to		posted name in the facility was	-		
	⁻	rom the spouse. Multiple		Resident #84 was placed on e			
		d, such as room change,		minutes watch from 7pm on 6/			
		vith a different name, or		9am. One on one supervision			
		to another location that the vare of. On 6/5/2018, the		initiated on 6/5/2018 in which a employee observes the reside			
		DSS social worker reached		times while in the facility.	iii ai aii		
	-	best course of action that		One on one supervision was d	liscontinued		
		84 from his spouse, while		on 6/27/2018, after the facility			
	•	y, self-determination, and		Assurance and Improvement (-		
		oration from this event is to		determine that resident #84 is			
		to another part of the		protected from his wife with the			
		's name was changed on		measures in place such as loc	king the		
	6/5/2018 to an alias t	o ensure his protection, per		means of egress, resident relo	cation to		
	facility abuse prohibit	ion process by the facility		another room and change resi	dent⊟s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						С	
		345213	B. WING _		<u> 0</u>	6/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
LININ/EDO		LINGTON		1995 EAST CORNELIUS HARNETT BO	DULEVARD		
UNIVERSA	AL HEALTH CARE LIL	LINGTON		LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 835	Continued From pa	age 131	F 8	35			
	Director of Nursing	, Executive Director and		name.			
		This measure is in alignment					
	with the facility abu	use policy and procedure.		IDENTIFICATION OF OTHE	RS		
				100% audit of all residents of	linical		
	Resident #84 was	relocated to another room in		documentation within the las	st 30 days was		
	the facility on 6/5/2	018 and the posted name in		completed by the Director of	Nursing,		
		inged. Resident #84 was		Assistant Director of Nursing			
	·	minutes watch from 7pm on		Supervisor to determine if th	•		
		One on one supervision was		documentation in any reside			
		18 in which an employee		records that indicate allegati			
		ent at all times while in the		neglect, or injury of unknowr			
	-	e care will continue until the		any, determine whether a 24			
	facility receives confirmation that resident #84's			days investigation reports w			
	wife is arrested.			and reported to the state ago other officials as required by	•		
	IDENTIFICATION	OE OTHERS		and/or Elder Justice Act. The	-		
	100% audit of all re			revealed two other documen			
		nin the last 30 days was		of abuse, and/or neglect doc	-		
		Director of Nursing, Assistant		resident medical records. Th			
		and/or Nurse Supervisor to		completed on 6/6/18 & 6/7/1			
	_	s any documentation in any		this audit is documented on	_		
		ecords that indicate allegation		records audit tool located at	the facility		
		or injury of unknown sources, if		compliance binder.	•		
	any, determine wh	ether a 24 hours and 5 days					
		ts were completed and		100% audit was completed t	by the Center		
	reported to the sta	te agency and other officials as		Executive Director for all alle	gation of		
	required by regulat	tion and/or Elder Justice Act.		abuse and/or neglect submit			
		two other documented		from 1/24/2018 to 6/7/2018 (
	_	e, and/or neglect documented		the alleged perpetrator was	•		
		records. This audit was		during investigation to protect			
		18 & 6/7/18. Findings of this		resident, 24 hours complete			
		ed on clinical records audit tool		hours of the allegation, and	•		
	located at the facili	ty compliance binder.		completed and submitted to			
	100% audit was sa	emploted by the Caster		agency as required by regula			
		ompleted by the Center		Elder Justice Act in a timely			
		for all allegation of abuse mitted in the last from		audit revealed 5 of 5 comple			
	_	O18 determine is the alleged		abuse/neglect reports indica alleged perpetrator was susp			
		spended during investigation		pending investigation per ab			
	POIPORATOI WAS SU	Spended during investigation	1	policing invodigation per ab	u		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C 06/08/2018	
	345213	B. WING		06		
NAME OF PROVIDER OR SUPPLIER	0.02.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		0/00/2016	
NAME OF TROVIDER OR 3011 EIER						
UNIVERSAL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOL	JLEVARD		
			LILLINGTON, NC 27546			
PREFIX (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)	N SHOULD BE	(X5) COMPLETION DATE	
F 835 Continued From page	e 132	F 83	35			
to protect the residen 2 hours of the allegat and submitted to the regulation and Elder manner. The audit re abuse/neglect reports perpetrator was susp per abuse prohibition however all 5 of 5 init submitted within two months noted with de Alleged Perpetrator(s audit was completed On 06/06/2018, 100% by Director of Rehab Office Manager, Active Records Supervisor and oriented resident other resident with an Neglect. Two other re Resident #3 voiced an eglect. Alleged perpensuspended while the by the facility Execution of Nursing. 24 hour re 6/6/2018. A thorough resident's attending Party were notified of and #3, will be informactions taken when the by the Center Execution of Social Services. The Director of Social Director and Director and Director of Nursing, Upirector and Director.	att, 24 hours completed within ion, and 5 days completed state agency as required by Justice Act in a timely vealed 5 of 5 completed indicated the alleged ended pending investigation policy and procedure, tial 24 hour reports were not hours of the allegation. Two etail investigation and the sy were suspended. This on 6/7/2018. 6 interviews was completed dilitation Center, Business wity Director, Medical and MDS for all current alert is in the facility to identify any in allegation of Abuse and/or estrators identified were investigation is conducted verbigation in initiated. The Physician and Responsible of the allegation. Resident #2 and ine investigation is completed investigation in c	F 83	prohibition policy and procedulall 5 of 5 initial 24 hour reports submitted within two hours of allegation. Two months noted investigation and the Alleged Perpetrator(s) were suspended was completed on 6/7/2018. On 06/06/2018, 100% intervice completed by Director of Reh Center, Business Office Mana Director, Medical Records Sul MDS for all current alert and cresidents in the facility to idented resident with an allegation of and/or Neglect. Two other resident#2, and Resident #3 allegation of abuse and/or negative and/or Director identified suspended while the investigation of attending Physician and thorough investigation initial resident's attending Physician Responsible Party were notificallegation. Resident #2 and # informed of the findings and a when the investigation is commodered to the second control of Social Services. The Director of Social Services Director of Nursing, Unit Mana Admission Director and Director Rehabilitation Services intervires ponsible parties for resident able to answer questions	s were not the I with detail ed. This audit ews was abilitation ager, Activity pervisor and oriented orie		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C		
NAME OF D	ROVIDER OR SUPPLIER	040210			STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	08/2018	
NAIVIE OF F	ROVIDER OR SUFFLIER							
UNIVERSAL HEALTH CARE LILLINGTON				1995 EAST CORNELIUS HARNETT BOULEVARD				
			L	LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG						
F 835	Continued From page 133			835				
		mental capacity deficit on			6/7/18. No family member voiced any			
		ember voiced any allegation			allegation of abuse and/or neglect.			
	of abuse and/or neg				anegation of abase and/of fregreet.			
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			SYSTEMIC CHANGES			
	SYSTEMIC CHANG	GES			Effective 6/7/18 the facility will conduct	an		
	Effective 6/7/18 the	facility will conduct an			interdisciplinary weekly team building			
		ekly team building meeting			meeting that with the department			
	that with the departi	ment supervisors to discuss			supervisors to discuss culture change			
		atives to be implemented in			initiatives to be implemented in the fac-	lity.		
		neetings will be held without			These meetings will be held without			
	affecting resident ca	are activities.			affecting resident care activities.			
	Effective 6/7/2018 to	he facility established an			Effective 6/7/2018 the facility establish	ed		
		tion Committee (EAC) chaired			an Employee Appreciation Committee	Ju		
		uman Resources. Initial			(EAC) chaired by the Director of Huma	n		
	I -	nmittee were selected by the			Resources. Initial members of this			
	facility Executive Di	rector and Director of Nursing			committee were selected by the facility	,		
		include the Activity Director,			Executive Director and Director of Nurs	sing		
		ervices, Nurse Aide #1,			Services. Members include the Activity			
	_	Laundry aide #1. This			Director, Director of Social Services,			
		monthly to discuss ways to			Nurse Aide #1, Dietary Aide #1 and			
	1 .	' morale in order to reduce			Laundry aide #1. This committee will m	ieet		
	effective 6/7/2018.	nprove work place culture			monthly to discuss ways to improve	toff		
	ellective 6/1/2016.				employees' morale in order to reduce s turnover and improve work place culture			
	Effective 6/7/2018	all alleged violations involving			effective 6/7/2018.	C		
		loitation or mistreatment,			01100110 07772010.			
		unknown source and, are			Effective 6/7/2018, all alleged violation	S		
		ly, but not later than 2 hours			involving abuse, neglect, exploitation of			
		s made to the Administrator of			mistreatment, including injuries of			
	the facility and to other officials to include; the				unknown source and, are reported			
	State Survey Agend	y, adult protective services,			immediately, but not later than 2 hours			
		en in accordance with State			after the allegation is made to the			
law through established fa		shed facilities policies and			Administrator of the facility and to othe	Г		
	procedures.				officials to include; the State Survey			
					Agency, adult protective services, the			
		The facility will report the			state Ombudsmen in accordance with			
		gations to the Administrator or			State law through established facilities			
	∣ his or her designate	ed representative and to other			policies and procedures.			

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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE LILLINGTON STREET ADDRESS, CITY, STATE, 2IP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546 BY PROVIDER CARD DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 835 Continued From page 134 officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Effective 6/7/2018, the facility interdisciplinary team to include Executive Director, Director of Nursing, Director of Social services and at least three other department supervisors will attend a monthly mandatory training that will be conducted by contracted management and consulting company that oversees the facility. This training will put an emphasis on all seven components of abuse prohibition to include screening, training, prevention, identification, investigation, protection, reporting and responses. This training will be interview of reach current employee at least once a year. The interview of reach current employee at least once a year. The interview for each current employee at least once a year. The interview process will be incorporated to the annual employee evaluating. Any staff member not interviewed by the anniversary date will not be
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Recreational Services and/or designated staff determine the employee understanding of member at least once every month to identify any the Center Abuse policies and
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will be documented on the psychosocial incorporated to the annual employee
assessment tool. Any voiced allegation of abuse, evaluating. Any staff member not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/08/2018		
		345213	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	700/2010
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSAL HEALTH CARE LILLINGTON				ILLINGTON, NC 27546			
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F 835	5 Continued From page 135		F 8	335	DETIGIENCY		
	and/or neglect will be Executive Director pro will be suspended pe	reported to the Center comptly. Alleged perpetrators anding investigation by the according to the regulatory			interviewed by the anniversary date will not be allowed to work until educated. Effective 6/7/2018, interviews for alert oriented residents will be completed by the Director of Social Services, Director	and	
	The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services will interview the responsible parties for residents who are not able to answer questions during the interview due to mental capacity deficit effective 6/7/18. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements.				Recreational Services and/or designate staff member at least once every mont identify any allegation of Abuse and/or Neglect. This interview will be documented on the psychosocial assessment tool. Any voiced allegation abuse, and/or neglect will be reported the Center Executive Director promptly Alleged perpetrators will be suspended pending investigation by the facility, an reported according to the regulatory requirements.	ed in to of co	
	readmission by the addesignated person duwill be placed in the nadvance directive tab accessibility by the number of the designation of the design	eived on admission or dmission director or uring the admission process, nedical file under the for easy identification and			The Director of Social services, Assistate Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services will interview the responsible parties for residents who a not able to answer questions during the interview due to mental capacity deficit effective 6/7/18. This interview will be documented on the psychosocial assessment tool. Any voiced allegation abuse, and/or neglect will be reported the Center Executive Director promptly Alleged perpetrators will be suspended pending investigation by the facility, and	e re e of oo .	
	guidelines such as su or not allowed on the will be added to resid appropriate information	pervised visits, no visitation, premises such measures ent's face sheet and on posted such as the d/or description in a readily			reported according to the regulatory requirements. Effective 6/7/2018 a copy of any reside protective orders received on admission or readmission by the admission direct	nt's n	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	101.02.1.01.00.1.2.2.1.			,	LIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLINGTON, NC			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PRO	OVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH	CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION	
F 835	335 Continued From page 136		F 8	35			
	Director of Nursing a complete 100% educe protective orders in excharts and the location to protect the resider education will also control to protective order to protective order interplan and to nursing a accessibility by both aides. Guidelines survisitation, or not allow be covered in this education will be accessed and appropriate information.	ventions to resident's care ide care guide for license nurses and nurse ch as supervised visits, no ved on the premises will also ucation. The education will be process that such lded to resident's face sheet mation posted such as the ind/or description to be a		admission primedical file up tab for easy is by the nursing. Effective 6/7/20 orders will be plan by the Albarrang superguide for accountress and roorder includes supervised wallowed on the will be added appropriate in the perpetrate.	d person during the rocess, will be placed in the under the advance directive identification and accessible staff. /2018; received protective added to resident's care admitting nurse and/or ervisor and nursing aide capessibility by both license nurse aides. If the protective seguidelines such as visits, no visitation, or not the premises such measured to resident's face sheet a sinformation posted such as tor picture and/or description cocessible location in the	e ve es and s	
	This education will be provided for all licensed nurses, nursing assistant to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides effective 6/7/2018, and will also be provided annually. Effective 6/7/2018, the center nursing administrative team, which includes DON, Nurse supervisors, Unit Managers, and/or SDC, added reviewing of DSS protective orders to an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24			Facility Direct Assistant Dir manager will on the location each residen location of in protect the ret This education be taken if th adding the pi to resident's care guide for nurses and re as supervise allowed on th covered in th will also emp	ctor of Nursing (DON), rector of Nursing and/or Ur I complete 100% education on of protective orders in at's medical charts and the attervention necessary to esident with protective order on will also cover process the protective order intervention care plan and to nursing a per accessibility by both lice nurse aides. Guidelines sure divisits, no visitation, or not the premises will also be his education. The education of the process that ation will be added to	ers. to de ns iide nse ch ot	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		'	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSAL HEALTH CARE LILLINGTON				ILLINGTON, NC 27546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	35 Continued From page 137		F	835			
F 835	hours, and Physician hours. By adding the orders to this process resident with prior his neglect, and/or injurie appropriate measures resident from the alleg 6/7/2018. This process Monday through Fridaresult of this systemic documented on the clamaintained in the "Date of the clamaintained in the "Date of the physician orders writt ensure that any allegate and/or injuries of unknown the facility Executive also incorporate revieworders to ensure the food address such order will take place every some attended to the supervisor report daily clinical meeting of the will print any protective the facility before bed	orders written in the last 24 review of DSS protective in it will ensure that any tory of allegation of abuse, is of unknown sources has is in place to protect the ged perpetrator, effective is with take place daily ays effective 6/7/2018. The inical meeting form ily Clinical meeting binder." e week end Registered for designated licensed cal documentation for the ted skin assessments, e last 24 hours, and en in the last 24 hours to ation of abuse, neglect	F	835	resident's face sheet and appropriate information posted such as the perpetrator picture and/or description to be a readily accessible location in the facility. This education will be provided for all licensed nurses, nursing assistant to include full time, part time and as need licensed nursing staff. This education who be completed by 6/7/2018. Any employ not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides effective 6/7/2018, and will also be provided annually. Effective 6/7/2018, the center nursing administrative team, which includes DC Nurse supervisors, Unit Managers, and SDC, added reviewing of DSS protectivorders to an existing process of review clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written the last 24 hours. By adding the review DSS protective orders to this process, will ensure that any resident with prior history of allegation of abuse, neglect, and/or injuries of unknown sources has appropriate measures in place to prote the resident from the alleged perpetrate effective 6/7/2018. This process with taplace daily Monday through Fridays	ed vill vee ON, l/or ve ing ast in v of it	
	the facility before bed provide copies of the facility Executive Dire	is offered. The AD will then			effective 6/7/2018. This process with ta	ike	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345213	B. WING			C 06/08/2018		
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	00/2010	
HMIVEDS/	AL HEALTH CARE LILLI	NCTON		19	95 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL NEALIN CARE LILLII	NGTON		LI	LLINGTON, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 835	Continued From page	e 138	F 8	335				
	referrals with DSS pro admitting resident to	place to protect the resident			the clinical meeting form maintained in "Daily Clinical meeting binder." Effective 6/7/2018, the week end Registered Nurse supervisor and/or	the		
	Effective 6/7/2018 the	e facility Executive Director,			designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments,			
	services will discuss new admits and re-admits to the facility during their daily department head meeting to validate that any admitted or readmitted resident with protective orders has measures in place to protect the resident against the alleged perpetrators. Effective 6/7/2018 any alleged perpetrator with restraining orders for visitation will not be allowed				incident reports for the last 24 hours, a Physician orders written in the last 24 hours to ensure that any allegation of	nd		
					abuse, neglect and/or injuries of unkno sources reported/documented is investigated thoroughly, the alleged	wn		
					perpetrator is suspended pending investigation, and ensure the event is reported to the facility Executive Direct	or.		
	locked and can only b	the facility exit doors are be accessed using an rs will utilize the facility main			This process will also incorporate reviewing of any DSS protective orders ensure the facility put measures in place			
	All the facility exit doo	premises, effective 6/7/18. ors are locked using a releases in case of fire. In			to address such orders. This systemic process will take place every Saturday and Sunday. Any negative findings will			
	case of any other emergency, each locked facility exit door is equipped with an emergency release override switch located beside each exit door to allow the door to demagnetize and open from the				documented on the week end supervis report form and maintained in the daily clinical meeting binder, effective 6/7/20	or		
	inside. The magnetic equipped with a mast each nurse's station. North Carolina life sa posted on all exit doo	lock system is also er override switch located at This is in compliance with fety code. Signs have been rs to direct visitors to the			Effective 6/7/2018 the Admission Directive (AD) will print any protective order for a referral to the facility before bed is offer. The AD will then provide copies of the protective order to the facility Executive.	any red.		
	(DON), Assistant Director of Social Ser	ector, Director of Nursing ector of Nursing and/or vices will complete 100% ocation of protective orders			Director, Director of Nursing, Director of social services and/or designated licen nurse. The IDT team will then review a referrals with DSS protective orders pri to admitting resident to the facility to ensure measures are put in place to protect the resident when admitted to the	sed II or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		· ,	(X3) DATE SURVEY COMPLETED	
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		345213	B. WING _		06	06/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•		
				1995 EAST CORNELIUS HARNETT BO	DULEVARD		
UNIVERSA	AL HEALTH CARE LII	LLINGTON		LILLINGTON, NC 27546			
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
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F 835	Continued From p	age 139	F8	335			
	importance of imp	lementing approaches to		facility.			
		nt's protection, per facility abuse					
	prohibition process	s. This education will be		Effective 6/7/2018 the facility	y Executive		
	provided for all lice	ensed nurses, to include full		Director, Director of Nursing	, and/or		
	time, part time and	d as needed licensed nursing		Director of social services w	ill discuss		
	staff. This education	on will be completed by		new admits and re-admits to	the facility		
	6/7/2018. Any em	ployee not educated by		during their daily departmen			
		e allowed to work until		meeting to validate that any			
		ucation will also be added on		readmitted resident with pro-			
		tation process for all new		has measures in place to pro			
		ffective 6/7/2018, and will also		resident against the alleged	perpetrators.		
	be provided annua	ally.		F#+: 0/7/0040	!		
	MONITODING DD	000500		Effective 6/7/2018 any allege			
	MONITORING PR	the facility will conduct a		with restraining orders for vis be allowed to visit the facility			
		nce improvement plan with the		facility exit doors are locked			
		the Contracted and		be accessed using an appro	-		
	· ·	pany, to assist the facility on		Visitors will utilize the facility			
		anges and reduce employee		entrance to enter the premis			
		be accomplished through		6/7/18. All the facility exit do			
		3 times a week visits by the		using a magnetized lock that			
	, ,	anagement and consulting		case of fire. In case of any o			
		eks, then once weekly for three		emergency, each locked fac			
		of compliance is maintained.		is equipped with an emerger	•		
	-			override switch located besid	de each exit		
	Effective 6/7/2018	, the facility will conduct a		door to allow the door to der	nagnetize and		
		and performance improvement		open from the inside. The m	agnetic lock		
		vith an agent from the		system is also equipped with			
	_	ement and consulting company		override switch located at ea			
		facility systematically identify		station. This is in compliance			
		s that needs performance		Carolina life safety code. Sig	•		
	· •	ssure the facility maintain and		posted on all exit doors to di			
retain substantial compliance. Thi				the main entrance, effective	6///18.		
		e months or until the facility		Facility Executive Director 5	Director of		
	shows the pattern	or compliance.		Facility Executive Director, D			
	Effective 6/7/2049	Evocutive Director and an		Nursing (DON), Assistant Di			
		, Executive Director and or		Nursing and/or Director of S			
		Services will review all alleged a thorough investigation is		will complete 100% re-education of protective orders			
	violation to ensure	a morough mycollydlion io	1	location of protective orders	III C auli	1	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	2.522.5	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	00/00/2010	
NAME OF T	TOVIDER OR SOLT EIER				ADD	
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		1995 EAST CORNELIUS HARNETT BOULEVA	AKD	
				LILLINGTON, NC 27546		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE COMPLETION	
F 835	Continued From page	e 140	F 83	35		
	completed and report	ed to the state agency and		resident's medical charts and the		
		ired by regulation and/or		importance of implementing appro	paches	
	-	/ issues identified during this		to ensure the resident's protection		
		ill be addressed promptly.		facility abuse prohibition process.	-	
		nitoring process will be		education will be provided for all li		
	_	e prohibition tool and filed in		nurses, to include full time, part tir		
	daily meeting binder a	after proper follow ups are		as needed licensed nursing staff.	This	
	done. This monitoring	process will take place		education will be completed by 6/7	7/2018.	
	daily to include Sature	days and Sundays for 2		Any employee not educated by 6/		
	weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.			will not be allowed to work until ed		
				This education will also be added		
				new hire orientation process for al		
				licensed nurses effective 6/7/2018	3, and	
		e facility will conduct a		will also be provided annually.		
		d performance improvement		MONITORING PROCESS		
	meeting monthly with	ent and consulting company		Effective 6/7/2018 the facility will of	conduct	
	_	npany to ensure that the		a directed performance improvem		
		identify and address areas		with the direct oversees by the Co		
		buse and neglect and		and management company, to as		
		olicies and procedures is		facility on making culture changes		
		Il take place for the next		reduce employee turnover. This w		
	twelve months or unti	I the facility shows the		accomplished through weekly visi		
	pattern of compliance	s.		3 times a week visits by the memb	per of	
				the management and consulting of	company	
		rector of Nursing, Assistant		for 4 weeks, then once weekly for	three or	
		nd/or Staff Development		until the pattern of compliance is		
		itor compliance with resident		maintained.		
		abuse prohibition process,		F 0.7.10040 H		
	thorough investigation			Effective 6/7/2018, the facility will		
		neglect by conducting		a quality assurance and performa		
		This meeting will allow the		improvement meeting monthly wit		
		egation of abuse, incidents		agent from the contracted manage		
		urred from the prior clinical otective orders and any		and consulting company to ensure		
		ion that indicate suspicion of		the facility systematically identify a address areas that needs perform		
		d to ensure measures are in		improvement to assure the facility		
		esident. Any issues identified		maintain and retain substantial		
		process will be addressed		compliance. This will take place for	or the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345213		` '	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345213	B. WING			C 06/08/2018			
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546		,	00,2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	documented on a dai filed in the clinical meters follow up is done. The take place daily for 4 weeks, then monthly pattern of compliance. Effective 6/7/2018, Defindings of this monitor. Quality Assurance are Improvement Commit monitoring or modification months, or until the period months. The QAF plan to ensure the factor of the compliance. RESPONSIBLE PARE Effective 6/7/2018, the and the Director of Noresponsible to ensure of correction for this area of correction for this area of correction for the facility removal was validated the IJ on 06/07/18, are interviews, in-service observations. The in r/t Resident #84's new	om this meeting will be ally clinical report form and beeting binder after proper is monitoring process will weeks, weekly x 2 more x 3 months or until the exist is maintained. Irrector of Nursing will report foring process to the facility and Performance there for any additional sation of this plan monthly x 3 seattern of compliance is PI committee can modify this cility remains in substantial TY TY THE EXECUTIVE DIRECTOR UNITS WILLIAM SERVICE TO THE SERVICE OF	F8	335	next twelve months or until the facility shows the pattern of compliance. Effective 6/7/2018, Executive Director or Director of Social Services will revier all alleged violation to ensure a thoroug investigation is completed and reported the state agency and other officials as required by regulation and/or Elder Jus Act. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on abuse prohibition tool and filed in daily meeting binder after proper follow ups are doned This monitoring process will take placed daily to include Saturdays and Sunday for 2 weeks, weekly x 2 more weeks, the monthly x 3 months or until the pattern compliance is maintained. Effective 6/7/2018, the facility will conduct a quality assurance and performance improvement meeting monthly with an agent from the contracted management and consulting company that oversees company to ensure that the facility systematically identify and address are related to resident's abuse and neglect and ensuring the abuse policies and procedures is implemented. This will taplace for the next twelve months or until the facility shows the pattern of compliance.	w gh d to dice gg s nen of uct the as			
	Resident #84, monito facility's main entrand Resident #84's wife p	d one on one (1:1) staff with ored entry and exits from the ce, and a photograph of posted at every nursing n. A care plan was initiated			Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or S Development Coordinator, will monitor compliance with resident protection, pe	taff			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING	B. WING		C 06/08/2018	
NAME OF PROVIDER OR SUPPLI	ER .			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
			1	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSAL HEALTH CARE LILLINGTON			L	ILLINGTON, NC 27546			
PREFIX (EACH DEF	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
and social isola goals included Interventions in relocation to an name, 1:1 supe change, room of	sed of tion raint clude other rvision hang	on "Safety: At risk for injury /t spousal abuse." The stated ained safety from his wife. d, but were not limited to, room, identify by a different on, staff education on name e, safety interventions, es in mood or behavior, and	F	835	facility abuse prohibition process, thorough investigation, injuries of unknown sources and resident neglect conducting clinical meeting daily. This meeting will allow the team to review a allegation of abuse, incidents or accide that occurred from the prior clinical meeting. Any DSS protective orders ar any documented information that indicas uspicion of abuse will be reviewed to ensure measures are in place to protect the resident. Any issues identified during this monitoring process will be address promptly. Findings from this meeting where documented on a daily clinical report form and filed in the clinical meeting binder after proper follow up is done. The monitoring process will take place daily 4 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern compliance is maintained. Effective 6/7/2018, Director of Nursing report findings of this monitoring procest to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. Effective 6/7/2018, Director of Nursing report findings of this monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. Effective 6/7/2018, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation of this plan of correction for this alleged noncompliance to	III III III III III III III III III II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION SUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C 06/08/2018		
NAME OF P	ROVIDER OR SUPPLIER		ı	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010	
				19	95 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LI	LLINGTON, NC 27546			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 835	Continued From page	nued From page 143		335	the facility remains in substantial			
F 867 SS=E			F 8	867	compliance."		7/10/18	
	§483.75(g) Quality as	ssessment and assurance.						
	assurance committee (ii) Develop and imple action to correct iden This REQUIREMENT by: Based on record rev facility 's Quality Ass Committee (QAA) fail procedures and effect interventions that the	ement appropriate plans of tified quality deficiencies; is not met as evidenced iew and staff interviews the essment and Assurance led to maintain implemented			F867 ROOT CAUSE This alleged noncompliance resulted from the center's failure to be administered in manner that use the resources effective efficiently, and consistently to ensure the	n a ely,		
	survey and was recite recertification survey in the area of 483.12 neglect & exploitation the facility to sustain surveys of record der facility 's inability to s	11/16/2017 complaint ed on the current The deficiencies were cited (freedom from abuse, a). The continued failure of compliance during 2 federal monstrates a pattern of the sustain an effective Quality The findings included:			facility implemented the abuse prohibitic policies and procedures to protect residents from abuse and/or neglect and ensure the facility attain and maintain regulatory compliance consistently to avoid repeated deficient practices. The analysis conducted also indicated that the facility failure is resulted from the high turnover in administrative staff that cause inconsistences on processes as	nd he t		
	and exploitation: Bas resident, physician, a Services staff intervie protect 1 of 3 residen physical abuse when	eedom from abuse, neglect ed on record review, staff, and Department of Social ews, the facility failed to ts (Resident #84) from			the result quality outcome is diminished. The high turnover rate is concluded to lidue to the poor work place culture. Repeated citation caused by the facility failure to follow through with plan of act set forth on the previous surveys. F600 & F607: This alleged noncompliance resulted from the center failure to follow the abuse policy and	d. be / tion		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C 06/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/00/2010
NAME OF T	TO VIDER OR OUT FEILER				DD
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		1995 EAST CORNELIUS HARNETT BOULEVA	עא
				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 CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE COMPLETION
F 867	Continued From page	e 144	F 86	7	
	his spouse in his facil During the complaint facility was cited for 4 a resident from staff t for 1 of 1 residents. 1b) CFR 483.12 - Der Abuse/Neglect policie and staff interviews, t the policy to screen the and protect 1 of 3 resistor to resident phy	survey of 11/16/17 the 83.12(a)(1) failure to protect or esident physical abuse velop/Implement es: Based on record review he facility failed implement he resident, prevent abuse idents (Resident #84) from sical abuse. The facility		procedures that led to not protectir resident with prior history of suspe domestic abuse from a spouse. Or 4/25/2018 the facility admitted resi #84 for rehabilitation and long term placement. Resident #84 had a proorder named "Ex parte order" filed Harnett County Clerk of Superior C 4/24/2018. The protective order was presented to the facility at the time admission on 4/25/2018 by the ass Social worker from the Departmen Social Services. The protective order.	cted n dent n care otective in court on as of signed t of
	Department of Social Services Social Work admission on 4/25/18 physically abused. For Resident #84 was ass physical injuries and of treatment.	easures specified by the Services Adult Protective er prior to Resident #84's to protect him from being bllowing the physical assault sessed and did not have any did not require medical		included information that the "depa of Social services is concerned wit possibility of physical abuse and n it also added that "Without a protect order department of Social Services concerned the wife will remove respondent from the hospital/rehalt This alleged noncompliance result the facility failure to implement abu	h the eglect", ctive es is c." ed from use
	facility was cited for fathe areas of preventice and reporting for staff 1c) CFR 483.12 Invest Alleged Violation: Bas review, facility staff, Nedical Director intersubmit a 24-hour and Agency for 1 of 1 resi with a bruise of unknown (Resident #19). During the complaint facility was cited for father and the area of the staff of	views, the facility failed to 5-day report to the Sate dents who was observed own origin to the left eye survey of 11/16/17 the		policies and procedures on the are proper screening, identification, pro and reporting that resulted from the broken communication process from resident's admission to the facility necessary information to include protective orders for resident #84. result the resident's alleged perpet visited resident #84 multiple times appropriate interventions to protect resident #84. Root cause analysis also conclude the facility misinterpreted regulator requirements that requires the facility protect each resident while in the fand reporting any allegation of abuimmediately but no later than two his properties.	otection e m for As the rator with no t d that y lity to acility, use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			1	08/2018	
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F 867			F 8					
	F 867 Continued From page 145 state agency and failed to thoroughly investigate the allegation of abuse. During an interview with the Administrator on 6/8/18 at 4:40 PM he stated the Quality Assurance committee met monthly and the medical director also attended monthly. He reported the facility was monitoring abuse and the reporting of abuse due to previous citations. He stated they had appointed one person so the reporting and investigation would be centralized to one person and the Administrator would provide oversite for guidance and review of any incidents to be sure the process will be followed through and completed in a timely manner. The Administrator added that the corporate consultant would also attend all QAPI meetings for the next 12 months until compliance is achieved and maintained.		F 867		after the allegation is made. The facility also failed to follow the policies and procedures to put measures in place to protect residents while in the facility ev when they are under the custody of DS The root cause analysis, concluded that the systemic failure that resulted onto resident #84 incident on 6/4/2018 includes, broken communication proce from admission for necessary informati to include protective orders for resident #84. As a result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions protect resident #84. The broken communication process resulted from a lack of a systemic process set forth on how protective orders was to be communicated by the Admission Direct to the rest of the IDT. Although the facility received the documentation on admission on 4/25/2018, and was notified by the DSS	en SS. at, ss ion t e to		
					4/25/2018, and was notified by the DSS social worker of the protective orders of this resident, there is no indication that facility put forth measures to protect Resident #84 from his wife. Admission Director failed to communicate the pertinent information to the interdisciplinary team necessary to instresident #84 was protected while in the facility from his wife. On 6/4/2018 the resident's spouse was witnessed by the facility Activity Aide, & Central Supply Aide #1 in the room with the Resident #84. Activity Aide and Central Supply Aide stated they witnes resident's spouse kicking resident's legand stepping on his feet. Resident and	of the		

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F 867	Continued From page	e 146	F8	<u> </u>	mplete was nurse ed, reside ns of pain e alleged at on nd the ance was ector of gulatory ghly known he noted I based or ury he resulted against the t he did n n since he injury also ed the tors as he ees, a ther staff to gain t might hav onducted ate surve e DON nication also did n source	ent n or d e not e e the ve on ey	

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F 867	Continued From page	e 147	F	causative factors; something that sho have been done after the reporting of injury of unknown source to the State Agency, Adult Protective Services an other officials as required by the state within two hours of the occurrence. Colinical Officer from the Consulting at Management Company contracted by facility re-educated the Center Execut director and the Director of Nursing of 7/2/2018 on reporting expectation if the is an injury of unknown origin noted from any resident in the facility. IMMEDIATE ACTION TAKEN The Executive Director counselled the facility Admission Director on 6/7/2014 address the communication failure the caused the deficient practice. The New Executive director was hiree 2/15/2018 to manage and supervise facility's operation. The Executive director is rebuilding the facility management by hiring qualified personnel to manathe departments in the facility to ensurand assure quality outcomes. The Executive Director has hired qualified Assistant Director of Nursing, Two Registered nurse Supervisors, Busing Office Manager, and Director of Food Services. The Executive Director is leading the team towards systematical identifying and addressing quality defined the has put systems and processes in place to improve facility systems and processes. Chief Clinical officer from the Management and consulting companion.	d hief and with the tive an area or at the ector staffinge are ess ally icits.		

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F 867	Continued From page	e 148	F 8	that manages the center, re-educenter Executive Director and the Director of Nursing 6/7/2018 on the Abuse Prohibition and Investigate policies and procedures, and enter the importance of screening, idee protecting, investigating and reporter the regulatory required agencies immediately but no later than two from the time the allegation is meducation also emphasized on the importance of ensuring residents screened for potential abuse and measures are put forth to protect while residing in the facility. The Chief Clinical officer from the Management and consulting content that manages the center, re-educated facility management team that contenter's Abuse Prohibition and Investigation policies and procede emphasized on the importance of screening patients and employed hire, protecting resident(s), and any allegation of abuse or Negled Direct supervisor and the Execution Director in a timely manner as we the Regulatory required agencies immediately but no later than 2 he forming suspicion, witness the all and/or after a resident, another stand/or family member alleged at On 6/04/2018 at approximately 5 the Central Supplies aide separates and resident #84 from his wife by pusout of the room to the hallway. To supplies aide remained with resion the hallway, and notified Assion the hallway, and notified Assion the supplies aide remained with resion the hallway, and notified Assion the supplies aide remained with resion the hallway, and notified Assion the supplies aide remained with resion the hallway, and notified Assion the supplies aide remained with resion the hallway, and notified Assion the supplies aide remained with resion the hallway, and notified Assion the supplies aide remained with resion the hallway, and notified Assion the supplies aide remained with resion the hallway, and notified Assion the supplies aide remained with resion the hallway, and notified Assion the supplies aide remained with resion the hallway.	the center the center ion apphasized ntification orting to be on the center of the cen	d d d d d d d d d d d d d d d d d d d	

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F 867	Continued From page	e 149	F	s s r n N S a p tt U a ir d C F tt a ir tt U w # tt a N w w b tt s L N tt n ir o r s	Director of Nursing (DON) who was standing in the proximity at the nurse's station #2. ADON walked towards the esident accompanied by the Unit Manager #1 who relieved the Central Supplies aide and took over supervision and protection, per facility abuse prohibition process of resident #84, per the facility abuse policy and procedures. Unit Manager #1 completed a head to the assessment of the resident and noted injuries. Resident denied pain or discomforts. Central Supplies aide notified a Medical Records supervisor who was standing the nurse station #1. Medical Records aide walked to the resident's room mmediately and met Unit Manager #1 the room. Medical Records aide assisted unit manager #1 while the Unit manager was assessing the patient. Unit Manager #1 and Medical Records supervisor ransferred resident #84 to the wheel count moved the resident to the dining and Medical Records supervisor remained with resident #84 until the police arriver with a brief period when she was relieved the resident when Medical Records supervisor departed. Likewise, the ADON who left Unit Manager #1 with resident#84 walked to the Executive Director's office for notification. On 06/04/2018 the 24 hour intial report was sent to the Department of Health and Human Services related esident #84's witnessed abuse by the spouse. These reports were completed and submitted by the Director of Nursing and submitted by the Director of N	n s. toe no al at in ed er er hair rea. d ed with	

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F 867	Continued From pag	e 150	F 86	The Five day report was completed or 6/7/2018 after a detail investigation we conducted by the Center Executive Director, Director of Social Services a Director of Nursing. The incident on 6/4/2018 against resident #84 was substantiated based on findings of the investigation conducted by the Facility Department of Social Services, and Harnett county Police Department. Resident #84's spouse is ordered by the court not to visit or be in contact with the resident effective 6/5/2018. Facility hay yet to receive a confirmation of actions taken legally against the spouse. Facility legally against the spouse. Facility Interested in the spouse inability to come to the facility. The photograph of the alleged perpett (resident#84 wife) is currently posted the front desk, and at each nurse's stated for easy identification and notification effective 6/6/18. The photograph is located on the pertinent location where employees can identify resident #84's wife. Facility Executive Director, Director of Nursing, and Social Worker from Department of Social Services met bron 6/5/2018 to discuss the incident the happened on 6/4/2018. The team discussed the possible actions necess to protect the resident from the spouse Multiple ideas were discussed, such a room change, identify the resident with different name, or transfer resident #8 another location that the spouse will not be aware of. On 6/5/2018, the facility well as the DSS social worker reached	as as as and as and as a a a a a a a a a a a a a a a a a a		

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F 867	Continued From page	e 151	F 86	conclusion that, the best course of acti that will protect resident #84 from his spouse, while maintaining his dignity, self-determination, and reduce risk for deterioration from this event is to reloc resident #84 to another part of the facil Resident #84's name was changed on 6/5/2018 to an alias to ensure his protection, per facility abuse prohibition process by the facility Director of Nursi Executive Director and Admission Director. This measure is in alignment with the facility abuse policy and procedure. Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was change Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was initiated on 6/5/2018 in which an employee observes the resident at all times while in the facility. One on one supervision was discontinu on 6/27/2018, after the facility Quality Assurance and Improvement Committed determine that resident #84 is safe and protected from his wife with the other measures in place such as locking the means of egress, resident relocation to another room and change resident s name. F610: On 6/4/2018, the 24 hour report and 5 day report were sent to the Department of Health and Human Services, for resident #19s injury of unknown source identified. These repowere completed and submitted by the Director of Nursing. No further actions	ate lity. n ing, e ed. o ued ee d

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F 867	Continued From page	e 152	F		IDENTIFICATION OF OTHERS 100% audit of all residents clinical documentation within the last 30 days of completed by the Director of Nursing, Assistant Director of Nursing and/or Nu Supervisor to determine if there is any documentation in any resident medical records that indicate allegation of abusineglect, or injury of unknown sources, if any, determine whether a 24 hours and days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed two other documented allegate of abuse, and/or neglect documented in resident medical records. This audit was completed on 6/6/18 & 6/7/18. Findings this audit is documented on clinical records audit tool located at the facility compliance binder. 100% audit was completed by the Cent Executive Director for all allegation of abuse and/or neglect submitted in the I from 1/24/2018 to 6/7/2018 determine if the alleged perpetrator was suspended during investigation to protect the resident, 24 hours completed within 2 hours of the allegation, and 5 days completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed 5 of 5 completed abuse/neglect reports indicated the alleged perpetrator was suspended pending investigation per abuse prohibition policy and procedure, hower	e, if i5 ited ion is s of ter ast s		

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F 867	Continued From page	e 153	F8	all 5 of 5 initial 24 hour reports wer submitted within two hours of the allegation. Two months noted with investigation and the Alleged Perpetrator(s) were suspended. The was completed on 6/7/2018. On 06/06/2018, 100% interviews were completed by Director of Rehabilities. Center, Business Office Manager, Director, Medical Records Supervit MDS for all current alert and orient residents in the facility to identify a resident with an allegation of Abus and/or Neglect. Two other resident Resident#2, and Resident #3 voice allegation of abuse and/or neglect. Alleged perpetrators identified were suspended while the investigation conducted by the facility Executive Director and/or Director of Nursing hour reports were submitted on 6/6 A thorough investigation initiated. Tresident's attending Physician and Responsible Party were notified of allegation. Resident #2 and #3, will informed of the findings and action when the investigation is complete Center Executive Director and/or Executive Director and/or Executive Director and Director of Social Services. The Director of Social Services interviewed responsible parties for residents we not able to answer questions durin interview due to mental capacity de 6/7/18. No family member voiced a allegation of abuse and/or neglect. F610: 100% audit was completed to the finding and and the finding and and the finding and action of abuse and/or neglect.	detail is audit as as ation Activity sor and ed ny other es s, d es 24 //2018. The the be s taken d by the irector sistant the no were g this eficit on ny		

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F 867	Continued From page	e 154	F&	Director of Nursing of completed within the identify any injuries of and ensure that a prowas completed and a within two hours as ware completed and sagency as required be Elder Justice Act. The other incident of injuried. This audit was 6/7/2018. Findings of documented on incide located at the facility F610: 100% skin assactive residents common of Nursing, Assistant and/or Unit Manager resident with an injure The audit revealed in injury of unknown so was completed on 6/1/2018, Chief Completed re-training Administrator and the regarding the quality performance improve (QAPI) process. This include how to identificate as well as ways to eswill ensure consistent outcomes. The educemethods on how to the aswell as best praction and the regarding the quality performance improves (QAPI) process. This include how to identificate as well as ways to eswill ensure consistent outcomes. The educemethods on how to the aswell as best practical analysis. Effective 07/10/2018 correction will be incompleted or complete incompleted or correction will be incompleted or correction will be incompleted or correction will be incompleted or completed or complet	e last 30 days to of unknown source oper investigation a an initial report well as 5 days repoubmitted to the state of the	orts ite orce cool r. ctor g er cce. of udit		

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F 867	F 867 Continued From page 155		F	867	,		
					committee were selected by the facility Executive Director and Director of Nurs Services. Members include the Activity Director, Director of Social Services, Nurse Aide #1, Dietary Aide #1 and Laundry aide #1. This committee will monthly to discuss ways to improve employees' morale in order to reduce sturnover and improve work place cultureffective 6/7/2018. Effective 6/7/2018, all alleged violations involving abuse, neglect, exploitation of mistreatment, including injuries of unknown source and, are reported immediately, but not later than 2 hours after the allegation is made to the Administrator of the facility and to other officials to include; the State Survey	eet taff e	

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F 867	Continued From page	e 156	F	Agency, adult protective services, the state Ombudsmen in accordance with State law through established facilities policies and procedures. Effective 6/7/2018, The facility will rep the results of all investigations to the Administrator or his or her designated representative and to other officials in accordance with State law, including the State Survey Agency, within 5 wordays of the incident, and if the alleged violation is verified appropriate correct action must be taken. Effective 6/7/2018, the Center Director Human Services, and/or employee dis supervisor and/or designated staff member will conduct interviews for eacurrent employee at least once a year. The interview will be intended to determine the employee understanding the Center Abuse policies and Procedures. The interview process wis incorporated to the annual employee evaluating. Any staff member not interviewed by the anniversary date word to work until educated. Effective 6/7/2018, interviews for alert oriented residents will be completed by the Director of Social Services, Direct Recreational Services and/or designal staff member at least once every more identify any allegation of Abuse and/or Neglect. This interview will be documented on the psychosocial assessment tool. Any voiced allegation abuse, and/or neglect will be reported the Center Executive Director promption Alleged perpetrators will be suspended pending investigation by the facility, a	orking I tive r of ect ch ill be fill and y or of ted th to r n of to y. d	

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F 867	Continued From page	e 157	F8	reported according to the regulator requirements. The Director of Social services, Ast Director of Nursing, Unit manager Admission Director and Director on Rehabilitation Services will interview responsible parties for residents who not able to answer questions during interview due to mental capacity deffective 6/7/18. This interview will documented on the psychosocial assessment tool. Any voiced allege abuse, and/or neglect will be reported the Center Executive Director profective profective Director profective decording to the regulator requirements. Effective 6/7/2018 a copy of any reprotective orders received on admor readmission by the admission or designated person during the admission process, will be placed medical file under the advance directly the nursing staff. Effective 6/7/2018; received protectly the nursing supervisor and nursing aireguide for accessibility by both licently supervised visits, no visitation, or allowed on the premises such measure will be added to resident's face shappropriate information posted surthe perpetrator picture and/or descinal readily accessible location in the readily ac	esistant few the cho are ng the eficit be ation of rted to mptly. nded y, and ry esident's ission lirector in the estive essibility ctive care rde care nse tective not assures eet and ch as cription	

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F 867	Continued From page	e 158	F	facility. Facility D Assistant manager on the loc each resi location of protect th This educ be taken adding th to resider care guid nurses ar as super allowed of covered i will also of such info resident's informatic perpetrat be a reac facility. This educ licensed include for licensed be compl not educa allowed t education hire orier licensed effective provided Effective administr	Director of Nursing (DON), at Director of Nursing and/or Ursing the Director of Nursing and/or Ursing and/or Ursing the Director of Protective orders in ident's medical charts and the of intervention necessary to the resident with protective orderation will also cover process if the protective order intervention the protective order intervention the protective order intervention of the protective order intervention on the premises will also be in this education. The education of the protective on the process that the protective on the process that the protective and propriate on posted such as the corpicture and/or description to dilly accessible location in the coation will be provided for all nurses, nursing assistant to all time, part time and as need nursing staff. This education will time, part time and as need nursing staff. This education will educated. This in will also be added on the neutation process for all new nurses and nursing aides 6/7/2018, and will also be annually. 6/7/2018, the center nursing rative team, which includes DO opervisors, Unit Managers, and opervisors, Unit Managers, and opervisors, Unit Managers, and opervisors, Unit Managers, and opervisors.	ers. to de ns ide nse ch ot on t O	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345213	B. WING _			06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, Z			
				1995 EAST CORNELIUS HARNET	T BOULEVARD		
UNIVERS	AL HEALTH CARE LI	LLINGTON		LILLINGTON, NC 27546			
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F 867	Continued From p	page 159	F	SDC, added reviewing or orders to an existing proclinical documentation for hours, which includes consessments, incident reconsessments, incident reconsession and Physician the last 24 hours. By add DSS protective orders to will ensure that any reside history of allegation of an and/or injuries of unknown appropriate measures in the resident from the allest effective 6/7/2018. This place daily Monday through effective 6/7/2018. The systemic process will be the clinical meeting form "Daily Clinical meeting be Effective 6/7/2018, the vertical documentation for hours, completed skin an incident reports for the last Physician orders written hours to ensure that any abuse, neglect and/or in sources reported/documinvestigated thoroughly, perpetrator is suspended investigation, and ensure reported to the facility Ethis process will also increviewing of any DSS prensure the facility put meto address such orders. Process will take place of and Sunday. Any negations are such contents.	cress of reviewing or the last 24 completed skin eports for the last orders written in ding the review of this process, it dent with prior buse, neglect, who sources has a place to protect eged perpetrator, process with take ugh Fridays result of this documented on a maintained in the binder." I week end visor and/or se will review or the last 24 sessments, ast 24 hours, and in the last 24 viallegation of juries of unknown mented is the alleged dipending the the event is executive Director. Corporate or otective orders to deasures in place This systemic every Saturday		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546		
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F 867	Continued From page	e 160	F	867			
					documented on the week end supervis	or	
					report form and maintained in the daily		
					clinical meeting binder, effective 6/7/20)18.	
					Effective 6/7/2018 the Admission Direct	tor	
					(AD) will print any protective order for a	-	
					referral to the facility before bed is offe	red.	
					The AD will then provide copies of the		
					protective order to the facility Executive		
					Director, Director of Nursing, Director of social services and/or designated licen		
					nurse. The IDT team will then review a		
					referrals with DSS protective orders pri		
					to admitting resident to the facility to	O.	
					ensure measures are put in place to		
					protect the resident when admitted to t	he	
					facility.		
					Effective 6/7/2018 the facility Executive	÷	
					Director, Director of Nursing, and/or		
					Director of social services will discuss		
					new admits and re-admits to the facility	<i>!</i>	
					during their daily department head		
					meeting to validate that any admitted o		
					readmitted resident with protective orders has measures in place to protect the	515	
					resident against the alleged perpetrato	rs	
					Effective 6/7/2018 any alleged perpetra		
					with restraining orders for visitation will		
					be allowed to visit the facility. All the		
					facility exit doors are locked and can or	nly	
					be accessed using an approved card.		
					Visitors will utilize the facility main		
					entrance to enter the premises, effective		
					6/7/18. All the facility exit doors are loc		
					using a magnetized lock that releases	/T1	
					case of fire. In case of any other	or	
					emergency, each locked facility exit do		
					is equipped with an emergency release override switch located beside each ex		
					door to allow the door to demagnetize		
					assi to allow the aboli to definagiletize	J. 10	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(>	(3) DATE SURVEY COMPLETED
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NAME OF D	DOVIDED OD SUDDUED	343213		STREET ADDRESS, CITY, STATE, ZIP CODE		06/08/2018
NAME OF P	ROVIDER OR SUPPLIER					
UNIVERS	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BOUL	EVARD	
				LILLINGTON, NC 27546		
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F 867	Continued From page	e 161	F8	open from the inside. The maging system is also equipped with a override switch located at each station. This is in compliance we Carolina life safety code. Signs posted on all exit doors to direct the main entrance, effective 6/7 Facility Executive Director, Direct Nursing (DON), Assistant Direct Nursing and/or Director of Social will complete 100% re-education location of protective orders in cresident's medical charts and the importance of implementing appetro ensure the resident's protect facility abuse prohibition processeducation will be provided for a nurses, to include full time, part as needed licensed nursing stateducation will be completed by Any employee not educated by will not be allowed to work until This education will also be addense hire orientation process for licensed nurses effective 6/7/20 will also be provided annually. F610: Effective 7/10/2018, Facility will investigate any injury of unknown immediately but not later than the after the injury being noted to the Executive Director and to other officials including the State Surand to the Adult Protective Servaccordance with State law. Effective 7/10/2018, the center administrative team, which included ADON, Unit Manager, Nurse surand to Managers, and/or SDC will managers, and/or SDC will	master in nurse's inth North is have bee ct visitors to 7/18. ector of ctor of al Service on on the each ne proaches ion, per ss. This ill licensed t time and off. This 6/7/2018. deducated ed on the r all new 018, and I thorough wn source wo hours he facility state vey Agency vices in the nursing udes DON upervisors	to ss

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(>	(3) DATE SURVEY COMPLETED
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT E	BOULEVARD	
				LILLINGTON, NC 27546		
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F 867	Continued From pag	e 162	F8		completed skir incident reports has a known he proper d investigating acility Abuse is process of ded on an ing clinical 24 hours, skin orts for the last ders written incess will take he Fridays esult of this ocumented on anintained in the er. eek end for and/or will review in completed skir incident reports has a known he proper d investigating acility Abuse is process of ded on an ing clinical 24 hours, skin orts for the last ders written in the last ders written in	t e n t
				will take place every Saturo Sunday. Any negative findi documented on the week of	ings will be	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED
		345213	B. WING			С
		345213	B. WING _			06/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BOULE	EVARD	
0				LILLINGTON, NC 27546		
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F 867	Continued From page	e 163	F8	report form and maintained in the clinical meeting binder, effective 7/10/2018. Chief Clinical officer completed education on through investigation injury of unknown sources to the Executive Director, Director of Nand Director of Social Services of 7/2/2018. This re-education emponents and employer of unknown source persolution and process of the executive Director of Social Services of Nand Social Services of Injury of unknown source persolution will also be added hires orientation process for all and Executive Director, Director of Nand Social Services Director of Social Services Director of Nand Social Services Director of Nand Social Services Director of Nand Social Services Director of Nursing (ADON) and Development Coordinator (SDC complete 100% re-education on facility sabuse/neglect policy are procedures including notification protocols, and investigation procedures including notification protocols, and investigation procedures tate officials including the Survey Agency and to the Adult Services in the accordance with This education will be provided the employees, to include full time, and as needed staff. This education be completed by 7/10/2018. Any employee not educated by 7/10/2018. Any employee not educated by 7/10/2018. Any employee not educated by 7/10/2018.	an ion of e facility Aursing on phasized ghly se, negle the facility ed on new Aursing fective rided stant d/or Staff c) will a the ad new Aursing source wo hours and to e State Protective rided stant do not be state and to e State part time ation will y /2018 will	ect ity w

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UNIVERSA	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOULEVARD	
				LILLINGTON, NC 27546	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.
F 867	Continued From pag	<u>'</u>	F 86	DEFICIENCY)	ew II Luct plan cted he she f any e or tive of f the sis g, his t duct
				and consulting company to ensure tha	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			1995 EAST CORNELIUS HARNETT BOULEVARD	
UNIVERS	AL HEALTH CARE LILL	INGTON		LILLINGTON, NC 27546	
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F 867	Continued From page	ge 165	F 86	the facility systematically identify and address areas that needs performance improvement to assure the facility maintain and retain substantial compliance. This will take place for the next twelve months or until the facility shows the pattern of compliance. Effective 6/7/2018, Executive Director or Director of Social Services will revial alleged violation to ensure a thorous investigation is completed and reported the state agency and other officials as required by regulation and/or Elder Ju Act. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on abuse prohibition tool and filed in daily meeting binder after proper follow ups are don This monitoring process will take placed daily to include Saturdays and Sunda for 2 weeks, weekly x 2 more weeks, monthly x 3 months or until the pattern compliance is maintained. Effective 6/7/2018, the facility will con a quality assurance and performance improvement meeting monthly with an agent from the contracted management and consulting company that oversee company to ensure that the facility systematically identify and address and related to resident's abuse and neglect and ensuring the abuse policies and procedures is implemented. This will the place for the next twelve months or untile facility shows the pattern of compliance. Effective 6/7/2018, Director of Nursing Assistant Director of Nursing, and/or states.	e and ew ugh ed to sastice g e ng e e ys then n of duct n nt s the eas ct ake ntil

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
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UNIVERSA	AL HEALTH CARE LILLII	NGTON		1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	JULEVARD	
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F 867	Continued From page	e 166	F 8	Development Coordinator, we compliance with resident profacility abuse prohibition profacility abuse prohibition profunds investigation, injurised unknown sources and reside conducting clinical meeting and meeting will allow the team allegation of abuse, incident that occurred from the prior meeting. Any DSS protective any documented information suspicion of abuse will be referensure measures are in place the resident. Any issues identify in the resident of a daily of form and filed in the clinical binder after proper follow up monitoring process will take the 4weeks, weekly x 2 more we monthly x 3 months or until the compliance is maintained. Effective 6/7/2018, Director report findings of this monitor to the facility Quality Assural Performance Improvement of this plan monthly x 3 monthe pattern of compliance is The QAPI committee can measure the facility remains substantial compliance. F610: Effective 7/10/2018, Director cand/or Staff Development Comonitor compliance with inverse porting of injuries of unknown by conducting clinical meeting between the setting of the pattern of compliance with inverse porting of injuries of unknown by conducting clinical meeting between the setting of the pattern of compliance with inverse porting of injuries of unknown by conducting clinical meeting between the setting of the pattern of compliance with inverse porting of injuries of unknown by conducting clinical meeting between the setting clinical meeting the province with inverse porting of injuries of unknown by conducting clinical meeting between the setting clinical meeting the province with inverse porting of injuries of unknown by conducting clinical meeting between the setting the province with inverse porting of injuries of unknown by conducting clinical meeting the province with inverse porting of injuries of unknown by conducting clinical meeting the province with inverse porting of injuries of unknown by conducting clinical meeting the province with inverse the facility province with inverse the facility provin	otection, per ocess, lies of ent neglect daily. This to review all is or accide clinical erorders and that indical eviewed to be addressed meeting willinical report meeting or is done. The place daily eeks, then the pattern of Nursing process nee and Committee modification of this, or until maintained odify this plas in Director of of Nursing, oordinator, estigation are own sources of the power of the power of the pattern	by II Ints Id ate et ing ed iiII it this for of will ss for on I d. Ian will and s

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NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLII	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
				L	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	e 167	F	867	This meeting will allow the team to reverse the daily clinical meeting checklist to ensure completion and proper follow through, incidents or accidents occurre from the prior clinical meeting to ensure any injury of unknown source was note investigated and reported per abuse policy. The nursing administrative team will also review completion of skin assessments from prior day and ensure any documented injury of unknown sour was followed through per policy. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report for and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or untit the pattern of compliance is maintained. RESPONSIBLE PARTY Effective 7/10/2018, the center Execution Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction to ensure the facility attain and maintain substantial compliance, and prevent repeat deficiencies.	d e e d n in e urce orm d f.	