PRINTED: 03/16/2022 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345213	B. WING _			C <b>02/04/2022</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O		02/04/2022
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546	JOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	
E 000	Initial Comments		E 0	000		
F 000	investigation survey v 01/30/2022 through 0 found in compliance v	n2/04/2022. The facility was with the requirement CFR Preparedness. Event ID #	FO	000		
	survey was conducte 02/04/2022. 2 of 10 complaint alle resulting in deficienci Care was identified a	complaint investigation d from 01/30/2022 through gations were substantiated es. Substandard Quality of t:				
F 550 SS=D	self-determination, ar access to persons an	cise of Rights (2)(b)(1)(2)  Rights. ght to a dignified existence, and communication with and	F 5	550		3/15/22
ABODATORY	with respect and dign resident in a manner promotes maintenand her quality of life, rec- individuality. The faci promote the rights of	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and		TITLE		(X6) DATE

Electronically Signed 02/28/2022

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345213	B. WING _		C <b>02/04/2022</b>
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION
F 550	§483.10(a)(2) The faraccess to quality care severity of condition, must establish and material provision of services residents regardless.  §483.10(b) Exercise The resident has the rights as a resident or resident of the United Services and the services interference, coercion from the facility.  §483.10(b)(1) The faractic from the facility.  §483.10(b)(2) The refree of interference, coercion from the facility.  §483.10(b)(2) The refree of interference, coercion from the facility.  §483.10(b)(1) The refree of interference, coercion from the facility.  §483.10(b)(1) The refree of interference, coercion from the facility.  From the facility and to be supplexered on record revinterviews the facility for 1 of 1 resident (Reexpressed she felt ignowerless.  The findings included Resident #110 was a diagnoses that included diabetes mellitus and	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.  of Rights. right to exercise his or her f the facility and as a citizen ted States.  cility must ensure that the his or her rights without an discrimination, or reprisal esident has the right to be soercion, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this is not met as evidenced eiew and resident and staff failed to answer the call light esident #110). The resident mored, disrespected and	F 5	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this procession or agreement by the provide truth of the facts or alleged or the correctioness of the conclusions set from the statement of deficiencies. The of correction is prepared and submit solely because of the requirement u state and federal law, and to demont the good faith attempts by the provide provide/improve the quality of life of	olan of ider of e orth e plan ted nder strate der to

Facility ID: 943230

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		' IDENTIFICATION NUMBER: '		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING				0.4/2022	
NAME OF DE	ROVIDER OR SUPPLIER	343213	5: 11::10	- C	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2022	
NAIVIE OF FI	NOVIDER OR SUFFLIER							
UNIVERSA	AL HEALTH CARE LILLI	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD			
					ILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 550	Continued From page	e 2	F 5	550				
		sident #110 required staff			resident.			
	assistance for all act			resident.				
	assistance for all act	aviacs of daily living.			F550			
	Resident #110's mos	t recent Minimum Data Set			IMMEDIATE ACTION:			
	(MDS) assessment d			Nurse aide #3 entered resident room a	nd			
	, ,	I she was cognitively intact			provided care to resident #110 on			
	with no behaviors. Sh			1/30/2022 at 3.50pm. Resident #110				
	assistance with bed r			needs were met.				
	dressing, and person			Nurse #4 turned the tone "back on" on				
		ent for transfers and toilet			call bell monitoring system located at the	ne		
		sed as always incontinent of			nurse's station #2 (the station with			
	bowel and bladder.				resident #110 room) on 1/30/2022 whe			
	O 4/00/00 -+ 0-40 D	M. D: J #440			realized the sound was turned off on th	e l		
		M, Resident #110 was			system and could hear the call bell afterward.			
	interviewed. During the	d she was wet and needed			aiterward.			
		o one had responded to her			IDENTIFICATION OF OTHERS:			
	_	ed she felt ignored and			100% inspection of call bell monitoring			
		ent #110 indicated she felt			system in the facility were completed b			
		uests for assistance made			the Director of Nursing on February 22			
		he reported her call light had			2022, to identify any other system with			
		eceiving her lunch tray but			low/no volume. It was noted that the			
	was unaware of the t	ime. Resident #110 stated			sound of nurse's station #1 and nurses	, <b>,</b>		
	her call light was free	quently not answered but			station #2 were turned on and audible	on		
	was not able to give	additional specifics.			February 22, 2022. Findings of this			
					inspection is documented on a call sys			
		ation was conducted on			monitoring audit tool located in the faci	lity		
		/I until 3:44 PM and no staff			compliance binder.			
		10's room. Her call light was			4000/ 10 6			
	•	om the hallway staff could be			100% audit of current resident clinical	h -		
	observed sitting at th	e nurse's station.			documentation, and grievance log for the last 2 weeks was completed by Director			
	Nurse #4 was interviewed on 1/30/22 at 3:45 PM.				Nursing on February 22, 2022, to ident			
		nurse's station with Resident			any issues with call bells not being	ıı y		
	_	e of vision. He stated he did			answered in a timely manner. No other			
		and was unaware Resident			issues identified during this audit. Findi			
	#110 had pressed he				of this audit is documented on a "a call			
		·· <del>·o</del> ·····			bell audit tool" located in the facility			
	Nurse #4 was observ	ed entering Resident #110's			compliance binder.			

	DF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED		
		345213	B. WING _			C <b>02/04/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LININ/EDO	AL HEALTH CARELINA	ICTON		1995 EAST CORNELIUS HARNETT BOULI	EVARD	
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	DATE
F 550	station he stated Res assistance was needed An interview was con with Nurse #4 on 1/30 Nurse #4 misundersto be changed.	7 PM, upon his return to the nursing tated Resident #110 denied any was needed.  Was needed.  Was conducted with Resident #110 was contacted by the Corporate Plar operation consultant. The licensed wis came on site on February 22, 2022, the contracted vendor who deals with the call bell so was contacted by the Corporate Plar operation consultant. The licensed with the call bell so was contacted by the Corporate Plar operation consultant. The licensed was came on site on February 22, 2022, the contracted vendor who deals with the call bell so was contacted by the Corporate Plar operation consultant. The licensed vendor was consultant.			bell syste e Plant sed vend 022, and n all the nis	lor
	#110's room at 3:55 F  During an interview w 1/31/22 at 9:00 AM sl when NA #3 entered s 2/4/22 at 2:55 PM, the her expectation was f answered as soon as were sitting at the nur	of M.  with Resident #110 on the stated she was changed the room as observed. On the Director of Nursing stated		remains on at all times.  Effective March 8, 2022, the fact treat each resident with respect dignity through answering call be timely manner, and the call belt system will be audible at all time manufacturer's specification.  100% education of all current eto include full time, part time, ar needed employees completed be Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #1, emphasis of this education inclusional to the importance of call bells in a timely manner, an each residents' needs, ensuring bell monitoring system is audible ensure each resident is treated dignity and respect. This education place of the importance of completed by March 15, 2022. It is educated. This education has be on new hire orientation for all needs effective March 8, 2022.	cility will t and bells in a monitori es per mployees nd as by the Director of , #2) 2). The udes, but answerir nticipating g the call le, and with ation will Any ch 15, rk until been adde	s f t ng d

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			CONSTRUCTION	(X3) DATE COMP	SURVEY		
		345213	B. WING				C (0.4/2022
NAME OF D	DOVIDED OD CUDDUED	040210	1 2	CT	DEET ADDRESS OITY STATE ZID CODE	02/	04/2022
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE LILLII	NGTON			95 EAST CORNELIUS HARNETT BOULEVARD LLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	4	F	550	Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) will complete call bell monitoring to ensure employees are answering call bells in a timely manner anticipating each residents' needs, and ensuring that each resident is treated vignity and respect. This monitoring process will be accomplished by interviewing five residents daily for two weeks, weekly for two more weeks, the monthly for three months, or until the pattern of compliance is established.  Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) will complete call bell monitoring to ensure the call bell monitoring system is audible. This monitoring system is audible. This monitoring process will be accomplished by inspecting the call bell monitoring station at each nurse's station to ensure the volume is audible daily for two wee weekly for two more weeks, then mont for three months, or until the pattern of compliance is established.  Effective March 15, 2022, the Director Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Qualit Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications monthly for three months, or until the pattern of compliance is achieved established.	re f vith en f l ed eks, hly	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(	2
		345213	B. WING _			02/	04/2022
	ROVIDER OR SUPPLIER  AL HEALTH CARE LILLII	NGTON		19	TREET ADDRESS, CITY, STATE, ZIP CODE 195 EAST CORNELIUS HARNETT BOULEVARD 11LLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 550	Continued From page	e 5	F	550	RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attain and maintain substantial compliance.	I	
F 558 SS=D	CFR(s): 483.10(e)(3)  §483.10(e)(3) The rig services in the facility accommodation of re preferences except we endanger the health of other residents.	tht to reside and receive with reasonable sident needs and	F	558			3/15/22
	Based on observation review, the facility fail water cup in reach to fluids as desired for of for accommodation of the findings included Resident #112 was a 4/29/21 with diagnost weakness, unsteadin language disorder the communicate).  The quarterly Minimulassessment dated 11 112's cognition was shad no behaviors and	dmitted to the facility on es that included muscle ess of feet and aphasia (a at affects a person's ability to			IMMEDIATE ACTION: Unit coordinator #1 moved the water pitcher and placed it within resident #1 reach on 2/3/2022.  IDENTIFICATION OF OTHERS: 100% inspection of current residents w water Pitchers/cups in the facility was completed by the Director of Nursing, UManager #1, and/or Unit Manager #2 of February 23, 2022, to identify any othe Pitchers/cups in the facility not within residents' reach. It was noted that all of residents with water pitcher/cup were within their reach on February 23, 2022 Findings of this inspection is document on a "water pitcher audit tool" located in the facility compliance binder.	ith  Jnit n r ther	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						С	
		345213	B. WING _	<del></del>	02	2/04/2022	
NAME OF P	ROVIDER OR SUPPLIER	-		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 CO	ORRECTION	(X5)	
PREFIX 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 558	Continued From page 6		F 5	58			
	transfers. locomot	ion on/off unit, dressing, eating,					
		hygiene, and bathing.		100% audit of current reside	nt clinical		
	0.1	, ,		documentation, and grievand	ce log for the		
	An observation wa	as conducted on 1/30/22 at 3:28		last 2 weeks was completed	by Director of		
	PM. Resident #11	2 was lying on her back in her		Nursing on February 23, 202	22, to identify		
		cup was observed to be in the		any documented concerns re			
		ner reach. Resident #112 was		routinely used items not bein	•		
	unable to be inter	viewed.		resident's reach. No other is:			
				identified during this audit. F			
		as conducted of Resident #112		audit is documented on a "ar			
		AM. She was observed lying		accommodation of needs au			
· ·		located in the facility complia	ance binder.				
	reach.	roximately five feet out of her		SYSTEMIC CHANGES:			
	Teach.			Effective March 8, 2022, the	facility will		
	During an observa	ation on 2/2/22 at 8:34 AM		ensure each resident receive	-		
		s observed eating breakfast.		the facility with reasonable	3 331 11000 111		
		d feeding herself and drinking		accommodation of resident r	needs and		
		ay. Her water cup was		preferences to include keepi	ng the water		
		indowsill out of her reach.		pitchers/cups within their rea			
				appropriate.			
	An interview with	conducted with Nursing					
	1 ' '	on 2/3/22 at 10:53 AM. She		100% education of all curren			
		familiar with Resident #112.		to include full time, part time			
		ent #112's water cup should be		needed employees complete			
		e would be able to get water as		Director of Nursing, Assistan			
		ated Resident #112 was able to		Nursing, MDS coordinators (			
	drink unassisted.			and/or Unit Coordinators (#1	. ,		
	An interview was	conducted with the Unit		emphasis of this education in not limited to, the importance			
		2 at 11:00 AM regarding		each resident receive service	•		
		vater cup not being placed within		facility with reasonable accord			
		ated resident water pitchers		resident needs and preferen			
	should always be	•		keeping the water pitchers/ci			
				their reach as appropriate. T	•		
	During an intervie	w with the Director of Nursing		will be completed by March			
		ed residents should always be		employee not educated by M	•		
	able to access the	eir water cups . She further		2022, will not be allowed to v			
	stated water cups	should not be placed out of a		educated. This education wil	ll be added to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING		(X3) DATE SURVEY COMPLETED					
		345213	B. WING _				04/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOUL		<u>  021</u>	U4/2U22
(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 BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page resident's reach.	e 7	F	558	new hire orientation for all new hires effective March 8, 2022.  MONITORING PROCESS: Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2) will complete accommodation of needs monitoring process. This monitoring process will b accomplished by observing residents to ensure employees are providing service in the facility with reasonable accommodation of resident needs and preferences to include keeping the water pitchers/cups within their reach as appropriate. The monitoring process wiinclude five residents daily for two weel weekly for two more weeks, then month for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Direct of nursing promptly. This monitoring process will be documented on an "accommodation of needs monitoring to located in the facility compliance binder Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Qualit Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive	e o es er ill ks, hly e tor ool" r.	

		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			1	04/2022	
	ROVIDER OR SUPPLIER	IGTON		19	REET ADDRESS, CITY, STATE, ZIP CODE 195 EAST CORNELIUS HARNETT BOULEVARD LLINGTON, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 558	Continued From page	e 8	F s	558	Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correctio and ensure that the facility attains and maintains substantial compliance.			
F 570 SS=C	The facility must pure otherwise provide ass Secretary, to assure t funds of residents del This REQUIREMENT		F	570			3/15/22	
	facility failed to have a greater than the balar account. This deficier to affect 118 of 118 re home.  Findings included:  During an interview w Manager (BOM) on 2 the amount in the res \$167, 234.70. She s surety bond was \$150 was unaware the sure or greater than the an account. She further had been some discuincreasing the surety anything about the an increase.	ith the Business Office /4/22 at 1:09 PM she stated idents' fund account was tated the amount of the 0,000. The BOM stated she ety bond needed to be equal mount in the residents' funds stated she believed there ssion by the Administrator of bond but had not heard			IMMEDIATE ACTION: No resident was named in this alleged noncompliance. Business Office Manager notified the Eastern Regional Business Office Consultant of the needed Surety Bond increase on February 03, 2022 On February 14, 2022, the facility received a copy of the surety bond that assure the security of up to \$190,000 call personal funds of residents deposite with the facility. The bond was signed of February 11,2022 with an effective date November 01, 2021.  IDENTIFICATION OF OTHERS: 100% audit of residents' personal funds deposited with the facility was complete by the business office manager on February 23, 2022, to identify if the total amount in the resident's fund account exceeds the surety bond amount	of ed on e of s ed		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRU		(X3) DATE SURVEY COMPLETED				
	345213	B. WING			l	0 <b>4/2022</b>
ROVIDER OR SUPPLIER	0.02.0			TREET ADDRESS CITY STATE ZIP CODE	02/	04/2022
AL HEALTH CARE LILLII	NGTON					
OUR MARRY OF	ATTIMENT OF PERIORNALES		_	<u> </u>		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		×	(EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
Continued From page	e 9	F 5	570			
An interview with the conducted on 2/4/22 the facility had reques	Administrator was at 4:15 PM which he stated sted an increase in the			in resident fund account did not exceed the surety bond that assure the security all personal funds of residents deposite with the facility.  SYSTEMIC CHANGES: Effective February 23, 2022, Business office manager will notify the facility	d y of ed	
				Office Consultant if/when the resident trust account gets within \$5,000 of the surety Bond and secure an increase of the Surety Bond (when applicable) to a amount sufficient to assure the security	in of	
				emphasis of this education includes the importance of ensuring that surety bon assures the security of all personal fun of residents deposited with the facility at the importance of communicating with regional business office manager when the resident trust amount is within \$500 of the surety bond. This education is added on new hire orientation for any resulting business office manager and new Administrator effective February 24, 20 MONITORING PROCESS:  Effective February 23, 2022, Business office Manager will complete monitoring	e d ds and the n 00 new 022.	
	ROVIDER OR SUPPLIER  AL HEALTH CARE LILLII  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From page which revealed the fa increasing the bond a  An interview with the conducted on 2/4/22 the facility had reques	CORRECTION IDENTIFICATION NUMBER:	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 9  which revealed the facility was working towards increasing the bond amount.  An interview with the Administrator was conducted on 2/4/22 at 4:15 PM which he stated the facility had requested an increase in the	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9  which revealed the facility was working towards increasing the bond amount.  An interview with the Administrator was conducted on 2/4/22 at 4:15 PM which he stated the facility had requested an increase in the	ROWIDER OR SUPPLIER  345213  B WIND  STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELINE HARRETT BOULEVARD LILLINGTON, NC 27548  SUMMARY STATEMENT OF DEPCIENCIES  (EACH DEPCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  Continued From page 9  which revealed the facility was working towards increasing the bond amount.  An interview with the Administrator was conducted on 2/4/22 at 4:15 PM which he stated the facility had requested an increase in the surety bond amount but it was not in place yet.  SYSTEMIC CHANGES: Effective February 23, 2022, Business office manager with the facility.  Regional Business Office Consultant if/when the resident trust account gets within \$5,000 of the surety Bond and secure an increase of the Surety Bond (when applicable) to a amount sufficient to assure the security all personal funds of residents deposite with the facility.  Regional Business Office Consultant provided an education to the facility the importance of ensuring that surety bon assures the security of all personal funds of residents deposite with the facility the importance of ensuring that surety bon assures the security of all personal funds of residents deposite with the facility the importance of communicating with regional business office manager and new Administrator effective February 24, 202. The surety bond. This education is added on new hire orientation for any the surety bond. This education is added on new hire orientation for any the surety bond. This education is added on new hire orientation for any the surety bond. This education is added on new hire orientation for any the surety bond. This education is added on new hire orientation for any the surety bond of the surety bond. This education is added on new hire orientation for any the surety bond. This education is added on new hire orientation for any the surety bond. This education is added on new hire orientation for any the surety bond. This education is added on new hire orientation for any the surety bond. This	A BUILDING  345213  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARRIETT BOULEVARD  LILLINGTON, NC 27546  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9  which revealed the facility was working towards increasing the bond amount.  An interview with the Administrator was conducted on 2/4/22 at 4:15 PM which he stated the facility had requested an increase in the surety bond amount but it was not in place yet.  F570  SYSTEMIC CHANGES: Effective February 23, 2022, Business office manager will notify the facility Administrator gets within \$5,000 of the surety Bond flow security of all personal funds of residents deposited with the facility.  Regional Business Office Consultant provided an education to the facility Business office manager and the Administrator or an amount sufficient to assure the security of all personal funds of residents deposited with the facility.  Regional Business Office Consultant provided an education to the facility Business office manager and the Administrator or February 24, 2022. The emphasis of this education includes the importance of ensuring that surety bond assures the security of all personal funds of residents deposited with the facility and the importance of communicating with the regional business office manager and the Administrator or February 24, 2022. The emphasis of this education includes the importance of communicating with the regional business office manager and new Administrator or february 24, 2022. Business office Manager with complete monitoring of resident trust account balance to ensure

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345213	B. WING _				04/2022
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2022
LINIVEDO	N. UEALTU CADE LULU	UCTON		19	95 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LI	LLINGTON, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 SS=D	CFR(s): 483.21(b)(1)  §483.21(b) Comprehe §483.21(b)(1) The faci implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The con describe the following	comprehensive Care Plan ensive Care Plans cility must develop and tensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fied in the comprehensive the prehensive care plan must		570 656	\$5000 of the surety bond. This monitor process will be done daily (Monday through Friday) for two weeks, weekly two weeks, then monthly for 3 months ountil a pattern of compliance is established.  Effective March 15, 2022, the Business office manager will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY:  Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	for or sis y , e I	3/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	040210	1	STREET ADDRESS, CITY, STATE, ZIP CO		2/04/2022	
IVAIVIL OF T	NOVIDEN ON OUT FEET			1995 EAST CORNELIUS HARNETT BO			
UNIVERS	AL HEALTH CARE LIL	LINGTON		LILLINGTON, NC 27546	OLL WILL		
(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 OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	physical, mental, ar required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS. rationale in the resident's represent (A) The resident's represent (A) The resident's putture discharge. Fawhether the resider community was asselical contact agency entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section.  This REQUIREMENT by:  Based on observatinterview, and recorded the page of th	dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6).  services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)-goals for admission and oreference and potential for acilities must document and's desire to return to the sessed and any referrals to ites and/or other appropriate pose.  Is in the comprehensive care es, in accordance with the rth in paragraph (c) of this NT is not met as evidenced ation, resident interview, stafferd review, the facility failed to ensive care plan for 2 of 2 for activities (Resident #371)	F	F656 IMMEDIATE ACTION: MDS coordinator #1 develop comprehensive person-cente care plan for resident #67 an #371 on 2/04/2022 that inclu measurable objectives, person preferences, and activities of	ered activity nd resident ndes onal		

NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON  (X4) ID PREFIX TAGK  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 656  Continued From page 12  The admission Minimum Data Set (MDS) assessment dated 1/27/22 indicated Resident #371's cognition was moderately impaired. He had no behaviors and no rejection of care.  A review of Resident #371's comprehensive care plan dated 1/30/22 did not include a care plan for activities.  During an interview with the Activities Assistant on 2/2/22 at 12:09 PM she stated she began her position as the Activities Assistant on 1/11/22.  SUMMARY STATEMENT OF DEFICIENCY  STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546  IDENTIFICATION OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 656  IDENTIFICATION OF OTHERS: 100% audit of current residents' care plans completed by MDS coordinator #1 and/or MDS coordinator #2 on February 28, 2022, to identify any other resident without an activity care plan No other residents identified without activity care plan durit is documented on a "care plan audit tool" located in the facility compliance binder.  SYSTEMIC CHANGES: Effective March 8, 2022, the facility will develop and implement a comprehensive	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON  (X4) ID PREFIX TAGK  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 656  Continued From page 12  1/20/22 with diagnoses that included hypertension and aphasia.  The admission Minimum Data Set (MDS) assessment dated 1/27/22 indicated Resident #371's cognition was moderately impaired. He had no behaviors and no rejection of care.  A review of Resident #371's comprehensive care plan dated 1/30/22 did not include a care plan for activities.  During an interview with the Activities Assistant on 2/2/22 at 12:09 PM she stated she began her position as the Activities Assistant on 1/11/22.  STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546  STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546  SUMMARY STATEMENT OF DEFICIENCY  DIPSETIX PROVIDERS PRECEDED BY FULL PREFIX TAG  PREFIX CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 656  IDENTIFICATION OF OTHERS:  100% audit of current residents' care plans completed by MDS coordinator #1 and/or MDS coordinator #2 on February 28, 2022, to identify any other resident without an activity care plan. No other residents identified without activity care plan during this audit. Findings of this audit is documented on a "care plan audit tool" located in the facility compliance binder.  SYSTEMIC CHANGES:  Effective March 8, 2022, the facility will develop and implement a comprehensive			345213	B. WING			C <b>02/04/2022</b>
CAJ ID   PREFIX   TAG   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PREFIX   TAG   PREFIX   PREFIX   PREFIX   TAG   PREFIX   PREFIX   PREFIX   PREFIX   PREFIX   TAG   PREFIX   PREFIX   PREFIX   TAG   PREFIX   PREFIX   PREFIX   PREFIX   PREFIX   TAG   PREFIX   PREFIX   TAG   PREFIX   TAG	NAME OF P	PROVIDER OR SUPPLIER	R OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			OLI O-II LOLL	
F 656  Continued From page 12  1/20/22 with diagnoses that included hypertension and aphasia.  The admission Minimum Data Set (MDS) assessment dated 1/27/22 indicated Resident #371's cognition was moderately impaired. He had no behaviors and no rejection of care.  A review of Resident #371's comprehensive care plan dated 1/30/22 did not include a care plan for activities.  During an interview with the Activities Assistant on 2/2/22 at 12:09 PM she stated she began her position as the Activities Assistant on 1/11/22.  F 656  IDENTIFICATION OF OTHERS:  100% audit of current residents' care plans completed by MDS coordinator #1 and/or MDS coordinator #2 on February 28, 2022, to identify any other resident without an activity care plan. No other residents identified without activity care plan during this audit. Findings of this audit is documented on a "care plan audit tool" located in the facility compliance binder.  SYSTEMIC CHANGES:  Effective March 8, 2022, the facility will develop and implement a comprehensive	UNIVERS	AL HEALTH CARE LILL	NGTON			LEVARD	
1/20/22 with diagnoses that included hypertension and aphasia.  IDENTIFICATION OF OTHERS: 100% audit of current residents' care plans completed by MDS coordinator #1 and/or MDS coordinator #2 on February 28, 2022, to identify any other resident without an activity care plan. No other residents identified without activity care plan during this audit. Findings of this audit added 1/30/22 did not include a care plan for activities.  During an interview with the Activities Assistant on 2/2/22 at 12:09 PM she stated she began her position as the Activities Assistant on 1/11/22.  IDENTIFICATION OF OTHERS: 100% audit of current residents' care plans completed by MDS coordinator #1 and/or MDS coordinator #2 on February 28, 2022, to identify any other resident without an activity care plan during this audit. Findings of this audit is documented on a "care plan audit tool" located in the facility compliance binder.  SYSTEMIC CHANGES: Effective March 8, 2022, the facility will develop and implement a comprehensive	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
She reported she was not doing any assessments or participating in any care planning meetings.  An interview was conducted with the Administrator on 2/2/22 at 12:15 PM he stated the facility had an interim Activities Director who worked in the Therapy Department.  An interview was conducted with the interim Activities Director on 2/2/22 at 12:35 PM who stated she is an Occupational Therapist who was approached by the Assistant Administrator regarding being the interim Activities Director. She stated she continued to have her same therapy caseload and did not consider herself the "director". The interim Activities Director stated the Activities Assistant was leading all the activities in the building. She further stated she was not participating in care plan meetings or conducting any assessments.  including a care plan for each resident including a care plan for activities will be activites will be activited he stated the following systemic changes.  Effective March 8,2022, the facility Executive Director will ensure the activity program, develop an activity care plan for each resident including a care plan for activities will be accomplished by implementing the following systemic changes.  Effective March 8,2022, the facility executive Director will ensure the activity program, develop an activity care plan for each resident, and revise the activity care plan as appropriate based on resident wishes and preferences.  Effective March 8,2022, MDS coordinator revise the activity care plan for each resident and revise the activity care plan for each resident and revise the activity care plan as appropriate based on resident and revise the activity care plan as appropriate based on resident wishes and preferences in the	F 656	1/20/22 with diagnose hypertension and aposition assessment dated 1, #371's cognition was had no behaviors and A review of Resident plan dated 1/30/22 diactivities.  During an interview of 2/2/22 at 12:09 PM is position as the Activities have assessments or part meetings.  An interview was con Administrator on 2/2/1 facility had an intering worked in the Therapy.  An interview was con Activities Director on stated she is an Occuproached by the Aregarding being the is She stated she contituted the Activities Assistant activities in the build was not participating	num Data Set (MDS) /27/22 indicated Resident moderately impaired. He d no rejection of care.  #371's comprehensive care id not include a care plan for  with the Activities Assistant on she stated she began her ties Assistant on 1/11/22. Is not doing any icipating in any care planning  Inducted with the /22 at 12:15 PM he stated the in Activities Director who by Department.  Inducted with the interim 2/2/22 at 12:35 PM who upational Therapist who was assistant Administrator interim Activities Director. Inducted to have her same d did not consider herself the in Activities Director stated int was leading all the ing. She further stated she in care plan meetings or	F 65	IDENTIFICATION OF OTHER 100% audit of current resident plans completed by MDS coordinator #2 or 28, 2022, to identify any other without an activity care plan. It residents identified without act plan during this audit. Finding audit is documented on a "car tool" located in the facility combinder.  SYSTEMIC CHANGES: Effective March 8, 2022, the fadevelop and implement a comindividualized care plan for eatincluding a care plan for activity development of a care plan for will be accomplished by imple following systemic changes.  Effective March 8,2022, the fadexecutive Director will ensure program is always directed by professional who will be response the activity program, activity care plan for each resirevise the activity care plan as based on resident wishes and preferences.  Effective March 8,2022, MDS #1 and/or MDS coordinator #2 responsible for developing an plan for each resident and revactivity care plan as appropria	ts' care rdinator #1 n February resident No other tivity care s of this re plan audit npliance  acility will nprehensive nch resident ties. The r Activities menting the acility the activity a qualified onsible to develop an ident, and a appropriate coordinator will be activity care rise the ate based on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	MULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
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		345213	B. WING _			02/	04/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LINIVEDO	NI HEALTH CARELINA	INICTON		19	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLI	ING I ON		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 656	had relayed the informesidents' likes and of Assistant.  An interview was contassistant on 2/4/22 at Resident #371 had purely bingo, and bowling. Some the room when these seemed to like them stated she had not down with Resident #371.  An interview was contadministrator on 2/4/2 the facility was in the Activities Director.  Resident #371 was used. Resident #371 wa	tivities portion of the ssessments. She stated she mation regarding the dislikes to the Activities at 11:54 AM who stated participated in coffee time, She stated he was already in a activities began, and he activities began, and he activities Assistant one any individual sessions and activities of hiring an admitted to the facility on a state obstructive pulmonary assessment dated 12/18/21 agnitively intact. She had no n of care.  It #67's comprehensive care and in part, "unable to be des due to bed rest". The care by individual activities.	F	356	On February 28, 2022, Regional Direct of operation re-educated the facility Executive Director on the regulatory requirement related to Activity program This education included the importance ensuring the activity program is always by a qualified professional who will be responsible for development and revision of care plans. This education is will also be added to new hire orientation for any new Executive Director at the facility effective March 8, 2022.  Education will be provided to the interinal Activity director, MDS coordinator #1 and/or MDS coordinator #2 by the facility executive Director. The emphasis of the education includes, but not limited to ensuring that the activity program is always directed by a qualified professional, developing an activity care plan for each resident, and revising the activity care plan as appropriate based resident wishes and preferences. This education will be completed by March 2022, any employee not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all new hires effective March 8, 2022.  MONITORING PROCESS: Effective March 8, 2022, MDS coordinators #1, and/or MDS Coordinat#2 will complete a monitoring process to	e of led on or y is e on 15, w		
	Interventions include	d: schedule individual ly and create an activity plan			ensure each resident has an activity ca plan developed and revised and ensuri that each activity care plan is person-centered with measurable goals	re ng		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345213	B. WING			02/	04/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WAWL OF T	TO VIDER OR GOLT EIER							
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F 656	2/2/22 at 12:09 PM st position as the Activitical She reported she was assessments or particular meetings. She reported aily and visited other. The Activities Assistant schedule for individual she had met with Restlet her do her nails. The believed Resident family would bring he she was unaware of Finterests.  An interview was conconced on 2/2/22 at 12:52 PM comprehensive care president-specific and activity preferences. An observation was component was conconced on 2/4/22 at 11:35 AM. Statistant has come to approximately three was room, she had not see	with the Activities Assistant on the stated she began her ties Assistant on 1/11/22. It is not doing any cipating in any care planning ted she did group activities in residents as she had time. In the stated she did not have a sal sessions. She reported sident #67 and the resident the Activities Assistant stated to the Activities Assistant stated at #67 liked to read and her in books. She further stated Resident #67's other ducted with MDS Nurse #2 M who stated Resident #67's colan should be include Resident #67's conducted on 2/3/22 at 3:23 sistant was observed with boom sitting having a ducted with Resident #67 on the reported the Activities to her room weekly for weeks. Resident #67 stated Assistant coming to her en anyone from the Resident #67 stated she Resident #67 stated she	F	656	This monitoring process will be accomplished by reviewing care plan for all completed Omnibus Budget Reconciliation Act (OBRA) MDS assessment to ensure Activity Care platis included. This will be done daily (Monday to Friday) for two weeks, weet for two more weeks, then monthly for three months, or until the pattern of compliance is established.  Effective March 15, 2022, Interim Activ Director, Activity Director, MDS coordinators #1, and/or MDS Coordinators #2 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendatio and/or modifications, monthly for three months, or until the pattern of compliant is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executiv Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	n kly ity tor le e ns		
	_	rith the Administrator on ostated the facility was in an Activities Director.						

Facility ID: 943230

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		PLETED
		345213	B. WING _			l	C <b>04/2022</b>
	ROVIDER OR SUPPLIER	NGTON		19	TREET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546	, <u>v</u> =.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679 F 679 SS=D	Continued From page Activities Meet Intere CFR(s): 483.24(c)(1)	st/Needs Each Resident		679 679			3/15/22
	the comprehensive a and the preferences program to support reactivities, both facility individual activities at designed to meet the physical, mental, and each resident, encourand interaction in the This REQUIREMENT by:  Based on observation interviews, and recomprovide an ongoing reprogram based on idinterests for 1 of 1 re (Resident #67).  The findings included Resident #67 was ad 2/6/20 with diagnose mellitus and chronic of disease.  Her quarterly MDS as revealed she was conbehaviors or rejection.  Resident #67's annual 8/9/21 revealed her anoted to be very imposite the program to suppose the program of the program of the program is a suppose the program of the program	cility must provide, based on ssessment and care plan of each resident, an ongoing esidents in their choice of responsored group and and independent activities, interests of and support the psychosocial well-being of raging both independence community.  To is not met as evidenced ons, family member and staffed review, the facility failed to esident centered activities entified resident's individual sident reviewed for activities.  It:  Imitted to the facility on so that included diabetes obstructive pulmonary			F679 IMMEDIATE ACTION: MDS coordinator #1 developed/revised comprehensive person-centered activit care plan for resident #67 to includes measurable objectives, personal preferences, and activities of choice.  IDENTIFICATION OF OTHERS: 100% interview for all current residents the facility completed by MDS coordina #1, MDS coordinator #2, and/or Activity assistant on February 28, 2022, to iden preferences of each resident to ensure ongoing activity program support each resident in their choice of activities to include one on one activity in residents room. Findings of this audit was used to revise each resident activity program and/or activity care plan completed on February 28, 2022. Findings of this audit documented on a "care plan audit to located in the facility compliance binder	in tor / htify an , o	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	l ` ′	PLE CONSTRUCTION  G		E SURVEY MPLETED
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NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
				1995 EAST CORNELIUS HARNETT B	OULEVARD	
UNIVERSA	AL HEALTH CARE LI	LLINGTON		LILLINGTON, NC 27546		
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F 679	Continued From p	age 16	F 67	79		
	plan dated 12/7/2: participate in activities in room of around resident's  During an interview 2/2/22 at 12:09 PM Activities Assistant did group activities residents as she in Assistant stated si #67's room and sh want to be bothere with Resident #67 resident let her do	ent #67's comprehensive care 1 read in part, "unable to ities due to bed rest". The care joy individual activities." Ided schedule individual daily and create an activity plan preferences.  W with the Activities Assistant on M she reported she began as t on 1/11/22. She reported she is daily and visited other had time. The Activities he had stopped by Resident he felt like Resident #67 did not led. She reported she had met on one occasion and the her nails. She further stated of Resident #67's activity		100% interview for all curre family members for those reare rarely/never understood MDS coordinator #1, MDS and/or Activity assistant on 2022, to identify preference resident to ensure an ongoi program support each residence of activities to includactivity in residents' room.  On February 28,2022, empwith the resident were interfamily member or significan available for interview for the who are rarely/never undersidentify preferences of each ensure an ongoing activity support each resident in the activities to include one on residents' room.	esidents who I completed by coordinator #2, February 28, s of each ing activity Ident in their ie one on one Iloyees familiar viewed when a it other was not iose residents stood to in resident to program eir choice of	
	An observation was conducted on 2/3/22 at 3:23 PM. The Activities Assistant was observed with Resident #67 in her room sitting having a conversation.  An interview was conducted with Resident #67 on 2/4/22 at 11:35 AM. She stated the Activities Assistant has been coming by her room for approximately three weeks. She stated until the past three weeks she was not receiving individual activities in her room. Resident #67 stated she could not remember receiving individual activities in her room prior to the Activities Assistant's visits.  An interview was conducted with the Administrator on 2/4/22 at 4:15 PM who stated the Activities Assistant was new in her position			SYSTEMIC CHANGES: Effective March 8, 2022, the provides based on comprehassessment and care plant preferences of each resider program to support resident choice of activities, both factoric activities, both factoric activities independent. This will be actimplementing the following modifications: Effective March 8,2022, the Executive Director will ensure program is directed by the coprofessional at all times wheresponsible to oversee the program, develop activity care	nensive and the nt, an ongoing ts in their cility-sponsored es and ecomplished by systemic e facility are the activity qualified o will be activity	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION			3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		1 02/0	J-1/2022	
				1995 EAST CORNELIUS HARNETT BO	OULEVARD			
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F 679	79 Continued From page 17		F 6	579				
		ties Director worked as an		each resident, and provide/of activity program based on resident and preferences as indicated assessment.  Effective March 8, 2022, the to include activity director, in director, and activity aide will to each resident's activity as care plan maintained in each electronic medical records. Will provide activity program each resident's assessment plan.  Effective March 8,2022, MD #1 and/or MDS coordinators responsible to develop active for each resident and revise care plan as appropriate bas resident wishes and prefere absence of the Activity Director on the responsible to develop active Director on the responsible to activity Director on the responsible to activity Director on the responsible for development of care plan. This education added the ensuring the activity program qualified personnel at all tim responsible for development of care plan. This education added to new hire orientation executive Director at the fact March 8, 2022.  An education will be provided interim Activity director. To for this education includes, be activity Executive Director. To for this education includes, be activity Executive Director. To for this education includes, be activity Executive Director. To for this education includes, be activity entre and the entrem activity Director. To for this education includes, be activity program and the entrem activity Director. To for this education includes, be activity program and the entrem activity Director. To for this education includes, be activity program and the entrem activity Director. To for this education includes, be activity program and program and program and program and program activity program and program activity program activity entrem activ	esident wish don their exactivity starterim activill have accesses ment at he resident's Activity started based on and care at 2 will be activity sed on an exactivity sed on an exactivity program importance in the activity program importance in sed by the sed to the Scoordinat #2 by the sed to th	hes  aff ity ess and s ff  tor n / or e of l be on be ew /e		

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				LILLINGTON, NC 27546			
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F 679	Continued From page	e 18	F 6	to ensure that the activity predirected by the qualified protimes, develop activity care resident, and revise the activate as appropriate based on reseand preferences. This educated by March 15, 202 employee not educated by I 2022, will not be allowed to educated. This education is hire orientation for all new homostal march 8, 2022.  MONITORING PROCESS: Effective March 8, 2022, MI coordinators #1, and/or MD #2 will complete interview reselected five residents to enreceive an ongoing resident activities program based the interests. This will be done to Friday) for two weeks, we more weeks, then monthly from months, or until the pattern is established.  Effective March 15, 2022, In Director, Activity Director, March 15, 2022, In Director, Activity Director, March 15, 2021, In Director, Activity Director, March 15, 2022, In Director, Activity Director, March 15, 2022, In Dire	ofessional are plan for each vity care plan for each vity care plan identity care they are they are they are they are they identity id	ch an es e new /e tor al lay o nce ity tor de ns nce	

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	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIF 1995 EAST CORNELIUS HARNET LILLINGTON, NC 27546		OZ/O-WZOZZ
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE
F 679	Continued From pag	e 19	F€	Director and the Director be ultimately responsible implementation of this pla and ensure that the facilit maintains substantial cor	for the an of correction by attains and	
F 680 SS=F	S483.24(c)(2) The addirected by a qualified qualified therapeutic activities professional (i) Is licensed or registate in which practic (ii) Is:  (A) Eligible for certificate recreation specialist professional by a recording recreational program of which was full-time program; or  (C) Is a qualified occoccupational therapy (D) Has completed at the State.  This REQUIREMENT by:  Based on observation interviews the facility Director in place who directing the develop supervision, and ong activities program. To	ctivities program must be d professional who is a recreation specialist or an all whostered, if applicable, by the bing; and cation as a therapeutic or as an activities ognized accrediting body on apply; or experience in a social or within the last 5 years, one in a therapeutic activities oupational therapist or	F	F680  IMMEDIATE ACTION: On February 28, 2022, th Administrator appointed t assistant who has had m years' experience in a rec	he former activi ore than two creational	3/15/22 ty
	The findings included	<b>t</b> :		program within the last 5 which was full-time in a th	•	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION		X3) DATE SURVEY COMPLETED	
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UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546			
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F 680	2/2/22 at 12:09 PM sl position on 1/11/22. Sthis position there wa reported no knowledge currently. The Activities he had questions, sl who had worked in ac Assistant Administration to doing any assess care planning meeting.  An interview was con Administrator on 2/2/2 stated an Occupation serve as the interim A 1/6/22.  Review of an undated Activity Director posities ential functions and Completes assessing gathers information to multi-faceted, meets functional levels are interests of each patient Through activities, solace, promotes phy emotional health.  Provides patients we remain in their rooms keeping with life-long	with the Activities Assistant on the reported she started her of the stated when she started is no Activities Director. She ge of an Activities Director ites Assistant stated when the asked another employee of civities previously or the for. She reported she was ments or participating in any ges.  I ducted with the 22 at 12:20 PM and he call Therapist had agreed to activities Director as of the dipole description for the fine read in part: and responsibilities: ments, MDS, care plans and to design activities that are patients' and reflects needs and the ent.  I provides stimulation or resical, cognitive, and/or who are confined or chose to with in-room activities in interest and	F	680	activities program in our facility. The neinterim activity director will be responsite to oversee the activity program effective March 08,2022.  On February 28, 2022, the facility Administrator reposted the activity directory and will continue to review applicants for potential candidates.  IDENTIFICATION OF OTHERS: 100% audits of all regulatory required positions completed on February 28, 2022, by the facility administrator to ensure all required positions are filled with the qualified personnel. Findings of this audit is documented on a "regulatory required position audit tool" located in the facility compliance binder.  SYSTEMIC CHANGES: Effective March 8,2022, the facility administrator will ensure the activity program is always directed by a qualified professional who will be responsible to oversee the activity program, develop activity care plan for each resident, and provide/oversee the activity program based on resident wishes and preferences as indicated on their assessment.	ole e ctor s or vith he		
	Director on 2/2/22 at	ey can work on  with the interim Activities 12:35 PM she stated she sistant Administrator to serve			Effective March 8, 2022, the activity state to include activity director, interim activity director, and activity aide will have accept to each resident's activity assessment accare plan maintained in each resident's electronic medical records. Activity states	ity ess and		

Facility ID: 943230

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 680	Continued From page	e 21	F	680			
		es Director 1/5/22 after the			will provide activity program based on		
	previous Activities Dir				each resident's assessment and care		
	•	cility. She reported the			plan.		
		pes all the group activities.			Press.		
		Director stated she was			On February 28, 2022, Regional Direct	or	
	aware the Activities A	ssistant was conducting			of operation re-educated the facility		
	activities because she	e had observed activities in			Administrator on the regulatory		
	passing. She reporte	ed she still worked with her			requirement related to Activity program	ı.	
		The interim Activities			This education included the importance		
		ould not consider herself the			ensuring the activity program is always	led	
		v to ensure the Activities			by a qualified professional who will be		
		cting activities. She reported			responsible for development and revisi		
		e in care plan meetings or			of care plan. This education is will also		
	•	nent related to activities. The			added to new hire orientation for any n		
		ctor stated she had not			administrator at the facility effective Ma	ircn	
	provided any supervis				8, 2022.		
	residents. She verifie	ne activity needs of the			Education will be provided to the intering	m	
		e was not responsible for			Activity director, MDS coordinator #1	11	
		ment, implementation,			and/or MDS coordinator #2 by the facil	itv	
	supervision, and ong				Administrator. The emphasis of this	ity	
	activities program.	oning overded on the			education includes, but not limited to		
	donvinos program.				ensuring that the activity program is		
	An interview was con	ducted with the Director of			always directed by a qualified		
	Rehabilitation on 2/2/	22 at 12:40 PM who stated			professional, developing an activity car	·e	
	his department had n	ever been responsible for			plan for each resident, and revising the		
		previously. He indicated the			activity care plan as appropriate based		
	interim Activities Dire	ctor had a full case load and			resident wishes and preferences. This		
	there were no change	es when she was titled the			education will be completed by March	15,	
	"Interim Activities Dire	ector".			2022, any employee not educated by		
					March 15, 2022, will not be allowed to		
		as conducted with the			work until educated. This education is		
		n 2/2/22 at 3:40 PM. The			added to new hire orientation for any n	ew	
		ated she was doing some			Activity director, MDS coordinator #1	ĺ	
		em in a binder. She stated			and/or MDS coordinator #2 effective	ſ	
	she kept the binder in				March 8, 2022.	ĺ	
		know what to do with them.					
		nt stated she did group			MONITORING PROCESS:		
	activities daily and vis	sited other residents as she			Effective March 8, 2022, the Facility		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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F 680	Continued From page	22	F 6	380			
	schedule during Janu	d she followed the January ary. The Activities Assistant been a February schedule			Administrator will review open positions ensure any regulatory required position are filled with a qualified person to incluan activity director position. This will be done daily (Monday to Friday) for two	ns ude e	
	A follow up interview was conducted with the interim Activities Director on 2/2/22 at 4:06 PM. The interim Activities Director revealed she had not been consulted about the schedule and/or plan for activities for February. She further revealed she was not responsible for planning and/or scheduling activities.				weeks, weekly for two more weeks, the monthly for three months, or until the pattern of compliance is established.	n	
					Effective March 15, 2022, facility Administrator will report findings of this monitoring process to the facility Qualit Assurance and Performance		
	Administrator on 2/3/2 Administrator stated thad been terminated	ducted with the Assistant 22 at 2:30 PM. The Assistant he former Activities Director from the facility. She further			Improvement Committee (QAPI), for recommendations and/or modifications monthly for three months, or until the pattern of compliance is achieved.	,	
	a calendar for activities so one had not been would advise the interneed for a schedule. reviewed the job description.	stated the interim Activities orming the essential			RESPONSIBLE PARTY: Effective March 15, 2022, the facility administrator will be ultimately respons for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	ible	
F 684 SS=D		ducted with the 22 at 4:15 PM who stated tly recruiting for an Activities	F 6	384			3/15/22
	applies to all treatmen	are ndamental principle that nt and care provided to ed on the comprehensive					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION		TE SURVEY MPLETED	
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UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546		
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F 684	Continued From page	÷ 23	F 68	34		
F 684	assessment of a reside that residents received accordance with profer practice, the comprehence plan, and the resident practice, the comprehence plan, and the resident plan, and the resident plan, and the resident plan plan plan plan plan plan plan plan	dent, the facility must ensure treatment and care in essional standards of tensive person-centered sidents' choices. This is not met as evidenced on, record review, staffician interview, the facility of blood pressure of 72/45 tent an admission sign data for 1 of 1 for care (Resident #71) and dident after a fall before for 1 of 1 resident reviewed for 1.	F 68	F684 IMMEDIATE ACTION: Resident #71 is no longer in th Nurse #2 documented in reside medical records on February 4 late entry documentation" that assisted fall happened on Janu 2022.  IDENTIFICATION OF OTHERS 100% audit of all blood pressur in the last 30 days completed c 28, 2022, by Director of Nursin coordinator #1, and/or Unit maidentify any other blood pressur systolic value (top number) les or diastolic value (bottom number) and than 60 documented in medical without being rechecked. No or pressure results identified with appropriate follow through. Fin this audit is documented on a "pressure audit tool" located in a compliance binder.  100% audit of all incident report the last 30 days completed on 28, 2022, by Director of Nursin coordinator #1, and/or Unit ma	ent #27  I, 2022 "a included an uary 31,  S: re obtained on February 19, Unit 19, Un	
	hospital on 1/24/22. Sa a blood pressure of 7	She stated Resident #71 had		identify any other incidence of assisted falls not documented records. No other incidents/acc	falls or in medical	

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NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON  UNIVERSAL HEALTH CARE LILLINGTON  DIAMOND (LAURIOTON, WEST BE PRECIDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  FRERIX (LACAH DEPICION, WEST BE PRECIDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  F 684  Continued From page 24 also stated she did not re-check his blood pressure during the remainder of her shift.  On 21/422 at 3:25 PM an interview was conducted with the unit manager, and she stated the Resident #71's assessment and vital signs should have been rechecked.  An interview was conducted with the Administrator on 21/422 at 4:20 PM. He stated Nurse #1 should have rechecked Resident #71's vital signs.  A telephone interview was conducted with Resident #71's physician on 21/422 at 4:05 PM and he stated he would have expected the nurse to recheck a blood pressure of 12/445 and call him for if there was no change.  A review of the medical record revealed no documentation of an admission assessment and the vital sign data for Resident #71 on 1/24/22.  On 21/4/22 an interview was conducted with Nurse #1 at 12.35 PM. She stated she was the nurse on duty when Resident #71 on 1/24/22.  On 21/4/22 an interview was conducted with Nurse #1 at 12.35 PM. She stated she was the nurse on duty when Resident #71 on 1/24/22.  On 21/4/22 an interview was conducted with Nurse #1 at 12.35 PM. She stated she was the nurse on duty when Resident #71 on 1/24/22.  A review of the medical record revealed no documentation of an admission assessment and two vital signs into the medical record revealed on admission assessment with vital signs on Resident #71 and any one that the record software used by the facility. This charge will be a pressure less than 90 and/or diastolic blood pr		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON  SUMMANY STREEMS OF DEFICIENCIES PROFITS TAG  SUMMANY STREEMS OF DEFICIENCIES PROFITS TAG  COntinued From page 24 also stated she did not re-check his blood pressure during the remainder of her shift.  On 2/4/22 at 3.25 PM an interview was conducted with the unit manager, and she stated the Resident #71's assessment and vital signs.  A telephone interview was conducted with Resident #71's physician on 2/4/22 at 4.20 PM. He stated Nurse #1 should have rechecked Resident #71's vital signs.  A telephone interview was conducted with Resident #71's physician on 2/4/22 at 4.05 PM and he stated he would have expected the nurse to recheck a blood pressure less than 60 in the electronic health record software used by the facility. This change will ensure any documented of binder.  A review of the medical record revealed no documentation of an admission assessment and the vital sign and far Resident #71 and wrote it on the 24-hour nurses report sheet. She stated she didint put the assessment or his vital signs into the medical record.  A review was made of the 24-hour nurses report sheet for 1/24/22. Whiten data on the sheet included Resident #71's vital signs, blood glucose level, diagnosis, notation of a wound, and medications.								С
UNIVERSAL HEALTH CARE LILLINGTON    MAI 10   SUMMARY STATEMENT OF DEFICIENCIES   EACH DEPICIENCY MUST BE PRECEDED BY FULL   PROPRIET   RAN OF CORRECTION   (EACH CORRECTIVE ACTION SHOULD BE   CONFIDENCE   CONFIDENC			345213	B. WING _			02	/04/2022
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F 684  Continued From page 24 also stated she did not re-check his blood pressure during the remainder of her shift.  On 2/4/22 at 3:25 PM an interview was conducted with the unit manager, and she stated the Resident #71's assessment and vital signs should have been rechecked.  An interview was conducted with the Administrator on 2/4/22 at 4:20 PM. He stated Nurse #1 should have rechecked Resident #71's vital signs.  A telephone interview was conducted with Resident #71's physician on 2/4/22 at 4:20 PM. He stated hand have rechecked Resident #71's vital signs.  A telephone interview was conducted with Resident #71's physician on 2/4/22 at 4:05 PM and he stated he would have expected the nurse to recheck a blood pressure of 72/45 and call him for if there was no change.  A review of the medical record revealed no documentation of an admission assessment and the vital sign data for Resident #71 on 1/24/22.  On 2/4/22 an interview was conducted with Nurse #1 at 12:35 PM. She stated she was the nurse on duty when Resident #71 returned from the hospital on 1/24/22. She stated she didn't put the assessment or his vital signs into the medical record.  A review was made of the 24-hour nurses report sheet for 1/24/22. Written data on the sheet included Resident #71's vital signs, blood glucose level, diagnosis, notation of a wound, and medications.	UNIVERSA	AL HEALTH CARE LIL	LLINGTON		L	ILLINGTON, NC 27546		
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documentation of an admission assessment and the vital sign data for Resident #71 on 1/24/22.  On 2/4/22 an interview was conducted with Nurse #1 at 12:35 PM. She stated she was the nurse on duty when Resident #71 returned from the hospital on 1/24/22. She stated she did an assessment with vital signs on Resident #71 and wrote it on the 24-hour nurses report sheet. She stated she didn't put the assessment or his vital signs into the medical record.  A review was made of the 24-hour nurses report sheet for 1/24/22. Written data on the sheet included Resident #71's vital signs, blood glucose level, diagnosis, notation of a wound, and medications.  incident report entered in "incident report module" to automatically transfer to the facility's clinical documentation to ensure each incident is documented at the same time when an incident report is entered.  Effective March 1, 2022, the facility's Licensed nurses, Medication aides, and Certified nursing aides will document all resident assessments, vital signs, tital signs, tital signs, tital signs, tital signs into the medical record.  A review was made of the 24-hour nurses report sheet for 1/24/22. Written data on the sheet included Resident #71's vital signs, blood glucose level, diagnosis, notation of a wound, and medications.		A review of the me	dical record revealed no					
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hospital on 1/24/22. She stated she did an assessment with vital signs on Resident #71 and wrote it on the 24-hour nurses report sheet. She signs into the medical record.  A review was made of the 24-hour nurses report sheet for 1/24/22. Written data on the sheet included Resident #71's vital signs, blood glucose level, diagnosis, notation of a wound, and medications.  Licensed nurses, Medication aides, and Certified nursing aides will document all resident assessments, vital signs, and/or incident/accidents to include assisted falls to each resident's electronic medical records.  100% education of all current Licensed nurses, Medication aides, and Certified nursing aides to include full time, part time and as needed employees completed by							1.	
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included Resident #71's vital signs, blood glucose level, diagnosis, notation of a wound, and medications.  nurses, Medication aides, and Certified nursing aides to include full time, part time and as needed employees completed by			•			4000/ advantion of all assessment !		
level, diagnosis, notation of a wound, and nursing aides to include full time, part time and as needed employees completed by								
medications. and as needed employees completed by								
		_	Diation of a wound, and					
		medicalions.					•	
On 2/4/22 at 3:25 PM an interview was conducted of Nursing, Unit coordinator #1 and/or Unit		On 2/4/22 at 3:25 I	PM an interview was conducted					

Facility ID: 943230

PRINTED: 03/16/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION		PLETED
		345213	B. WING _				C / <b>04/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE		0 11 20 22
				1	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 PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 684	Continued From page		F	684			
		r, and she stated Resident			coordinator #2. The emphasis of this		
		d vital signs should have			education includes, but not limited to, t	ne	
	been placed in the me	edical record.			importance of ensuring all resident's		
					assessments, vital signs, and/or		
	An interview was con				incident/accidents to include assisted f	alls	
		22 at 4:20 PM. He stated the			are documented on each resident		
		nt and vital signs should			electronic medical records; and ensure		
	nave been document	ed in the resident's record.			any systolic blood pressure less than 9		
					and/or diastolic blood pressure less tha		
	0 Decident #07	admitted to the facility as			60 is rechecked immediately following		
		admitted to the facility on			electronic medical records prompt. This		
	and unsteadiness on	ses include difficulty walking			education will be completed by March 2022. Any Licensed nurses, Medication		
	and unsteadiness on	ieet.			aides, and Certified nursing aides not	1	
	The care plan dated ?	3/10/2021 revealed Resident			educated by March 15, 2022, will not b	_	
	-	Is and injury related to			allowed to work until educated. This	C	
		ed mobility. Interventions			education is added to new hire oriental	ion	
	•	osition, resident in the center			for all Licensed nurses, Medication aid		
		ng the use of the call light to			and Certified nursing aides effective	55,	
	_	rranging furniture in his			March 8, 2022.		
	-	g for changes in condition			Maron 6, 2022.		
		eased supervision and			MONITORING PROCESS:		
	assistance and notify				Effective March 8, 2022, Director of		
	,	3 1 7			nursing, Assistant Director of Nursing,		
	The admission Minim	um Data Set (MDS)			and/or Unit coordinator #1 and/or Unit		
		12/2021 indicated Resident			coordinator #2, will monitor compliance	by	
	#27 was severely cog	nitively impaired with			reviewing incident reports, vital signs,	•	
	impairments to both le	ower extremities and			admissions, and readmissions in the da	aily	
	indicated no history o	f falls. The 5-day MDS			clinical meeting (Monday-Friday), to		
	dated 1/25/22 revealed	ed Resident #27 was			ensure that all resident assessments, v	rital 💮	
	severely cognitively in	mpaired with impairments to			signs and incident/accidents are		
	both upper and lower				documented in medical records. Any		
	experienced two or m	ore falls without injury.			issues identified during this monitoring		
					process will be addressed promptly. The		
	On 1/31/2022 at 10:0				monitoring process will be completed of	aily	
		hen Resident #27 was			Monday through Friday for two weeks,		
		ad and upper body on the			weekly for two more weeks, then mont	hly	
		ver the edge of the bed and			for three months or until the pattern of		
	his feet and legs were	e on the bed when entering			compliance is maintained. Findings of	his	

Facility ID: 943230

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILD	_		۱ ,	c
		345213	B. WING				04/2022
NAME OF P	ROVIDER OR SUPPLIER		<b>t</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 26	F	684			
	his room. The bed wa	as positioned low to the floor.			monitoring process will be documented	l on	
	Nurse #2 was called	to Resident #27's room.			"clinical documentation monitoring form	า"	
	Nurse #2 was observ	ed entering Resident #27's			located in the facility compliance binde	r.	
	room, assisting him to	o the floor and exiting his					
	room. Nurse #2 was i	not observed re-entering			Effective March 8, 2022, Director of		
		At 10:08 a.m. Nurse Aide			nursing, Assistant Director of Nursing,		
	` '	ere observed entering the			and/or Unit coordinator #1 and/or Unit		
	room to assist Reside	ent #27 back into the bed.			coordinator #2, will monitor compliance	-	
					reviewing blood pressures obtained in		
	I .	3 p.m. a review of the			prior 24 hours or from last clinical meet		
	nursing documentation				to ensure any systolic blood pressure l		
		all for Resident #27 on			than 90 and/or diastolic blood pressure		
	1/31/2022.				less than 60 was rechecked immediate	-	
	0= 0/4/2022 =+ 44.00				following the electronic medical records		
		a.m. in an interview with			prompt. This monitoring process will be		
		I on 1/31/2022 Resident #27 of the bed, and she assisted			completed daily Monday through Frida	у	
		stated since she assisted			for two weeks, weekly for two more weeks, then monthly for three months	or	
		did not consider it a fall.			until the pattern of compliance is	JI	
	I .	dent #27's head was on the			maintained. Findings of this monitoring		
		witness how Resident #27			process will be documented on a "Vital		
	got into that position.				signs monitoring form" located in the		
	1 -	27 after NA #1 and NA #2			facility compliance binder.		
		bed , and Resident #27 was			Effective March 15, 2022, the Director	of	
		ts of injury or complication.			Nursing and/or Assistant Director of		
	l	ed she did not know what the			Nursing will report findings of this		
	procedures were afte	r a fall.			monitoring process to the facility Qualit	ΣV	
	•				Assurance and Performance		
	On 2/4/2022 at 11:30	a.m. in an interview with the			Improvement Committee (QAPI), for		
	Director of Nursing, s	he stated she was not			recommendations and/or modifications	,	
	aware of a fall with R	esident #27 on 1/31/2022,			monthly for three months, or until the		
		all was not discussed at the			pattern of compliance is achieved.		
	morning meeting on 2						
	_	n the floor was considered a			RESPONSIBLE PARTY:		
	fall, and Nurse #2 sho				Effective March 15, 2022, the Executiv		
		to assess Resident #27			Director and the Director of Nursing will		
	before he was moved	l back to bed.			be responsible for the implementation		
					this plan of correction and ensure that		
	On 2/4/2022 at 3:43 r	o.m., a review of Nurse #2's			facility attains and maintains substantia	al	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345213	B. WING				0.4/0.000
NAME OF D	ROVIDER OR SUPPLIER	343213	5:		TREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2022
NAIVIE OF FI	NOVIDER OR SUFFLIER				995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON					
					ILLINGTON, NC 27546		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 684	Incident Reporting Pr	ealed a document, "Fall ocess" was signed and	F	684	compliance.		
F 687 SS=D	dated by Nurse #2 or Foot Care CFR(s): 483.25(b)(2)		F (	687			3/15/22
	and care to maintain health, the facility mu (i) Provide foot care a with professional start to prevent complication medical condition(s) a (ii) If necessary, assist appointments with a carranging for transport appointments. This REQUIREMENT by:  Based on observation interviews with facility provide foot care for #110) dependent on sliving (ADLs).  The findings included Resident #110 was and diagnoses that included diabetes mellitus and Review of Resident #1/14/22 revealed Resident #1/14/22 revealed Resident #110's quark R	nts receive proper treatment mobility and good foot st: and treatment, in accordance indards of practice, including ons from the resident's and st the resident in making qualified person, and reation to and from such is not met as evidenced in staff the facility failed to a 1 of 1 resident (Resident staff for activities of daily in activities			F687 IMMEDIATE ACTION: On February 2, 2022, Unit Coordinator provided nail care to resident #110. Resident #110 refused cutting and filing her toenails stating that "she prefers for them to remain long"  IDENTIFICATION OF OTHERS: 100% inspection of current residents' toenails was completed by Unit coordinator #1, and/or Unit manager #2 on February 23, 2022, to identify any or resident with a need for toenail care. No other issues were identified during this audit. Findings of this audit is document on a "Foot care audit tool" located in the facility compliance binder.	g r 2 ther o	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		E SURVEY IPLETED
		345213	B. WING			С
		345213	B. WING _		•	2/04/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
UNIVERS	AL HEALTH CARE LII	LINGTON		1995 EAST CORNELIUS HARNETT BO	OULEVARD	
0.11.7 = 1.10.				LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY 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 HE APPROPRIATE	(X5) COMPLETION DATE
F 687	Continued From p	age 28	F 6	87		
	was cognitively int	act with no behaviors. She				
		assistance with bed mobility,		SYSTEMIC CHANGES:		
	locomotion, dressi	ng, and personal hygiene.		Effective March 8, 2022, the	facility will	
				ensure that residents receive	e proper	
	An observation an	d interview on 1/31/22 at 10:09		treatment and care to mainta	ain mobility	
	AM revealed all Re	esident #110's toenails on both		and good foot health, to incl		
		y long, and the second toenail		foot care and treatment for a		
		as approximately 1/4 of an inch		accordance with professions		
	•	second toenail on her right foot		practice. This will be accomp		
		towards her toe. Resident #110		instituting the following syste	emic changes.	
		ked for her toenails to be		On Falance 05, 0000 the 5	Din	
		equests had been ignored. She		On February 25, 2022, the D		
	was unable to give	e specific times or dates.		Nursing revised the skin ass schedule utilized in facility. F		
	On 2/1/22 at 3:44	PM Resident #110 stated no		weekly skin assessments so		
		ner toenails although she had		show resident assessments		
		ner morning care from the		the inspection of toenails), d		
	Nurse Aide #4 on			the days of Sunday and Thu		
				week. This will allow monitor		
	On 2/2/22 at 11:45	5 AM Nurse Aide #4 observed		completion of scheduled ass	•	
	Resident #110's to	enails and stated they needed		members of nursing adminis	stration	
	to be trimmed. She	e stated nurses trim the		Monday-Friday. Any identifie	ed toenails	
	toenails of residen	ts with diabetes. NA #4 further		care needs discovered durin	•	
		look at Resident #110's		assessments will be reporte	-	
		provided care. She reported		Monday thru Friday in the m		
		e foot care during bathing. She		meeting. The revised sched		
		ught to notify the nurse if a		utilized in the facility effectiv	e March 1,	
	resident with diabe	etes mellitus required foot care.		2022.		
	On 2/2/22 at 12:0	0 PM the Unit Manager		Effective Merch 1 2022 the	facility's	
		t #110's toenails and stated		Effective March 1, 2022, the Licensed nurses will comple		
		trimmed. The Unit Manager		skin assessment to include i		
		to Resident #110. She further		toenails of residents following		
		ed the nurse aide assigned to		skin assessment schedule a	•	
		esident's nails needed to be		weekly. Licensed nurses wil		
	trimmed.			resident identified of a need	•	
				care will receive appropriate		
		conducted with the Director of 2/4/22 at 1:34 PM who stated		as appropriate.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		345213	B. WING _			1	C 04/2022
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		19	TREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546	02/04/2022	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 687	stated nurse aides sh resident was diabetic	mmed as needed. She sould trim toenails unless the . The DON stated nails nurses for residents with	F	687	Effective March 8, 2022, MDS coordinater #1 and/or MDS coordinator #2 will develop/revise individual resident's carplan for any resident who refuse nail cand/or prefer to have long toenails move forward.  100% education of all current licensed nurses completed by the Director of Nursing, Assistant Director of Nursing, Unit coordinator #1 and/or Unit coordinator #2. The emphasis of this education includes, but not limited to, the importance of ensuring toenail care is identified and provided as appropriate. The education also emphasized the importance of completing weekly skin assessment per revised schedule and address any toenail needs identified. The education will be completed by March 2022, any Licensed nurse not educated by March 15, 2022, will not be allowed work until educated. This education is added to new hire orientation for all licensed nurses effective March 8, 2022.  MONITORING PROCESS: Effective March 8, 2022, Director of nursing, Assistant Director of Nursing, and/or Unit coordinator #1 and/or Unit coordinator #2, will monitor compliance with resident's toenails care by reviewing the completion of the prior day weekly skin assessment on daily clinical meeting (Monday-Friday), to ensure any identification is monitoring process will be address promptly. This monitoring process will be address promptly. This monitoring process will be	he his 15, d to 2.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345213	B. WING			(	
NAME OF B		343213	B: Wiito		TREET ARRESTO OUT/ OTATE ZIR CORE	02/	04/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLI	NGTON	1995 EAST CORNELIUS HARNETT BOUL				
					ILLINGTON, NC 27546		
(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 689 SS=D	S483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents.	ards/Supervision/Devices (2)		687	completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months of until the pattern of compliance is maintained. Findings of this monitoring process will be documented on "skin assessment monitoring form" located in the facility compliance binder.  Effective March 15, 2022, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be responsible for the implementation of this plan of correction and ensure that if facility attains and maintains substantial compliance.	or  of  y  e  l  of the	3/15/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE S COMPL	
		345213	B. WING			00/	
NAME OF D	ROVIDER OR SUPPLIER	343213		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u> -	02/0	04/2022
NAME OF PI	ROVIDER OR SUPPLIER						
UNIVERSA	AL HEALTH CARE LILLI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	I	(X5) COMPLETION DATE
F 689	Continued From page	e 31	F 6	89			
	interviews, the facility residents (Resident # and failed to remain v for assistance after a (Resident #27) review  Findings included:  The facility's, "Reside Facility," policy dated residents who smoke using the Smoking As whether or not superv smoking or if resident The policy further sta independent smoking to keep cigarettes, pil	ent Smoking, Smoke Free February 2021 stated will be further assessed, esessment, to determine vision was required for t was safe to smoke at all. ted residents who have privileges were permitted pes, tobacco, and other eir possession, and only		F689 IMMEDIATE ACTION: Resident #109's smoking mate removed from his possession 4, 2022, by Unit Coordinator # smoking assessment was com February 4, 2022, for resident MDS Coordinator #2. Resident #27 was assessed a back into the bed by Nurse Aid Nurse Aide #2. Resident was have any injuries.  IDENTIFICATION OF OTHER 100% smoking audit of all resifacility was completed on Mare to identify any potential smoke facility by the Director of Nursicoordinators (#1, #2). Finding audit is documented on the "S	on February 1. A safe appleted or #109 by and assisted #1 and noted to S: dents in the half and us of this moking	ed Innot  the	
	10/27/2021. His diagree to left ankle and foot and mobility.  The safe smoking evaluated Resident #1  On 2/3/2022 at 2:52 p  Nurse #3, she stated conducted before result and stated smoking a conducted on admission stated Resident #109  She stated she had not seed to left and seed to lef	as admitted to the facility on noses included osteomyelitis and abnormalities of gait  aluation dated 10/28/2021 109 was a nonsmoker.  b.m. in an interview with a smoking assessment was idents were able to smoke assessments were ion and quarterly. She was not listed as a smoker ever observed Resident ed he did go out to the		Audit tool" and is in the facility binder.  100% audit of all incident report the last 30 days completed on 28, 2022, by Director of Nursing coordinator #1, and/or Unit maidentify any other incident of facts assisted fall not documented in records. No other incidents/actidentified not documented in marecords. Findings of this audit documented on a "Incident reptool" located in the facility combinder.  SYSTEMIC CHANGES:	rts writter February ng, Unit anager #2 all or n medical cidents nedical is port audit	n in / ? to	
		area, and he was allowed to		All current residents will have	an update	ed	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		SURVEY PLETED
		345213	B. WING_			C / <b>04/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	0.02.0	<del>                                     </del>	STREET ADDRESS, CITY, STATE, ZIP		104/2022
TVAIVIL OF T	TO VIDER OR GOLT EIER			, , ,		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT	BOULEVARD	
				LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From page	32	F 6	89		
	#109 was identified a smoking assessment needed to be reasses  The admission Minim	um Data Set (MDS)		smoking assessment to b the Director of Nursing, A of Nursing, Unit coordinat February 28, 2022, March March 2, 2022. A new sm generated on the complet	ssistant Director ors (#1, #2) on n 1,2022, and/or oking list will be tion of the	
	assessment dated 11/3/2021 indicated Resident #109 was cognitively intact, required supervision of one person for mobility and had no upper impairments.			assessment by the Direct March 2,2022 Effective March 8, 2022, a	all new residents	
		on revealed on 11/24/2021		will have a smoking asses completed on admission, with any changes in their	quarterly, and	
	Resident# 109 was found smoking in his room. Resident #109 was educated that smoking was			by the licensed nurse on or reviewed in the daily clinic	duty. This will be	
	allowed outside the fa	acility, and his cigarettes and the nurse 's station for		be documented on the fac- list. Moving forward, all re	cility smoking	
	safety concerns that	shift.		smoke will be listed on the residents who smoke" and	e facility's "list of d will be updated	
	Resident #109 had from	ng documentation revealed esh burn holes in his pants		weekly by the Director of	-	
	from smoking, and th monitor Resident #10	e nursing staff continued to 9.		Effective February 28, 20, will be left unattended after observed on the floor. Ar	er being	
	for smoking and safe	12/21/2021 revealed a focus ty. Interventions included to		who observes a resident of ensure the resident is safe	on the floor will e and then call	
	resident to maintain a nursing station, and to	noker apron, encourage Ill smoking materials at Dencourage to smoke only Exposted and in designated		for assistance by activating light. If no one comes impossible will step outside of location assistance.	mediately, staff	
	On the facility's list of 1/30/2022. Resident a smoker.	residents who smoke dated #109 was not listed as a		100% education of all cur include full time, part time employees will be comple Director of Nursing, Assis Nursing, and/or Unit Coor	e, and as needed sted by the tant Director of dinators (#1,	
	observed on the COV wheelchair with a pac	2 a.m., Resident #109 was 'ID unit in the hallway in his k of cigarettes rolled into his sident #109 stated he went		#2). The emphasis of this includes but not limited to of completing smoking as admission, quarterly and	, the importance sessment on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C <b>02/04/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	l .		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02.0 1.2022
LIMINEDO	NI HEALTH CARELLIL	INCTON		1995 EAST CORNELIUS HARNETT BOULEVARD	)
UNIVERSA	AL HEALTH CARE LILL	INGTON		LILLINGTON, NC 27546	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
F 689	Continued From pag	e 33	F 689	9	
		pointing down the hallway		smoking status, supervised smokers	
		oward the designated		to report any changes in resident's a	-
	smoking area in the	facility.		to smoke safely. This education will be	
	On 1/21/2022 at 10:	46 a.m. Resident #109 was		completed by March 15, 2022. Any smembers not educated by March 15,	
		bed with a pack of cigarettes		2022, will not be allowed to work until	
		pillow on top of his left upper		educated. This education will be prov	
		stated he used matches or a		annually and will be added to new him	
	lighter and needed s	ome matches. He stated he		orientation for all new employees effe	
	went out to smoke a	nd usually smoked alone.		March 8, 2022.	
	On 2/2/2022 at 11:56 a.m. in an interview with			100% education of all current staff to	
		e stated Resident #109 was a		include full time, part time, and as ne	eded
		seen him go out to smoke		employees will be completed by the	
	since returning from	the COVID unit.		Director of Nursing, Assistant Director	
	On 2/2/2022 at 11:59	3 a.m. in an interview with		Nursing, and/or Unit Coordinators. To emphasis of this education includes to the second secon	
		stated Resident #109 was an		not limited to, the incident and accide	
	independent smoker			process and safety of our residents.	
	'			education will be completed by March	
	On 2/4/2022 at 11:47	7 a.m. in an interview with the		2022. Any staff members not educat	
	Director of Nursing,	•		by March 15, 2022, will not be allowed	
		ompleted on admission and		work until educated. This education v	
		dition. She stated cigarettes		provided annually and will be added	to
		possession of residents		new hire orientation for all new staff	
		smoker. She stated Resident smoker and should have		members effective March 8, 2022.	
	been reassessed for			MONITORING PROCESS:	
	500111040000004101	omeking.		Effective March 8, 2022, the Director	of
	2. Resident #27 was	admitted to the facility on		Nursing, Assistant Director of Nursing	
		ses include difficulty walking		and/or Unit Coordinators (#1, #2) will	
	and unsteadiness or	n feet.		review all new admissions for the las	t 24
				hours or from last clinical meeting to	
	-	3/10/2021 revealed Resident		ensure that a smoking assessment h	
		alls and injury related to		been completed. Any negative finding	
		red mobility. Interventions position, resident in the center		will be corrected promptly. This moni process will be completed daily Mono	•
	-	ing the use of the call light to		through Friday for two weeks, weekly	-
		arranging furniture in his		two more weeks, then monthly for thi	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI	NG _	<del></del>	l ,	С
		345213	B. WING				04/2022
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGION		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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	0.34		600			
1 003	Continued From page		-	689			
		g for changes in condition			months or until the pattern of complian		
	-	reased supervision and			is maintained. Findings of this monitori	ng	
	assistance and notify	ring the physician.			process will be documented on the		
	The admission Minim	num Data Sat (MDS)			"smoking assessment tool for new residents" located in the facility		
		12/2021 indicated Resident			compliance binder.		
		gnitively impaired with			Effective March 8, 2022, the Director o	f	
		lower extremities and			Nursing, Assistant Director of Nursing,	'	
		of falls. The 5-day MDS			and/or Unit Coordinators (#1, #2) will		
	dated 1/25/22 revealed	•			review all incidents and accidents on d	ailv	
		mpaired with impairments to			clinical meeting to ensure that all	,	
	both upper and lower	•			residents were assisted promptly and r	not	
		nore falls without injury.			left unattended. This monitoring proces		
		, ,			will be completed daily Monday through		
	On 1/31/2022 at 10:0	03 a.m., a continuous			Friday for two weeks, weekly for two m		
	observation started w	vhen Resident #27 was			weeks, then monthly for three months	or	
	observed with his hea	ad and upper body on the			until the pattern of compliance is		
	floor, his waist was o	ver the edge of the bed and			maintained. Findings of this monitoring	3	
	his feet and legs wer	e on the bed when entering			process will be documented on the		
		as positioned low to the floor.			"Incidents and Accidents monitoring to		
	**	I to Resident #27's room.			located in the facility compliance binde	r.	
		ed entering the room,					
		27 to the floor and exiting the			Effective March 15, 2022, the Director	of	
		observed returning to her			Nursing will report findings of this		
		entering Resident #109's			monitoring process to the facility Qualit	.y	
		#27 laid on the floor. Nurse			Assurance and Performance		
		re-entering Resident #27's			Improvement Committee (QAPI), for		
		Nurse Aide (NA) #1 and NA			recommendations and/or modifications	,	
		tering the room to assist			monthly for three months, or until the		
	Resident #27 back in	no the pea.			pattern of compliance is achieved.		
	On 1/31/2022 at 10:0	08 a.m. in an interview with			RESPONSIBLE PARTY:		
		urse #2 had informed her			Effective March 15, 2022, the Executiv	е	
	Resident #27 was on				Director and the Director of Nursing wi		
					be ultimately responsible for the		
	On 2/4/2022 at 11:00	a.m. in an interview with			implementation of this plan of correction	n	
	Nurse #2, she stated	on 1/31/2022 Resident #27			and ensure that the facility attains and		
	was trying to get out	of the bed, and she assisted			maintains substantial compliance.		
	him to the floor She	stated she went to get some					

NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON  (XA) ID PREFIX TAG  TAG  COMPLETION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 35 help to assist Resident #27 back to bed. She stated she returned to Resident #27's room after NA #1 and NA #2 assisted him back to bed.  On 2/4/2022 at 11:30 a.m. in an interview with the Director of Nursing (DON), she stated if Nurse #2 needed help to assist Resident #27 back to bed, Nurse #2 should have stepped out of the room for help.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 35 help to assist Resident #27 back to bed.  On 2/4/2022 at 11:30 a.m. in an interview with the Director of Nursing (DON), she stated if Nurse #2 needed help to assist Resident #27 back to bed, Nurse #2 should have turned on the call light, and if no response and resident was safe, Nurse #2			245242	B WING			1	
UNIVERSAL HEALTH CARE LILLINGTON    1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546			345213	B. WING			02/	04/2022
F 689  Continued From page 35 help to assist Resident #27 back to bed.  On 2/4/2022 at 11:30 a.m. in an interview with the Director of Nursing (DON), she stated if Nurse #2 needed help to assist Resident #27 back to bed, Nurse #2 should have turned on the call light, and if no response and resident was safe, Nurse #2			NGTON		1995 EAST CORNELIUS HARI			
help to assist Resident #27 back to bed. She stated she returned to Resident #27's room after NA #1 and NA #2 assisted him back to bed.  On 2/4/2022 at 11:30 a.m. in an interview with the Director of Nursing (DON), she stated if Nurse #2 needed help to assist Resident #27 back to bed, Nurse #2 should have turned on the call light, and if no response and resident was safe, Nurse #2	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	( (EACH CORRECTIVE CROSS-REFERENCE	VE ACTION SHOULD B ED TO THE APPROPRIA		COMPLETION
She stated the medication cart could be locked and Nurse #2 should have assisted Resident #27 back in the bed before providing care to Resident #109. The DON stated Resident #27 should not had been left on the floor with no one in the room while waiting for staff to assist him back to the bed.  F 693  Tube Feeding Mgmt/Restore Eating Skills  CFR(s): 483.25(g)(4)(5)  \$483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  \$483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and  \$483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693	help to assist Resider stated she returned to NA #1 and NA #2 ass On 2/4/2022 at 11:30 Director of Nursing (Eneeded help to assist Nurse #2 should have if no response and re should have stepped She stated the medic and Nurse #2 should back in the bed before #109. The DON state had been left on the f while waiting for staff bed.  Tube Feeding Mgmt/f CFR(s): 483.25(g)(4)-(5) Ent (Includes naso-gastric both percutaneous er percutaneous endoscenteral fluids). Based comprehensive assessensure that a resident \$483.25(g)(4) A resident eat enough alone or venteral methods unlescondition demonstrate clinically indicated an resident; and	nt #27 back to bed. She Resident #27's room after isted him back to bed.  a.m. in an interview with the DON), she stated if Nurse #2 Resident #27 back to bed, turned on the call light, and sident was safe, Nurse #2 out of the room for help. ation cart could be locked have assisted Resident #27 te providing care to Resident d Resident #27 should not loor with no one in the room to assist him back to the  Restore Eating Skills (5)  teral Nutrition and gastrostomy tubes, hoscopic gastrostomy and on a resident's term who has been able to with assistance is not fed by ses the resident's clinical tes that enteral feeding was d consented to by the  tent who is fed by enteral ppropriate treatment and					3/15/22

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING				C / <b>04/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2022	
	1011211 011 001 1 21211				995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLI	NGTON			ILLINGTON, NC 27546			
0(0)15	CHMMADVC	TATEMENT OF DEFICIENCIES	- 15		PROVIDER'S PLAN OF CORRECTION		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 693	Continued From pag	e 36	F	693				
	and to prevent comp	lications of enteral feeding						
		ted to aspiration pneumonia,						
	_	ehydration, metabolic						
		asal-pharyngeal ulcers.						
	This REQUIREMEN	T is not met as evidenced						
	by:							
	Based on observation	ons, record review and staff			F693			
		y failed to provide nutritional			IMMEDIATE ACTION:			
		eral feeding as physician			On February 4, 2022, the contracted			
		sident reviewed for tube			dietician assessed resident #50's			
	feedings. (Resident	<del>4</del> 50)			nutritional needs. Registered dietician			
					discontinued resident continuous tube			
	Findings included:				feeding order.	-0		
	Pesident #50 was ac	dmitted to the facility on			No further actions taken for resident #5	Ю.		
		noses included mild protein			IDENTIFICATION OF OTHERS:			
	_	and gastrostomy status.			100% audit of all current residents who	,		
		and gaotrootomy status.			are fed by enteral means completed by			
	The care plan dated	8/19/2021 revealed Resident			the Director of Nursing on February 28			
	#50 had an inadequa				2022, to ensure each resident receive			
		d maintaining upright			appropriate feeding as ordered by			
		ed time after each tube			physician. All other resident who are fe	:d		
	feeding, referring to	dietician for evaluations for			by enteral means noted to receive tube	<del>)</del>		
	current nutritional sta	atus and determination of			feeding per physician order. Findings o	of		
	· ·	cking placement before			this inspection is documented on a "Tu			
		feedings and checking			feeding audit tool" located in the facility	1		
	residual before initial	tube feeding.			compliance binder.			
	The physician orders	dated 10/04/2021 revealed			SYSTEMIC CHANGES:			
		dered fortified nutritional			Effective March 8, 2022, nursing			
	supplement at sixty-f	five milliliters per hour for			employees that include licensed nurse	s,		
	,	ght o'clock in the evening to			and/or trained Medication aides will			
	eight o'clock in the m	norning via gastrostomy tube.			administer tube feeding to resident who are fed by enteral means based on	)		
	Dietary notes dated	10/8/2021 indicated Resident			physician orders.			
	· ·	d a 7.5% weight lost in the			Effective March 8, 2022, all resident w	าด		
	last 90 days, no weig	ght change in the last thirty			are fed by continuous enteral means w			
	days, and tube feedi				be scheduled to start the feeding at 5p			
	nocturnal (8 n m to 8	R a m ) to promote oral	1		daily to the stanning time as specified l	ΩV		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C <b>02/04/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>	
				1995 EAST CORNELIUS HARNETT BOUL	.EVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		LILLINGTON, NC 27546			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE	
F 693	Continued From page	e 37	F 69	3			
	intake.			an order, unless is contraindica			
				will ensure proper tracking whe	n the		
	assessment dated 12	e Minimum Data Set (MDS) 1/1/2021 indicated Resident		feeding is initiated/changed.			
		ntact, required extensive		100% education of all current I			
		son for eating and had a		nurses and medication aides to			
		The MDS indicated Resident		full time, part time, and as need			
		proached with the use of		employees completed by the D			
		e received more than fifty		Nursing, Assistant Director of N	_		
		ories and more than five iliters of fluid intake per day		and/or Unit Coordinators (#1, #	•		
	from his tube feeding			emphasis of this education inclinited to the importance of			
	nominis tube recuirig.	3.		administering tube feeding to re			
	Dietary notes dated 1	/25/2022 revealed Resident		who are fed by enteral means b			
	#50 received one can			physician orders and starting/cl			
		nt #50 consumed less than		tube feeding formula at 5pm un			
		neal, and fortified nutritional		specified on the order otherwise			
		ve milliliters per hour for		education will be completed by		,	
	twelve hours from eig	ht o'clock in the evening to		2022, Licensed nurses and me	dication		
	eight o'clock in the me	orning via gastrostomy tube.		aides not educated by March 1	5, 2022,		
				will not be allowed to work until	educated	.	
		ation Record (MAR) dated		This education is added to new			
	February 2022 reveal			orientation for all new Licensed			
		ve milliliters per hour for		and medication aides effective	March 8,		
		ht o'clock in the evening to		2022.			
	_	orning via gastrostomy tube		MONITORING PROCESS			
		alnutrition was scheduled		MONITORING PROCESS:	<b>.</b>		
		here was no documentation		Effective March 8, 2022, the Di			
	administered on 2/1/2	g the tube feeding has been		Nursing, Assistant Director of N MDS coordinators (#1, #2) and	_		
		2022 as scrieduled.		Coordinators (#1, #2) will comp			
	On 2/2/2022 at 7:06 a	a.m. Resident #50 was		monitoring to ensure licensed r			
		bed. There was no tube		and/or trained medication aides			
		I on the tube feeding pump		administer tube feeding to resid			
	and a label reading 8			are fed by enteral means based			
	_	feeding pump. Resident		physician orders and starting/cl			
		get his tube feeding during		tube feeding formula at 5pm un			
	the night.	- 0		specified on the order otherwise			

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NITIMBED:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				C <b>04/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2022
IINIVERS	AL HEALTH CARE LILLIN	NGTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NG TON		LI	ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 693	Nurse #5, he stated h a.m. shift on 2/1/2022 included Resident #50 was eating food the la him and stated he did Resident #50 to recei 2/1/2022 and did not p.m. on 2/1/2022 for I On 2/4/2022 at 11:52 Director of Nursing, s	a.m. in an interview with the worked the 7p.m. to 7 the worked the stated Resident #50 as time he was assigned to 1 the worked to worked the work	F 6	693	This monitoring process will be accomplished by reviewing documenta of all residents who are fed by enteral means to ensure the feeding is administered per physician order. This monitoring process will be completed of (Monday to Friday) for two weeks, wee for two more weeks, then monthly for three months, or until the pattern of compliance is established. Effective March 15, 2022, the Director Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications monthly for three months, or until the pattern of compliance is achieved.	daily kkly of	
F 695 SS=D	S 483.25(i) Respirator tracheostomy care and The facility must ensured respiratory care and tracheal succare, consistent with practice, the compreh	ry care, including and tracheal suctioning. Use that a resident who e, including tracheostomy etioning, is provided such professional standards of mensive person-centered and preferences,	F 6	695	RESPONSIBLE PARTY: Effective March 15, 2022, the Executiv Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attain and maintain substantial compliance.	II	3/15/22

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		IPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				04/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02.	<u></u>
				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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	: 39	Fé	895			
	by: Based on observation interviews, the facility safety signage indication of the small s	is not met as evidenced  ns, record review and staff failed to display cautionary ting the use of oxygen and resident reviewed for Resident #10)  Oxygen Safety and Storage" to post a "No Smoking" sign door to resident's room oxygen.  mitted on 04/22/2021, and d chronic obstructive COPD).  I/30/2021 revealed Resident ortness of breath related to ons included administration in ordered.			F695 IMMEDIATE ACTION: Central supplies coordinator placed cautionary safety signage related to no smoking on Resident #10's door on February 4, 2022.  IDENTIFICATION OF OTHERS: 100% inspection of resident's doors, for those who uses Oxygen supplementation in the facility was completed by the Central supply's coordinator on Februar 22, 2022, to identify any other resident who uses oxygen without cautionary safety signage related to no smoking of their door. No other door of a resident who uses oxygen supplementation with a no smoking signage noted. Findings this inspection is documented on a "no smoking sign audit tool" located in the facility compliance binder.  SYSTEMIC CHANGES:	or ion, ary on nout of	
	assessment dated 10 #10 was severely cogreceiving oxygen.	/26/2021 indicated Resident nitively impaired and			On February 28, 2022, central supplies coordinator placed extra no smoking signage in each medication room and i the Oxygen room for easy accessibility	in	
	Resident #10 was ord per minute via nasal d				when oxygen supplementation is initiat per physician order. Effective March 8, 2022, nursing employees that include licensed nurses	s,	
	there was no cautiona no smoking or oxyger Resident #10's door.	1 a.m. in the COVID unit, ary safety signage related to in use observed on Resident #10 was observed ring two liters per minute of			Medication aide, and/or Certified nursir aides will post a "No Smoking" sign on outside of the door to resident's room before starting use of oxygen.	- 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 04/2022	
NAME OF PROVIDER OR SUPF	PLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	0-1/2022	
				19	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSAL HEALTH CAP	RE LILLII	NGTON		L	ILLINGTON, NC 27546			
PREFIX (EACH D	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
admitted to the On 2/3/2022 Nurse #4, she oxygen due to posted cautio on the doorwal have a sign sknow why the on the doorwal On 2/4/2022 Director of Nushould have he door communicated nurses should have president #27  On 2/4/2022 Central Suppling gathered oxyging age when residents and resident 's round including the oxygen theral outside the enursing staff of the resident at the doorway in Resident #10 safety sign or from his room cautionary sa	asal cannot be covered as	nula. Resident #10 was D unit on 1/25/2022.  p.m. in an interview with Resident #10 received DPD and stated there was no fety sign for oxygen in use stated the doorway was to xygen was in use and did not hary safety signage was not  a.m. in an interview with the the stated Resident #10 autionary safety sign on his oxygen was in use. She central supply coordinator a cautionary safety sign on	F	695	100% education of all current nursing employees to include full time, part tim and as needed employees completed if the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2). The emphasis of this education includes, but not limited to the importance of placing safety signage related to no smoking to the doors of those residents who use oxygen supplementation. This education will be completed by March 15, 2022. Increase nursing employees not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all nernursing employees effective March 8, 2022.  MONITORING PROCESS:  Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2) will complete monitoring to ensure nursing staff are placing safety signage related to no smoking to the doors of those residents who use oxygen supplementation per policy. This monitoring process will be accomplished by inspecting doors of those residents who use oxygen supplementation to ensure safety signar related to no smoking to the doors. Thi monitoring will be completed daily (Monday to Friday) for two weeks, weefor two more weeks, then monthly for three months, or until the pattern of compliance is established.	by ctor  ut con Any  w		

NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON  (X4) ID PREFIX TAG  (EACH DEFICIENCY)  F 695  Continued From page 41  F 695  Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 695  Continued From page 41  F 695  Continued From page 41  F 695  Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive							(	С
UNIVERSAL HEALTH CARE LILLINGTON  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 695  Continued From page 41  F 695  Continued From page 41  F 695  F 695  Continued From page 41  F 695  F 695  Continued From page 41  F 695  Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive			345213	B. WING _			02/	04/2022
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION   CEACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   CROSS-REFERENCED TO THE APPROPRIATE   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY)   COMPLETION DATE      F 695   Continued From page 41   F 695   Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality   Assurance and Performance   Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved.    RESPONSIBLE PARTY:   Effective March 15, 2022, the Executive   Effective March 15, 2022, the Effecti								
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 695  Continued From page 41  F 695  Continued From page 41  F 695  Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive	UNIVERSA	AL HEALTH CARE LILLII	NGTON		LII	LLINGTON, NC 27546		
Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	х	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.  F 732  SS=B  CFR(s): 483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:  (i) Facility name.  (ii) The current date.  (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:  (A) Registered nurses.  (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).  (C) Certified nurse aides.  (iv) Resident census.  §483.35(g)(2) Posting requirements.  (i) The facility must post the nurse staffing data	F 732	Posted Nurse Staffing CFR(s): 483.35(g)(1)- §483.35(g) Nurse Staffas §483.35(g)(1) Data remust post the followir basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categoral unicensed nursing staresident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census.	g Information -(4) affing Information. equirements. The facility ng information on a daily  and the actual hours worked gories of licensed and taff directly responsible for it: s. Il nurses or licensed is defined under State law). des. g requirements.			Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Qualit Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and	e e II	3/15/22

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			02/	04/2022	
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2022	
					995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLII	NGTON		L	ILLINGTON, NC 27546			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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)		COMPLÉTION DATE	
F 732	Continued From page	e 42	F	732				
	· -	h (g)(1) of this section on a						
	daily basis at the beg							
	(ii) Data must be post							
	(A) Clear and readab							
		ace readily accessible to						
	residents and visitors	i.						
	\$492.35(a)(3) Dublic	access to posted nurse						
		cility must, upon oral or						
	written request, make							
		c for review at a cost not to						
	exceed the communit							
	\$400.05(a)(4) Fability	, data matamilian						
	§483.35(g)(4) Facility	acility must maintain the						
		affing data for a minimum of						
		uired by State law, whichever						
	is greater.	,,,						
	This REQUIREMENT	is not met as evidenced						
	by:							
		ons and staff interview, the			F732			
		e nursing staff data was			IMMEDIATE ACTION:			
	posted daily.				There was no Resident identified to be			
	Findings included:				affected by this alleged deficient practic	æ.		
	i ilianigo ilioladea.				IDENTIFICATION OF OTHERS:			
	During the initial tour	of the facility on 1/30/22 at			Any resident could have been affected	by		
		g of the daily nursing staff			this alleged deficient practice.			
	data was from 1/27/2	2.			On February 24, 2022, the facility Staff			
					coordinator, Executive Director, and/or			
		conducted on 2/2/22 at 9:25			Director of Nursing completed an audit			
	AM and the daily nurs	sing staff data was posted.			current facility staffing sheets for the last 30 days to identify any other day that	st		
	An interview was con	ducted with the facility			nursing staffing data were not posted a	,t		
		2 at 9:35 AM who stated the			the beginning of each shift. No other da			
		ta was posted by the facility			identified with missing posting of nursing	•		
	scheduler.				staffing information. Findings of this au			
					is documented on a "nursing staffing da			
	An interview was con	ducted with the scheduler on			audit tool" located in the facility			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				C / <b>04/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		04/2022	
					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON			ILLINGTON, NC 27546		
040.1=	CUMMA DV C	FATEMENT OF DEFICIENCIES			·		0/5)
(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 732	Continued From pag	e 43	F 7	732			
	2/2/22 at 9:39 AM wh	no stated she was off on			compliance binder.		
		nged the daily nursing staff					
		e stated it had not been			SYSTEMIC CHANGES:		
		22 and she was not sure			Effective February 24, 2022, The facilit	ty	
	who should have cha	anged it while she was off.			staffing coordinator will post nursing information for four consecutive days a	ıt a	
	An interview was cor	nducted with the			time on the posting board located at th		
		/22 at 9:43 AM who stated			facility's front lobby. The posting will	_	
	the facility scheduler	should have completed the			include the posting day and the following	ng	
	posting for 1/28-1/30	/22 prior to being off.			three days. The information posted will		
					changed as appropriate on a daily bas		
	_	with the scheduler on 2/2/22			reflect the correct number of nursing st		
		d she was unaware it was post the daily nursing staff			and census at the beginning of each sl by the staffing coordinator, receptionis		
	data prior to being of				nurse manager, manager on duty, and		
	data prior to being or				the Executive Director.	701	
					Facility Executive Director completed		
					training with the facility staffing		
					coordinator, receptionist, and nurse		
					managers, and managers on duty on		
					February 24, 2022. The emphasis of the education, including but not limited to,	ie	
					timely posting, documenting accurate		
					census/staffing numbers (licensed &		
					unlicensed staff) and updating of the		
					staffing sheet as needed when change	s	
					occur throughout the workday. This		
					education is also added on facility		
					orientation process for any new staffing	-	
					coordinator, receptionist, nurse manag	ers,	
					and/or managers on duty effective		
					February 24, 2022.		
					MONITORING PROCESS:		
					Effective February 24, 2022, the facility	/	
					Executive Director and/or Director of		
					Nursing will inspect the "nursing postin	g	
					board" located at the front lobby to ens	ure	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C
	ROVIDER OR SUPPLIER  AL HEALTH CARE LILLI			STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546	02/04/2022
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 732	Continued From page	e 44	F 73	nursing staffing information is posted if four consecutive days, and contain accurate information based on the starnumbers and census at the beginning the inspection shift. This monitoring process will be completed daily Mondathrough Friday for two weeks, weekly two more weeks, then monthly for thremonths or until the pattern of compliar is maintained. Findings of this monitor process will be documented in nursing staffing monitoring tool located in the facility compliance binder.  Effective February 24, 2022, the week manager on duty and/or Designated swill inspect the "nursing posting board located at the front lobby to ensure nursing staffing information is posted if four consecutive days, and contain accurate information based on the starnumbers and census at the beginning the inspection shift. This monitoring process will be completed every Saturand Sunday for two weeks, every othe Saturday and Sunday for two more weeks, then one weekend a month for three months or until the pattern of compliance is maintained. Findings of monitoring process will be documented in nursing staffing monitoring tool located the facility compliance binder.  Effective March 15, 2022, the Staffing coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications.	ffing of ay for se size sing send staff or this din shin shin street services and services se

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345213	B. WING				04/2022
NAME OF D	ROVIDER OR SUPPLIER	0.102.10			TREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2022
NAME OF T	NOVIDER OR SOLT LIER				995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON					
					ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732 F 745 SS=D	CFR(s): 483.40(d)	r Related Social Service		732	monthly for three months, or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	I	3/15/22
	maintain the highest pand psychosocial well This REQUIREMENT by: Based on record revision interviews the facility medical appointment sampled resident revisocial services (Resident #110 was addiagnoses that included diabetes mellitus and Review of Resident #1/14/22 revealed Resident #1/14/22 revealed Resident #110's most (MDS) assessment definition of the same of	ial services to attain or practicable physical, mental l-being of each resident. is not met as evidenced ew, resident and staff failed to ensure a resident's was rescheduled for 1 of 1 ewed for medically related dent # 110).  it is not met as evidenced ew, resident and staff failed to ensure a resident's was rescheduled for 1 of 1 ewed for medically related dent # 110).  it is not met as evidenced in the staff each test and staff each test and staff each resident.			F745 IMMEDIATE ACTION: On February 25, 2022, Medical record coordinator (Scheduler) rescheduled appointment for resident #110's medical appointment with a rehab center for ambulation options. New appointment is schedule to happen on March 28,2022. IDENTIFICATION OF OTHERS: 100% audit of current resident clinical documentation, and grievance log for the last three months was completed by medical records coordinator on Februal 23, 2022, to identify any documented concerns related to missing appointments/cancelled items that were not rescheduled. No other issues were identified during this audit. Findings of the second coordinator of the second concerns related to missing appointments/cancelled items that were not rescheduled. No other issues were identified during this audit. Findings of the second coordinator of t	is he ry	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245242	B WING					
		345213	B. WING			02/	04/2022	
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSA	AL HEALTH CARE LILLII	NGTON		19	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 745	assistance with bed right dressing, and person assessed as dependence.  An interview was conson on 1/31/22 at 9:00 AN cancelled an appoint ambulation options with 9/28/21 at 3:00 PM. appointment was not appointment was consolved an interview was consolved appointment was cansolved by a pointment was can appoint by a point by a pointment was can appoint by a pointment by	the required extensive mobility, locomotion, al hygiene. She was ent for transfers and toilet ducted with Resident #110 M who stated the facility had ment with a rehab center for thich was scheduled on She reported the rescheduled.  ducted with the scheduler on to stated Resident #110's incelled by the facility on the disciplination of Resident #110 was sported by the facility appointment. The feed the facility van was set to dialysis and was late by so Resident #110's incelled. She reported the rescheduled and it was an ted she would have been the the appointment.  ducted with the facility on 2/4/22 at 4:15 PM #110's appointment should	F	745	audit is documented on a "Medical appointment audit tool" located in the facility compliance binder.  SYSTEMIC CHANGES: Effective March 8, 2022, the facility will provide medically related social service to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resider to include ensuring medical related appointments are scheduled and rescheduled in a timely manner.  Effective March 8, 2022, the facility's clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 and/or Unit coordinator #1 and/or Unit coordinator initiated a process for reviewing clinical documentation to include the review of medical appointments ordered and/or scheduled in the last 24 hours or from the last held clinical meeting to ensure the appointment is scheduled and take place as ordered. This systemic process will take place daily (Monday through Frida Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/Unit coordinator #1/#2. Findings of this systemic change will be documented of the daily clinical report form and maintained in the daily clinical meeting binder.  100% education of all current clinical temembers to Director of Nursing, Assisting the process of the proce	es nt f #2 the ce by).		
					Director of Nursing, Medical records	urit		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	(X3) DATE COMF	SURVEY
		345213	B. WING			C <b>04/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2022
				1995 EAST CORNELIUS HARNETT BOULEVAR	)	
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 PREFI TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPROPERS OF T	) BE	(X5) COMPLETION DATE
F 745	Continued From page	e 47	F	coordinator, Unit coordinator #1 and Unit coordinator #2 completed by the Facility Administrator. The emphasis this education includes, but not limit the importance of ensuring each reserceive medically related social served to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resito include ensuring medical related appointments are scheduled and rescheduled and followed through in timely manner. The education also emphasized the process of reviewin medical appointment during the dail clinical meeting. This education will completed by March 15, 2022, any of team member not educated by March 2022, will not be allowed to work uneducated. This education is added thire orientation for all clinical team members effective March 8, 2022.  MONITORING PROCESS: Effective March 8, 2022, Director of nursing, Assistant Director of Nursin and/or Unit coordinator #1 and/or Unit coordinator #2, will monitor complian with resident's medical appointment reviewing the daily clinical meeting in to ensure completion and proper foll through. Any issues identified during monitoring process will be addresse promptly. This monitoring process we completed daily Monday through Frifor two weeks, weekly for two more weeks, then monthly for three month until the pattern of compliance is maintained. Findings of this monitor	of of ed to, ident ideas dent a grand of ed to, ident ideas dent a grand of ed to ed	

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 02/04/2022	
NAME OF P	ROVIDER OR SUPPLIER	0.02.0	<u> </u>	S7	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2022
					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON			ILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 745	745 Continued From page 48		the facility compliance binder.  Effective March 15, 2022, the Director Nursing Assistant, Director of Nursing and/or medical record coordinator wireport findings of this monitoring proto the facility Quality Assurance and Performance Improvement Committe (QAPI), for recommendations and/or modifications, monthly for three monor until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Execu		"appointment monitoring form" located the facility compliance binder.  Effective March 15, 2022, the Director of Nursing Assistant, Director of Nursing, and/or medical record coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Medical Records	of sss s,	
	CFR(s): 483.60(i)(1)(2)(2)(3)(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 from local producers, and local laws or regulii) This provision doe facilities from using positive states and provision does facilities from using positive states and safety and safety sa	re food from sources ed satisfactory by federal, ies. bod items obtained directly subject to applicable State	F	812	Coordinator will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.		3/15/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 02/04/2022	
NAME OF P	ROVIDER OR SUPPLIER		<del>                                     </del>	STREET ADDRESS, CITY, STATE, ZIP CODE		02/04/2022	
TO UNIC OF T	TO VIDER OIL OIL OIL I EIER			1995 EAST CORNELIUS HARNETT BOU			
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		LILLINGTON, NC 27546	LVAND		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	F 812 Continued From page 49		F 8	12			
	safe growing and food	d-handling practices.					
		es not preclude residents					
		s not procured by the facility.					
	\$483.60(i)(2) - Store.	prepare, distribute and					
		ince with professional					
	standards for food se	•					
This REQUIREMENT by:		is not met as evidenced					
	Based on observatio	ns and staff interview, the		F 812			
		date, and close food items		IMMEDIATE ACTION:			
	-	ed and stored in the in the		Dietary Manager discarded all			
	refrigerator and freez			open undated items and all da			
	observations in the fa	cility kitchen.		that were observed to be open refrigerator on January 30, 202			
	The findings included	:		items discarded included: One			
	Ŭ			opened mayonnaise that was			
	In observation of the	facility kitchen conducted		had no date to indicate when it	had been		
	with the morning cool	k in attendance on		originally opened, One 12-oun	ce package		
	1/30/2022 at 12:58 PI	M, the refrigerator was		of sliced bologna that was ope	ned but had		
	observed to contain the			no date to indicate when it was			
		ned mayonnaise that was		opened, One 20-lb. box of mix			
		ate to indicate when it had		vegetables that was opened a			
	been originally opene			but had not been closed or re-			
		ckage of sliced bologna that		the freezer, and One 10-lb. bo			
	-	no date to indicate when it		sausage patties that were ope			
	• • •	I, and the package was open		dated but had not been closed			
	to air in the refrigerate	or.		re-sealed and was open to air freezer.	in the		
	In observation of the	facility kitchen conducted		lieezei.			
	with the morning cook	-		IDENTIFICATION OF OTHER	S·		
		I, the freezer was observed		All residents have a potential to			
	to contain the following			affected by this practice, there			
		mixed vegetables that was		audit of the entire kitchen was			
		t had not been closed or		a Dietary Manager on Februar	•		
	-	en to air in the freezer.		to identify any food item/s with			
		sausage patties that was		date, and/or any food items that			
		t had not been closed or		been opened and stored in the			
		en to air in the freezer.		refrigerator and freezer withou			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			1	04/2022
	ROVIDER OR SUPPLIER  AL HEALTH CARE LILLII	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVARD  LILLINGTON, NC 27546			O-1/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPOPOPOPOPOPOPOPOPOPOPOPOPOPOPOPOPOP			(X5) COMPLETION DATE
F 812	that all dietary staff an food items should be or re-sealed. She rep been opened should the date the item was reported that opened	dietary manager was 122 at 2:15 PM and revealed re instructed that opened labeled, dated, and closed rorted food items that have be labeled and dated with roriginally opened. She also food items should be closed are protected from the air in	F	812	closed. Findings of this audit is documented on a "Kitchen inspection audit tool located in the facility compliar binder.  SYSTEMIC CHANGES: On February 28, 2022, the facility Dieta Manager re-established a cleaning assignment for dietary staff on duty to ensure the kitchen food storage locatio to include refrigerators, freezers, and d storage areas, are cleaned and all oper food items have labels with dates and a closed when food items have been opened and stored in the refrigerator at freezer. The new cleaning assignment be used effective February 28, 2022.  100% education of all active/current facility Dietary employees to include ful time, part time, and as needed employe will be completed by the Dietary Manage The emphasis of this education include but not limited to the importance of ensuring the kitchen food storage locations, to include refrigerators, freezers, and dry storage areas, are cleaned and all open food items include labels with dates and are closed when food items have been opened and store in the refrigerator and freezer. This education will be completed by March 2022. Any dietary employee not educate by March 15, 2022, will not be allowed work until educated. This education will provided annually and will be added to new hire orientation for all new dietary employee employees effective March 2022.	ary ons, lry n are nd will ll ees ger. es, e ed to l be	

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 02/04/2022	
	ROVIDER OR SUPPLIER	NGTON		1995	EET ADDRESS, CITY, STATE, ZIP CODE  EAST CORNELIUS HARNETT BOULEVARD  INGTON, NC 27546	1 027	0 <del>-1</del> /2022
(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 SHOU			(X5) COMPLETION DATE
F 812	Continued From page	÷ 51	F	E M nn for readir was nn pp co for wu nn pp so fa E dd pp so ffi and dh refin ne was for no o	MONITORING PROCESS: Effective March 8, 2022, the Dietary Manager will complete a kitchen monitoring process to ensure the kitche ood storage locations, to include efrigerators, freezers, and dry storage areas, are clean and all open food item include labels with dates and are close when food items have been opened an stored in the refrigerator and freezer. A negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday foor two weeks, weekly for two more weeks, then monthly for three months of antil the pattern of compliance is maintained. Findings of this monitoring process will be documented on "Food storage monitoring tool" located in the actility compliance binder.  Effective February 28, 2022, the cook of duty will complete kitchen monitoring process to ensure the kitchen food storage locations, to include refrigerato reezers, and dry storage areas, are cle and all open food items include labels we dates and are closed when food items have been opened and stored in the effigerator and freezer, any negative inding will be corrected promptly. This monitoring process will be completed every Saturday and Sunday for two weeks, every other Saturday and Sunday or two more weeks, then one week encount for three months or until the patt of compliance is maintained. Findings of this monitoring process will be	ns d hd Any be y or on with	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED				
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		345213	B. WING _			02/	04/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON			195 EAST CORNELIUS HARNETT BOULEVARD		
040.45	CLIMMADY CT	TATEMENT OF DEFICIENCIES			LLINGTON, NC 27546		0/5)
(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
_	Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not reresident-identifiable to (ii) The facility may reresident-identifiable to accordance with a coagrees not to use or except to the extent the do so.  §483.70(i) Medical reresident-identifiable to accordance with a coagrees not to use or coagrees not to use or coagrees not to use or coagrees to the extent the do so.	dentifiable Information 483.70(i)(1)-(5)  nt-identifiable information. elease information that is to the public. elease information that is o an agent only in elease under which the agent disclose the information the facility itself is permitted		312	documented on "food storage monitoring tool" located in the facility compliance binder.  Effective March 15, 2022, the Dietary Manager and/or Kitchen manager will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months or until the pattern of compliance is achieved.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Dietary Manager will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	e e e	3/15/22

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 <b>02/04/2022</b>	
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULE  LILLINGTON, NC 27546	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 842	all information conta regardless of the for records, except when (i) To the individual, representative where (ii) Required by Law (iii) For treatment, paragraph operations, as permit with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research medical examiners, a serious threat to he by and in compliance §483.70(i)(3) The far record information a unauthorized use.  §483.70(i)(4) Medica for- (i) The period of times	nented; ile; and rganized  cility must keep confidential ined in the resident's records, m or storage method of the n release is- or their resident e permitted by applicable law; is ayment, or health care tted by and in compliance	F 8	,			
	there is no requirem (iii) For a minor, 3 ye legal age under Stat	ent in State law; or ears after a resident reaches					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _		C <b>02/04/2022</b>
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 842	(i) Sufficient informati (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review of determinations condu (v) Physician's, nurse professional's progre (vi) Laboratory, radio services reports as re This REQUIREMENT by: Based on record rev facility failed to accur glucose levels and ur residents (Resident # failed to document a (Resident #27) review  The findings included  1. Resident #67 was 2/6/20 with diagnose mellitus and chronic of disease.  Resident #67's quarte (MDS) assessment of was cognitively intact rejection of care.	on to identify the resident; sident's assessments; ve plan of care and services of preadmission screening evaluations and acted by the State; ets, and other licensed ass notes; and logy and other diagnostic equired under §483.50.  To is not met as evidenced at the proof of the blood and the bloo	F 8	F642 IMMEDIATE ACTION: Resident #67 was seen by a Nurse Practitioner on February 14, 2022, a order was received to discontinue accuchecks with sliding scale and to accuchecks without sliding scale twic daily.  Resident #95 was seen by a Nurse Practitioner on February 28, 2022, a clarification order was received for accuchecks with sliding scale that co a place to document blood glucose obtained and entered in electronic he records by the Director of Nursing.  Nurse #2 documented in the medical record for resident #27 on February 4 2022 "a late entry documentation" the included an assisted fall that happene January 31, 2022.  IDENTIFICATION OF OTHERS: 100% audit of all current residents wi orders for accuchecks completed on	start e  ntain ealth  I, eat eed on

Facility ID: 943230

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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		345213	B. WING				04/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2022	
					995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLII	NGTON			ILLINGTON, NC 27546			
	OUR MAA DV OT	TELEVIT OF REFIGIENCES						
(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 842	Continued From page	e 55	F	842				
	Call physician for bloo	od sugar greater than 400 or			February 28, 2022, March 1,2022 and			
	less than 60.				March 2,2022 by Director of Nursing, U	Jnit		
					coordinator #1, and/or Unit coordinator			
	Review of Resident #	67's Medication			to identify any other resident with an			
	Administration Recor	d (MAR) for January 2022			accucheck order that was entered in th	е		
	revealed Resident #6	7 received 133 units of			system without a place to document bloom	bod		
		units of insulin on 1/6/22,			glucose correctly. Identified orders that			
		n 1/11/22, 130 units of insulin			were entered incorrectly were corrected	d l		
		of insulin on 1/18/22, 145			by the Director of Nursing, Unit			
		0/22, and 136 units on			coordinator #1, and/or Unit manager #2			
	1/22/22.				Findings of this audit is documented or "Accucheck audit tool" located in the	an		
	An interview with the	Unit Manager on 2/2/22 at			facility compliance binder.			
	4:00 PM revealed the				100% audit of all incident reports writte	n in		
	incorrect. She indica	ated the units of insulin were			the last 30 days completed on Februar			
	the same as the Resi	ident's blood glucose level.			28, 2022, by Director of Nursing, Unit			
	The Unit Manager sta	ated she was unsure how			coordinator #1, and/or Unit coordinator	#2		
		rther stated she was certain			to identify any other incidence of fall or			
		dministered however the			assisted fall not documented in medica	.I		
	documentation reflec	ted insulin was			records. No other incidents/accidents			
	administered.				were identified not documented in med	ıcal		
	Dunima an intamiauuu	ith Nivers #C vels for average			records. Findings of this audit is	1:4		
		vith Nurse #6 who frequently tion cart was conducted on			documented on an "Incident report aud tool" located in the facility compliance	ıı		
		ealed there was an issue			binder.			
		se #6 information from blood						
		number is automatically			SYSTEMIC CHANGES:			
		administered. She stated			Effective March 8, 2022, licensed nurse	es		
		rses should have deleted			and medication aides will document on			
	that information from	the system, and she			the medication administration records t	hat		
	neglected to do so.	She indicated she had not			insulin was not administered when bloo	bd		
	reported this issue to	anyone.			sugar is below qualifying sliding scale			
					value. This will allow Licensed nurses a			
		Director of Nursing on			medication aides to document the bloo			
		realed the documentation			sugar on the correct prompt and not as	,		
		rses on the medication cart			unit of insulin.			
		her of any problems with the			F# 11 NA 1 0 0000 11 -1	,		
	computer system.				Effective March 8, 2022, the Director o	i		
			1		nursing set the parameter that will	ļ		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345213	B. WING			02/	04/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				19	995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSA	AL HEALTH CARE LILLI	NGION		L	ILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 842	Continued From page	e 56	F	842				
		s admitted to the facility on			automatically transfer the details of			
	_	es that included diabetes			incident report entered in "incident repo			
	mellitus and hyperter	nsion.			module" to automatically transfer to the			
					facility's clinical documentation to ensu			
	Resident #95's signif	•			each incident is documented at the sar			
		8/22 revealed he was			time when an incident report is entered			
	assessed as having a	<del>-</del>			100% education of all current Licensed			
	impairment. He had no behaviors or rejection of care. He received insulin injections 7 of 7 days of the lookback period.				nurses and Medication aides, to include	3		
					full time, part time and as needed employees completed by the Director of	√f.		
	the lookback period.				Nursing, Assistant Director of Nursing,	"		
	A physician's order d	ated 9/27/21 read Accucheck			Unit coordinator #1 and/or Unit			
		oms use NovoLog insulin for			coordinator #2. The emphasis of this			
	blood sugar greater t			education includes, but not limited to, the				
	201-250=5 units			importance of entering accucheck orders				
	251-300=8 units				currently in Electronic Medical Records	i,		
	301-250=12 units				documenting on medication administra	tion		
	351-400=16 units				records that insulin was not administer	ed		
	· ·	od sugar greater than 400 or			when blood sugar is below qualifying			
	less than 60.				sliding scale value for applicable			
					residents, and/or ensuring that each			
	Review of Resident #				incident/accident to include assisted fall	ls I		
		d (MAR) for January 2022			are documented on each resident			
		95 received 154 units of I units of insulin on 1/4/22,			electronic medical records.			
		n 1/5/22, 176 units of insulin			This education will be completed by			
		lin on 1/6/22, 130 units of			March 15, 2022. Any Licensed nurses			
		of insulin on 1/7/22, 217			and/or Medication aide not educated by	v		
		10/22, 204 units of insulin on			March 15, 2022, will not be allowed to	<b>,</b>		
		insulin 0n 1/16/22, 148 units			work until educated. This education is			
		and 218 units of insulin on			added to new hire orientation for all			
	1/24/22.				Licensed nurses and Medication aides			
					effective March 8, 2022.			
		Unit Manager on 2/2/22 at						
	4:00 PM revealed the				MONITORING PROCESS:	ſ		
		ated the units of insulin were			Effective March 8, 2022, Director of			
		ident's blood glucose level.			nursing, Assistant Director of Nursing,			
		ated she was unsure how			and/or Unit coordinator #1 and/or Unit			
	this occurred. She ful	rther stated she was certain			coordinator #2, will monitor compliance	by		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			02/04/2022	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLII	NGTON			995 EAST CORNELIUS HARNETT BOULEVARD		
					ILLINGTON, NC 27546		
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F 842	Continued From page the insulin was not ac	e 57 Iministered however the	F	842	reviewing all new orders, Medication		
	documentation reflected insulin was administered.  During an interview with Nurse #6 who frequently works on the medication cart was conducted on				Administration records for residents wit orders for accucheck with sliding scale, and incident reports written from the priclinical meeting to ensure all accuchecl orders are entered correctly, document	ior k	
2/2/22 at 5:45 PM revealed there was an issue with the system. Nurse #6 information from blood glucose testing that number is automatically populated into insulin administered. She stated				accurately in medication Administration records, and incident/accidents are documented in medical records. Any issues identified during this monitoring			
	she and the other nurses should have deleted that information from the system, and she neglected to do so. She indicated she had not reported this issue to anyone.  An interview with the Director of Nursing on 2/3/22 at 3:30 PM revealed the documentation was incorrect and nurses on the medication cart should have advised her of any problems with the computer system.				process will be addressed promptly. The monitoring process will be completed d Monday through Friday for two weeks, weekly for two more weeks, then month	aily	
					for three months or until the pattern of compliance is maintained. Findings of t monitoring process will be documented "clinical documentation monitoring form located in the facility compliance binder	his on	
	3. Resident #27 was 3/3/2021. His diagnos and unsteadiness on				Effective March 15, 2022, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Qualit Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications monthly for three months, or until the pattern of compliance is achieved.	у	
	#27 was at risk for fal weakness and impair included bed in low p of the bed, encouragi request assistance, a reach, and monitoring	3/10/2021 revealed Resident and injury related to led mobility. Interventions osition, resident in the center ng the use of the call light to rranging furniture in his g for changes in condition leased supervision and ling the physician.			RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	l of :he	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345213	B. WING _			C 02/04/2022
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE 1995 EAST CORNELIUS HARN LILLINGTON, NC 27546		OZIO II ZOZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ID TO THE APPROPRIA ICIENCY)	
F 842	The admission Minimassessment dated 3/#27 was severely cogimpairments to both lindicated no history of 1/25/22 revealed Rescognitively impaired wupper and lower extratwo or more falls with On 1/31/2022 at 10:0 observed with his heafloor, his waist was othis feet and legs were his room. The bed was Nurse #2 was called Nurse #2 was observ #27's room, assisting the room. On 1/31/20 Aide (NA) #1 and NA Resident #27's room bed. Nurse #2 was not Resident #27's room. Review of the medical documentation of a fat 1/31/2022.  On 2/4/2022 at 11:00 Nurse #2, she stated was trying to get out thim to the floor. She shim to the floor, she on the nursing incident report. Nurse not know the facility's not know the facility's not know the facility's	um Data Set (MDS) 12/2021 indicated Resident gnitively impaired with ower extremities and f falls. The 5-day MDS dated ident #27 was severely with impairments to both emities and had experienced out injury.  3 a.m., Resident #27 was ad and upper body on the wer the edge of the bed and e on the bed when entering as positioned low to the floor. to Resident #27's room. ed entering the Resident him to the floor and exiting 022 at 10:08 a.m., Nurse #2 were observed entering to assist him back into the ot observed re-entering	F	342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		345213	B. WING		C 02/04/2022
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON		STREET ADDRESS, CITY, STATE, ZIP COI 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE COMPLETION DATE
F 842	Director of Nursing, s being on the floor wa Nurse #2 should had	she stated Resident #27 as considered a fall, and documented the fall in the es in Resident #27's medical d an incident report.	F	842	
SS=E	§483.80 Infection Co The facility must esta infection prevention a designed to provide a comfortable environr development and tra diseases and infection §483.80(a) Infection program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable distaff, volunteers, visit providing services un arrangement based un conducted according accepted national sta	ablish and maintain an and control program a safe, sanitary and ment and to help prevent the nsmission of communicable ons.  prevention and control ablish an infection prevention (IPCP) that must include, at wing elements:  em for preventing, identifying, and controlling infections iseases for all residents, tors, and other individuals ander a contractual upon the facility assessment to §483.70(e) and following			
	but are not limited to (i) A system of surve possible communical	: illance designed to identify ble diseases or y can spread to other			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345213	B. WING _			C 02/04/2022
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOUL LILLINGTON, NC 27546	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	communicable disease reported; (iii) Standard and trant to be followed to previously (iv) When and how is consident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employer.	m possible incidents of se or infections should be a smission-based precautions yent spread of infections; colation should be used for a set not limited to: action of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the ses under which the facility ees with a communicable	F	380		
	contact with residents contact will transmit to (vi)The hand hygiene by staff involved in dispersion of the staff involved in the staff involved in the staff involved involved in the staff invol	e procedures to be followed rect resident contact.  em for recording incidents acility's IPCP and the ten by the facility.  Ille, store, process, and is to prevent the spread of view.  Incident an annual review of its ir program, as necessary.				
	by: Based on observation facility failed to adher measures related to 0	is not met as evidenced on and staff interviews, the re to infection control COVID-19 when Nurse #2 nning a gown or gloves		F880 ROOT CAUSE ANALYSIS (RC The Governing body led by the Administrator and Director of N	facility	

		T	1			T T	<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	` '	SURVEY PLETED
, "AD I LAN OF	CONNECTION	DENTIFICATION NOWDER.	A. BUILD	ING _			
							С
		345213	B. WING			02	/04/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE LILLII	NGTON		19	995 EAST CORNELIUS HARNETT BOULEVARD		
ONIVERO	ALTIEALITI GARE LILLII	NOTON		L	ILLINGTON, NC 27546		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG	NEGOLATORI ORI		170		DEFICIENCY)		
F 880	Continued From page	e 61	F	880			
		ent care to 1 of 1 residents			collaboration with the facility Infection		
		he hallway and before			Preventionist and Quality Assurance ar	nd	
		or 2 of 2 residents (Resident			Performance Improvement (QAPI)		
		residing in the COVID-19			committee conducted the root cause		
	unit. This occurred du	uring a COVID pandemic.			analysis on February 24, 2022, to ident	tify	
					the causative factor for this alleged		
	Findings Included:				noncompliance and implemented		
	0:- 4/00/0000 -+ 0:40	)			appropriate measures to correct and	1	
On 1/30/2022 at 3:12 p.m. enhanced				prevent the reoccurrences of the allege			
	droplet-contact precaution signage and donning and doffing personal protective equipment (PPE)				noncompliance. The root cause analys identified that the alleged noncomplian		
	signage was observe				resulted from the failure of one facility	CE	
	residents in the COV				employee (Nurse #2) to adhere to the		
	residents in the oov	dilit.			facility infection prevention policy and		
	On 1/31/2022 at 10:0	9 a.m., Resident #371 was			procedures related to the needs of		
		chair at the medication cart.			Personal Protective Equipment use in t	the	
		red wearing N-95 mask and			COVID unit. The RCA further identified		
	not wearing goggles,	gown or gloves when			that the facility failed to ensure increase	ed	
	administering Reside	nt #371 his medications and			vigilance and supervision to ensure		
	taking his blood press	sure in the hallway on the			infection prevention policies and		
	COVID unit.				procedures are followed in the entire		
					facility to include the COVID unit.		
		2 a.m., Nurse #2 was					
		esident #109's room wearing			IMMEDIATE ACTION:	100	
		d not applying a gown or			Director of nursing assessed resident #		
	gloves before enterin	g the room.			#371, and resident #109 on February 2	<u>′</u> 4,	
	On 1/21/2022 at 10:1	4 a m. Nurse #2 wes			2022, no negative outcome noted		
		4 a.m., Nurse #2 was esident #63's room wearing			following this alleged noncompliance.		
		les and not wearing a gown			IDENTIFICATION OF OTHERS		
		vas observed performing an			All residents have a potential to be		
		d temperature on Resident			affected by this alleged noncompliance	<b>:</b>	
	#63 and exiting the ro						
					SYSTEMIC CHANGES		
	On 1/31/2022 at 10:1	6 a.m. in an interview with			Effective March 8, 2022, The governing	7	
		the residents were on			body including (in parts): the Facility	-	
	'	or COVID-19, and gloves,			Administrator, Director of nursing, and/	or	
		ggles were required when			Infection preventionist developed a		
		's rooms. She stated she			process that will increase vigilance and	I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _				04/2022
	ROVIDER OR SUPPLIER  AL HEALTH CARE LILLII	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVA  LILLINGTON, NC 27546			O-11/2022
(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 SHOULD			(X5) COMPLETION DATE
F 880	had received education protective equipment not have a reason whand gloves before en providing care to the On 2/1/2022 at 2:28 padministrator, Assistation Director of Nursing/In present, the Administrator protective wear, gowen	on on the use of personal for COVID residents and did by she did not apply gown tering resident rooms or residents on the COVID unit.	F	880	supervision to facility staff through increased infection control surveillance rounding to ensure personal protective equipment are adhered throughout the facility to include COVID unit. The new process will require designated department heads to conduct infection control surveillance round by randomly observing five employees weekly and document findings on a PPE compliant form. Any issues identified during this process will be addressed promptly. On February 28, 2022, the facilities Governing body, which includes (in par Administrator, Director of nursing, and infection preventionist, developed a process that will ensure an increased vigilance and supervision of the facility staff to ensure PPE compliance includic compliance with PPE in the COVID unit In the developed process, the Scheduli Coordinator and/or Director of Nursing designate one Licensed nurse on each shift in the COVID unit to aide on ensure the PPE compliance takes place. Scheduling coordinator will indicate on daily nursing assignment who the designated nurse is for that shift for proper communication effective Februar 28, 2022.  Effective March 8, 2022, the designated licensed nurse will ensure staff member wear their PPEs per facility policy and procedures. Any identified issues will be addressed promptly, and appropriate actions will be implemented by the Designated nurse, Director of Nursing and/or infection preventionist.	ts), ng t. ng will ring the ary	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
		345213	B. WING		C <b>02/04/2022</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546	02/04/2022	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 880	Continued From page	e 63	F 88	Effective March 8, 2022, the designate nurse will document any break down or infection prevention measures noted in the COVID unit in a COVID unit report form that will be given to the facility infection preventionist and/or Director nursing for further measures as appropriate.  Director of Nursing (DON) will complet 100% education for all employees in the facility to include full time, part time, and as needed employees. The emphasis this education includes, but not limited the importance of the functions of the designated nurse to enforce PPE adherence in the COVID unit, ensuring proper wear of PPE (mask covering not and mouth, gown, gloves, and goggles when applicable) always while in patie care areas, and the importance of following infection control practices to keep COVID out of the facility and/or manage it effectively in the facility. The Director if nursing uses Keep COVID of training video recommended by CDC apart of this training. This education will completed by March 15, 2022. Any employee not educated by March 15, 2022, will not be allowed to work until educated. This education is added to rhire orientation for all new hires and we be provided annually effective March 8, 2022, The Facility Administrator, Director of nursing,	of ee ne nd of to gese sont ee out as be	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  S		E SURVEY PLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEV.  LILLINGTON, NC 27546	•	02/04/2022 .RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 880	Continued From pag	e 64	F 88	Infection preventionist, and/or des administrative staff, will monitor compliance with infection control surveillance rounding by reviewing completion of PPE compliance to to conduct surveillance rounds), find previous day/days to ensure all employees used proper PPE per policy. Any issues identified during monitoring process will be address promptly. This monitoring process conducted daily for two weeks, we two more weeks, then monthly for months or until a pattern of complianchieved.  Effective March 8, 2022, The Fact Administrator, Director of nursing, Infection preventionist, and/or designative staff will monitor compliance with proper PPE use reviewing the COVID unit report for completed for the previous day/day ensure all employees used proper per facility policy. Any issues identify during this monitoring process will addressed promptly. This monitor process will be conducted daily for weeks, weekly for two more week monthly for three months or until and of compliance is achieved. Effective March 8, 2022, the facility of compliance is achieved. Effective March 8, 2022, the facility of compliance and Performance Improvement Committee for any additional monitoring or modificational monitoring or three months.	g the ool (used from facility g this seed s will be eekly for r three liance is sillity, signated by form ays to er PPE ntified II be ring or two ks, then a pattern ity on of this Quality ion of			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345213	B. WING			02/	04/2022
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLII	NGTON		19	TREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD 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 885 SS=B	Continued From page  Reporting-Residents,  CFR(s): 483.80(g)(3)	Representatives&Families		8880	a pattern of compliance is maintained. The QAPI committee can modify this pl to ensure the facility remains in substantial compliance.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	e I n	3/15/22
	sust—  §483.80(g)(3) Inform representatives, and facilities by 5 p.m. the the occurrence of eith infection of COVID-19 or staff with new-onse occurring within 72 he information must—  (i) Not include person (ii) Include information implemented to preve transmission, including facility will be altered; (iii) Include any cumu their representatives, or by 5 p.m. the next subsequent occurrenconfirmed infection of	families of those residing in e next calendar day following her a single confirmed a, or three or more residents et of respiratory symptoms burs of each other. This hally identifiable information; on mitigating actions ent or reduce the risk of ag if normal operations of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345213	B. WING		0.4	C	
NAME OF D	ROVIDER OR SUPPLIER	040210	1	STREET ADDRESS, CITY, STATE, ZIP CO	•	2/04/2022	
NAME OF FI	NOVIDER OR SUFFLIER			, , ,			
UNIVERSA	AL HEALTH CARE LI	LLINGTON		1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	OULEVARD		
240.15	CLIMMAR	V CTATEMENT OF DEFICIENCIES		· .	CORRECTION	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 885	Continued From p	age 66	F 88	35			
	new onset of resp	iratory symptoms occur within					
	72 hours of each	other.					
	This REQUIREME by:	ENT is not met as evidenced					
	Based on record	review, Resident		F885			
		nd staff interview, the facility		IMMEDIATE ACTION:			
		sident representatives and/or		Director of Nursing informed			
		sidents, (Resident #93, #60,		93□s representative on the			
		1 #81, #89, #70 and #76), by		status of the facility on Febr	uary 24, 2022.		
		calendar day following the		IDENITIES ATION OF OTHE	-00		
		onfirmed COVID-19 infection for		IDENTIFICATION OF OTHE			
		ed for COVID-19 testing for		100% audit of all current res			
	12/13/2021.			clinical documentation, and			
	Findings Included:			communication sheets, with December 13, 2021, and De			
	Findings included:	•		2021, completed by the Dire			
	Review of the CO	VID-19 testing log revealed 1		Nursing, Assistant Director			
	staff tested positiv			Unit Manager #1, and/or Un	-		
	otan tootoa pootav	0 011 12/10/2021.		to determine whether all res	_		
	A review of the fac	cility's Ambassador assignment		representatives were notifie			
		ietary Manager was assigned to		occurrence of confirmed CC			
		and was responsible for		infection from testing condu	cted on		
	notifying resident	representatives and families of		12/13/2021. Those identified	d without		
	the status of COV	ID-19 positives at the facility		documented notification we	re notified		
	involving staff and	/or residents.		promptly by Director of Nurs			
				Director of Nursing, Unit Ma	•		
		Resident #93's representative		and/or Unit Manager #2 on			
		11:27 AM revealed she hadn't		2022. This audit was comple			
		ne facility for "about a month"		February 24, 2022. Findings			
		ny cases of COVID-19 were in		are documented on COCID			
	the building.			audit tool located in the facil	lity compliance		
	An intensionalist s	the Administrator on 02/02/2022		binder.			
		the Administrator on 02/02/2022 ed the facility designated		SYSTEMIC CHANGES			
		ed the facility designated issigned resident rooms. He		Effective March 8, 2022, an	d movina		
		sadors were responsible for		forward, the facility will infor	•		
		ng families and their		and their representatives by			
		positive COVID-19 cases in		calendar day following the c	•		
		eir assigned rooms. He also		any confirmed COVID-19 in			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING				X3) DATE SURVEY COMPLETED		
		345213	B. WING			C <b>02/04/2022</b>
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CO 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546		02/04/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE
F 885	stated the Dietary Ma rooms 406a-410B an facility in late Deceml stated the facility did room to another staff Manager stopped wo Administrator stated to families and represer room numbers of 406	anager was assigned to d had stop working at the per 2021. The Administrator not reassign Resident #93's member after the Dietary rking at the facility. The he facility failed to notify statives for the assigned A-410B regarding a staff ositive for Covid-19 on	F 88	facility.  On February 24, 2022, the fact Administrator revised the Anassignment to include a bact ambassadors and floating At This new assignment will be effective February 28, 2022, ambassador will be respons out all the responsibilities of ambassador when the assig ambassador when the assig ambassador will be taking the responsibility only in the abstassigned, and back up ambassigned, and back up ambassigned, and back up ambassigned nurse on duty, and/ambassadors will inform restheir representatives by 5 procalendar day following the oany confirmed COVID-19 informed the notification on resident smedical records Ambassador communication maintained in the Ambassador had Ambassador communication maintained in the Ambassador the Administrator soffice.  The Facility Administrator, Donursing (DON), Assistant Dinursing and/or unit manager complete 100% education for ambassadors and licensed restaff. The emphasis of this each on the importance of informiand their representatives by	mbassador kup mbassadors used The backup ible to carry the assigned the floating nesence of the assadors.  Assigned seach of the floating nesence of the floating nesence of the assadors.  Assigned seach of the floating nesence of the floating nesence of the floating nesence of the floating nest of fection and not the floating nest of the floating nesence of frector of the floating nesence of firector of the floating nesence of the flo	d d d d das

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345213	B. WING				04/2022		
NAME OF P	ROVIDER OR SUPPLIER	111211		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2022		
11NIN/ED0	A	NOTON		19	95 EAST CORNELIUS HARNETT BOULEVARD				
UNIVERS	AL HEALTH CARE LILLI	NGTON		LII	LLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE		
F 885	Continued From page	e 68	F	385	calendar day following the occurrence any confirmed COVID-19 infection in the facility. This education will be completed by March 15,2022. Any Licensed Nurse Ambassador not educated by March 15,2022, will not be allowed to work untileducated. This education will also be added on new hires orientation process for all new licensed nurses and ambassadors and will also be provided annually effective March 15, 2022  MONITORING PROCESS  Effective March 15, 2022, The administrator, Director of Nursing, will monicompliance with COVID-19 notification residents representative by 5 pm nex calendar day following the occurrence any confirmed COVID-19 infection in the facility. This monitoring process will be accomplished by reviewing the documentation of notification following new case of COVID 19 in the facility in either resident smedical records and/ambassador communication sheets. An issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will take place daily for 2 week weekly x 2 more weeks, then monthly x months or until the pattern of compliance is achieved.  Effective March 15, 2022, the Director of Nursing and/or assistant Director of	or tor to to to fine a or my will mg			

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 04/2022
NAME OF P	ROVIDER OR SUPPLIER	040210		S <sup>1</sup>	FREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2022
				19	95 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LI	LLINGTON, 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 885 F 921 SS=D	Continued From page Safe/Functional/Sanit CFR(s): 483.90(i)	e 69 cary/Comfortable Environ		921	Nursing will report findings of this monitoring process to the facility Qualit Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications monthly for three months, or until the pattern of compliance is achieved established.  RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	e I	3/15/22
	The facility must provisanitary, and comfort residents, staff and the This REQUIREMENT by:  Based on record revisiterview, the facility for environment by having throughout the courty failed to post designathe deemed smoking.  Findings Included:  Review of facility policing resident Smoking, Sebruary 2021 reveals	ie public. is not met as evidenced iew, observation and staff failed to maintain a sanitary ig cigarette butts scattered and smoking areas and ted smoking area signs in areas.			F921 IMMEDIATE ACTION: House Keeping Manager cleaned the courtyard and removed all cigarette but from the ground in the courtyard on February 03, 2022.  Maintenance Director placed "designat smoking area" signs in the appropriate areas of the courtyard that designated smoking areas on February 28, 2022.  Maintenance Director also removed "Nismoking signs" from the designated	ed as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  . BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45040	D WING			1	С	
		345213	B. WING _			02/	04/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSA	AL HEALTH CARE LILLII	NGTON		1	995 EAST CORNELIUS HARNETT BOULEVARD			
ONIVERO	AL HEALIN OAKE EILEN	<b>TOTON</b>		L	LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 921	Continued From page	∍ 70	F 9	921				
		d resident smoking areas building. "Designated			smoking areas on February 28, 2022.			
	Smoking Area" signs	would be prominently			IDENTIFICATION OF OTHERS:			
	posted. No signs we	re observed that stated			100% inspection of the courtyard areas	3		
	_	Area" for Hall #1 and Hall			and outside facility grounds were			
	#5 in the deemed sm	oking areas.			performed on February 22, 2022, by the			
					Housekeeping Manager to identify any			
		facility's smoking area on			other areas with cigarette butts on the			
		I revealed 4 entrances and 4			ground. No other areas were identified			
	cigarette butts gather	ervation also revealed 30			with cigarettes butts on the ground.  Findings of this inspection is document	od		
		lled "Hall # 4" and a "No			on an "environmental services" audit to			
	Smoking" sign was po				located in the facility compliance binde			
		d there were scattered			located in the racinty compilation billion	'-		
	cigarette butts, appro				SYSTEMIC CHANGES:			
		ard on all four sections, two			On February 28, 2022, the facility House	se		
		oking" signage posted			Keeping Manager re-established a			
	above the entrance/e	xit doors. An interview with			cleaning assignment for housekeeping			
		orker on 02/02/2022 at 9:31			staff on duty to ensure the facility			
		ourtyard of the facility at the			courtyard is cleaned and sanitized dail			
		ealed the facility's deemed			The new cleaning assignment will be u	sed		
		the courtyard were "Hall #1			effective February 24, 2022.			
		cility's no smoking areas						
		II #7." The Social Worker			Effective February 28, 2022, employee			
	also stated she thoug	· · · · · · · · · · · · · · · · · · ·			residents, and visitors will be allowed t	)		
		sponsible for cleaning the cknowledged the cigarettes			smoke in areas with a posted sign "designated smoking area only". Anyon	20		
	_	n the ground but should be			observed smoking in an undesignated	ie.		
		on container and disposed in			smoking area will be redirected and			
		She also stated she was in			appropriate measures will be taken			
		see the residents who were			immediately for violating the facility			
	,	of this observation. One			smoking policy.			
		d outside smoking at the						
		No signs were observed			100% education of all active/current			
		ed Smoking Area" for Hall #1			facility House Keeping, and laundry			
	and Hall #5 in the dee				employees to include full time, part tim	e,		
					and as needed employees will be			
		Maintenance Director on			completed by the House keeping			
	02/03/22 11:26 AM re	evealed the housekeeping			manager. The emphasis of this educat	on		

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	04/2022
NAME OF P	ROVIDER OR SUPPLIER	l	<del>'</del>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	0-4/ <b>Z</b> 0 <b>Z</b> Z
				1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON			ILLINGTON, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 921	1 Continued From page 71		F 9	921			
	department cleaned t	he courtyard on Mondays			includes, but not limited to the importar	nce	
	and Thursdays. The I	Maintenance Director stated			of ensuring the courtyard is free of		
	his department did no	ot clean the courtyard.			cigarette butts, the new house keeping		
					cleaning schedule, and to ensure the		
		busekeeper on 02/02/2022			facility is clean and sanitary for residen		
	twice a week on Mon	the courtyard was cleaned			staff, and the public. This education will completed by March 15, 2022. Any	ı pe	
	twice a week on Mon	uays and Thursdays.			housekeeping/laundry employee not		
	An interview with the	Administrator on 02/02/2022			educated by March 15, 2022, will not b	e	
		he was unaware that			allowed to work until educated. This		
	residents were smoki	ng in the courtyard "no			education will be provided annually and	Ł	
		all staff had been educated			will be added to new hire orientation fo	r all	
		vho were observed smoking			new housekeeping/laundry employee		
		smoking areas. He added			employees effective March 8, 2022.		
		been cigarette butts on the			MONITORING PROCESS		
		rd area and housekeeping			MONITORING PROCESS:		
		e for cleaning the courtyard. ded there were "No Smoking			Effective March 8, 2022, the Housekeeping Manager will complete		
		inces/exits of "Hall #4 and			environmental rounds monitoring proce	288	
		ere no signs that stated,			to ensure the facility is clean and sanita		
		Area" per facility policy.			for residents, staff, and the public. This		
					will be done by inspecting the courtyard	d to	
					ensure it is without cigarette butts on the	ıe	
					ground, ensure the new cleaning		
					assignment is adhered to by the House		
					keeping staff. Any negative findings wil	l be	
					corrected promptly. This monitoring	,	
					process will be completed daily Monda through Friday for two weeks, weekly for		
					two more weeks, then monthly for three		
					months or until the pattern of compliance		
					is maintained. Findings of this monitori		
					process will be documented on the	-	
					"environmental rounds monitoring tool"		
					located in the facility compliance binde	r.	
					Effective February 28, 2022, the weeks	∍nd	
					manager on duty and/or Designated st		
					will complete environmental rounds		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILD		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  C 02/04/2022		
								NAME OF PROVIDER OR SUPPLIER
					1995 EAST CORNELIUS HARNETT BOULEVARD			
UNIVERSAL HEALTH CARE LILLINGTON				LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 921	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO		ity is and to the rday er r fthis ed on ee ity s, ve ager on		