PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	(X3)	DATE SURVEY COMPLETED	
		345213	B. WING _			C <b>04/11/2023</b>	
	ROVIDER OR SUPPLIER	NGTON	STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULE  LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 000	Initial Comments		E	000			
F 000	to conduct a recertific investigation survey. from 4/3/2023 to 4/6/Additional information 4/11/2023. Therefore 4/11/2023. The facili with the requirement Preparedness. Even INITIAL COMMENTS  The survey team ento conduct a recertific investigation survey. 4/3/2023 to 4/6/2023 information was obtatherefore, the exit datherefore, the exit datherefore, the exit datherefore, NC00192222, NC001NC00194565, NC001NC00199980 and NC0199980 and NC01999980 and NC01999980 and NC01999980 and NC01999999999999999999999999999999999999	The survey team was onsite 2023 and on 4/10/2023. In was obtained offsite on e, the exit date was ty was found in compliance CFR 483.73, Emergency at ID #UBVG11.  Stered the facility on 4/3/2023 cation and complaint  The survey team was onsite and 4/10/2023. Additional ined offsite on 4/11/2023. Event ID  stered was 4/11/2023. Event ID  were investigated: 192416, NC00193912, 196593, NC00199735, 200200365.	F	000			
ABORATORY	 DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 RE	TITLE		(X6) DATE	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

.\_\_

Electronically Signed 05/02/2023

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.

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		IPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED			
		345213	B. WING _			C <b>04/11/2023</b>	
	ROVIDER OR SUPPLIER	NGTON	STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULE  LILLINGTON, NC 27546		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 000	Continued From pag	e 1	F	000			
F 600 SS=J		l Neglect	F 6	600			
	Exploitation The resident has the neglect, misappropria and exploitation as dincludes but is not lin corporal punishment any physical or chemitreat the resident's mises 483.12(a) The facilities facilities abuse, corpinvoluntary seclusion. This REQUIREMENT by:  Based on record revision Medical Director, and facility failed to prote impaired resident fro On 3/18/23 nurse aid Resident #22's left the 3/20/23 Resident #22' and found to have a described as the "siz and swollen knee. X-Resident #22 had a gracture of the left disting the fracture site (the than one place and than angle to each other site of the second of t	ty must- e verbal, mental, sexual, or oral punishment, or i; Γ is not met as evidenced riew, staff, Nurse Practitioner, d Radiologist interviews, the ct a severely cognitively m injury of unknown origin. He #1 observed bruising on high and right fourth toe. On 2 was assessed by a nurse bruise to her left thigh e of a salad plate saucer"		Past noncompliance: no plan correction required.	of		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED	
		345213	B. WING _	<del></del>		C 04/11/2023	
	ROVIDER OR SUPPLIER  AL HEALTH CARE LILLIN	NGTON	STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEV.  LILLINGTON, NC 27546		·	ARD	
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	10/10/2018 with diagra Tourette's disease (a involving repetitive measures) cognitive corabnormal posture, va behavioral disturbance osteoporosis.  The annual Minimum assessment dated 1/4 was severely cognitive speech, and sometime others. The MDS shoextensive assistance transfers and total assember for bathing. #22 had not taken an have any behaviors of have any physical/verothers. The MDS shoessessment, Resident previous six months.  The care plan dated had a focused area of inappropriate/disruptive haviors of screaming Tourette's disorder, a and at risk for falls will Interventions included needed, use simple comobility at level reside assist with bathing, to transfers.	mitted to the facility on noses that included nervous system disorder ovements or unwanted nmunication deficit, scular dementia with es, convulsions, and  Data Set (MDS) 4/23 showed Resident #22 ely impaired, had unclear es was able to understand wed Resident #22 required from two staff members for sistance from one staff The MDS showed Resident y anticoagulants, did not frefusing care, and did not roal behaviors directed at wed at the time of t #22 had not fallen in the	F 6				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		OMPLETED
		345213	B. WING_			C <b>04/11/2023</b>
	ROVIDER OR SUPPLIER	LINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVA  LILLINGTON, NC 27546		04/11/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	bruising on her left to fourth toe. The show	ge 3 showed Resident #22 had chigh and bruising on her right wer sheet was signed by 18/23 and the Unit Manager	F 6	00		
	dated 3/20/23 read notice left knee was notified, order for le mobile x-ray mobile	note written by Nurse #2 "nurse aide was giving bath s swollen. Physician was ft leg to be x-ray, writer called imagining."  /23 of Resident #22's left				
	femur (thigh bone) s mineralization was o osteopenia (reduced than osteoporosis) of which bones become loss of tissue). The had a grossly displat distal femur with any and soft tissue swell	showed osseous decreased. This could reflect d bone mass lesser severity or osteoporosis (condition in the brittle and fragile from a report also read Resident #22 toced complex fracture of the gulation at the fracture site ling. (the femur was broken in the and the bone fragments				
	order to send Resid room for evaluation A nursing progress Manager dated 3/20	dated 3/20/23 showed an ent #22 to the emergency of a possible femur fracture.  note written by the Unit 0/23 read "Resident sent to ation and treatment per MD ur fracture."				
	3/20/23 read "Left le There is moderate s	m physical assessment dated eg has obvious deformity. swelling to left thigh with nal obvious trauma on exam."				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		E SURVEY PLETED	
		345213	B. WING			C / <b>11/2023</b>	
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOUL  LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	was not in any distret Resident #22 showed alert, and moved her The x-ray taken at the 3/20/23 showed Resignature (a fracture will least two places) that used to set broken be open) in the emerge orthopedic surgery of unable to provide the information related to injuries. Resident #2 hospital on 3/20/23 value a closed fracture of the femur. (a fracture of	signs were stable, and she	F 60	00			
	P.M. with Nurse Aide Resident #22 on 3/2 P.M. shift. NA #2 ind Resident #22. Resid communicate with st needs known. During indicated Resident # to hanging off the be without assistance fr interview, NA #2 indi work with Resident # A.M. to 7 P.M. shift a Resident #22 to have indicated when she we had not received a ru #22 had a fall or any behaved at her base	anducted on 4/4/23 at 1:29 be #2 who was assigned to 0/23 for the 7 A.M. to the 7 licated she was familiar with ent #22 was unable to faff and rarely made her go the interview, NA #2 field was able to move her legs and and sit up in the bed from staff. During the fielded she was assigned to field on 3/17/23 during the 7 fand had not observed the any bruising. NA #2 went to work on 3/20/23, she deport that stated Resident finjury and Resident #22 eline with no indication she dicated when she went to					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
		345213	B. WING			C )4/11/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVARD  LILLINGTON, NC 27546		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	bath she noticed bruiher left thigh approxiplate saucer." NA #2 over the side of the baseline saucer and interview was corp. M. with Nurse #2 vasident #22 on 3/20 p.M. shift. Nurse #2 received a report Reanother incident with Resident #22 was sleher shift on 3/20/23 value pain. During the interference and the indentation above assessed Resident #2 reported the indentation above assessed Resident #2 reported the indentation repositioned repositioned.  An interview was corp. M. with the Unit Maindicated she was unbruising on her left the resident #2 repositioned.	to provide her with a bed sing that was light in color on mately the size of a "salad indicated when she reached led, NA #2 observed a swollen knee. NA #2 to the assigned nurse.	F 6				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	COMPLETED	
		345213	B. WING		04/11/2023	3
	ROVIDER OR SUPPLIER	INGTON	STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEV  LILLINGTON, NC 27546		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLI	ETION
F 600	Resident #22. Durin Manager indicated for verbalize what caus head-to-toe assessiful following results: a little top of Resident to be a newer bruise bruise behind Reside bruise on a toe. The does not recall whice interview, the Unit Manager assessed her on 3/2 notified, and a mobil Physician gave order the emergency rooms showed a fracture. The after Resident #22 wan investigation was an investigation wa	g the interview, the Unit Resident #22 was unable to ed the bruise, so a ment was completed with the bruise the size of a softball on #22's left thigh that appeared be because it was not yellow, a ent #22's left knee, and a e Unit Manager indicated she had a bruise. During the danager indicated Resident for being in pain when she 20/23. The Physician was le x-ray was ordered. The ers to send Resident #22 to a when the x-ray results The Unit Manager indicated went to the emergency room is started by the Administrator.  Inducted on 4/4/23 at 3:42 for of Nursing (DON). During DN indicated the morning of the emergency room, the field a bruise of unknown origin	F 60			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345213	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	343213		STREET ADDRESS, CITY, STATE, ZIP CODE	0	4/11/2023
UNIVERSA	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOULEVALLILLINGTON, NC 27546	RD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	Continued From page	2 7	F 60	00		
	3:25 P.M. with the Nu NP indicated she was in a she was alerted by no needed to be assessed observed a large bruithe side of her left this under 24 hours old base her leg was a little sweathe NP indicated she possible fracture. The completed an investigation that injury occurred du Resident #22's combile #22's weak bones.  A telephone interview 8:22 A.M. with the Medical familiar with Resident to send her to the emfor a femur fracture. In indicated Resident #22 indicated Resident #22 indicated Resident #23 indicated Resident #24 indicated Resident #25 indicated Resident	was conducted on 4/6/23 at tree Practitioner (NP). The the building on 3/20/23 when ursing staff Resident #22 ed for a bruise. The NP se on Resident #22's top to gh that appeared to be ased on the coloration and collen. During the interview felt Resident #22 had a e NP indicated the facility gation and it was determined se to a mechanical lift, ativeness, and Resident  I was conducted on 4/5/23 at edical Director. During the I Director indicated he was effect and had given orders ergency room for evaluation. The Medical Director in was unable to				
	indicated when staff utransfer Resident #22 body were in different person who was not of Director further indicates weakened bones, the	he Medical Director further used a mechanical lift to the pressure points on her allocations compared to a contracted. The Medical uted with Resident #22's movement with the colling back and forth during a				
	shower, the bone ma displaced. During the Director indicated he #22 having a fall prior	y have become grossly interview, the Medical was unaware of Resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	COMF	(X3) DATE SURVEY COMPLETED C		
		345213	B. WING			/11/2023	
	ROVIDER OR SUPPLIER	NGTON	1	STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULE  LILLINGTON, NC 27546		VARD	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From pag	e 8	F 60	0			
	at 9:24 A.M. with Ra interview, Radiologiss #22's electronic med x-rays of Resident #2 taken while she was Radiologist #1 indica a recent fracture and within a day or less fradiologist indicated bone mineralization to fractures. During the femur (thigh bone the femur, the location with the femur, the location to fractures force from a fall, or a for this type of fracture.	was conducted on 4/11/23 diologist #1. During the t #1 accessed Resident ical record and reviewed the 22's left femur (thigh bone) in the emergency room. It is the left thigh fracture was a had occurred approximately from her hospitalization. The Resident #22 had diminished which made her more prone the interview, Radiologist #1 he severity of the break on the end of the break above the sthe resident had a fall. The lated an aggressive amount of car accident was required the interview of the steel and it was an unusual curred in a mechanical lift.					
	Jeopardy on 4/6/23 a The facility provided 4/8/23 which alleged	as notified of the Immediate at 5:00 P.M.  a corrective action plan on a date of completion of ve action plan indicated:					
	The root cause analy noncompliance result facility to ensure each of unknown origin for identified that an emmechanical lift proper policy and procedure bones resulting from	vsis identified that the alleged ted from the failure of the h resident is free from injury one resident #22. The RCA ployee failed to use the rly per facility mechanical lift es. Resident #22 have fragile					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C <b>)4/11/2023</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	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	Resident #22 condit likely that the sustai an improper use of aide #1 on 3/18/202 the extent of resider resident #22 medica of the mechanical lift. On 3/25/2023, Nursimmediately suspen investigation of the Resident #22.  Nurse #1 assessed and notified the atternance and notified the atternance and resident had a fractic contacted the Attendresident to be sent the evaluation and treat #1 notified the resident to the sent the evaluation and treat #1 notified the resident promote on 00 on 03/25/2023, Director one-on-one re-educated Nurse with a contacted Nurse on the importance of his mechanical lift. The re-educated Nurse with a contacted the sent include, but not limit remains free from in Resident #22 was received as the sustained in the sustai	RCA concluded that due to ion of osteopenia it is most ned fractures resulted from the mechanical lift by nursing 3. The RCA concluded that nt #22 injuries is related to al condition and improper use it.  Ing assistant #1 was ded to allow further allegation of abuse/neglect of allegation of abuse/neglect of allegation of abuse/neglect of abuse/neglect of allegation of a	F 60			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C <b>4/11/2023</b>
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOUL LILLINGTON, NC 27546		4/11/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	person's assistance	ge 10 or pain management and two with ADLs, and the use of nce with mechanical lift.	F 6	00		
		dentify other residents having ffected by the same deficient				
	are alert and oriented Director of Nursing, Coordinator, Unit Cocordinator on 3/25 resident with an alled other resident voice abuse/neglect. Find	poordinator #1 and/or MDS /23 to identify any other gation of abuse/neglect. No d any allegation of ings of this audit are esident abuse interview tool"				
	diagnosis completed Nursing, Staff Devel Coordinator #1, Unit Coordinator #2 on 0 other resident with costeoporosis and as care plan with interv persons for transfer, pathological and/or signal pathological path	nt resident's medical d by assistant director of opment Coordinator, MDS c Coordinator #1, and/or MDS 3/25/2023, to identify any liagnosis of osteopenia and or sure each resident has a ention such as use two to minimize risk for spontaneous fractures. t are documented on a "care located in the facility				
	on 03/25/2025, assu Assistance of Daily indicates the amoun	I and/or MDS Coordinator #2 ure each resident has an Living (ADL) care plan that t of assistance required nclude the use of mechanical				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	COMP	(X3) DATE SURVEY COMPLETED C	
		345213	B. WING		1	_ 11/2023
	ROVIDER OR SUPPLIER	LINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546	·	11/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 600	care plan "ADL aud compliance binder."  100% audit of all inclast 30 days comple Director of Nursing, Unit manager #2 to injury of unknown sunknown sources ic are documented on located in the facility.  100% audit of all cur for the last 30 days by Director of Nursi MDS coordinator #2 Unit Manager #2 to documentation of all further investigation sources were identif documented on "she	cident reports written in the eted on March 25, 2023, by Unit coordinator #1, and/or identify any other incident of ource. No other injuries of dentified. Findings of this audit an Incident report audit tool y compliance binder.  Irrent resident's shower sheets was completed on 03/25/2023 ng, MDS Coordinator #1, 2, Unit coordinator #1, and/or	F 60	00		
	changes made to el practice will not reconstructive 03/25/202 remains free from a misappropriation of exploitation, to incluunknown source.  Effective 03/25/202 company abuse pro	3, facility will ensure all buse, neglect, resident property, and ide be free from injuries of a facility employees follow the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345213	B. WING		04/11/2023	
	ROVIDER OR SUPPLIER	NGTON	STREET ADDRESS, CITY, STATE, ZIP COD 1995 EAST CORNELIUS HARNETT BOU LILLINGTON, NC 27546		ULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC	
F 600		use to include injuries of	F 60	0		
		least two employees are a mechanical lift from				
	bed mobility assessn admission, quarterly,	and with any changes in				
	This is reviewed in the be documented on the	tus, by the nurse on duty. ne daily clinical meeting and ne facility medical records				
	who requires mecha	nsive care plan. Any resident nical lift has a care plan for nce with the mechanical lift.				
	include the Director of Nursing, Unit Coor Coordinator #2 revise all new admits/readn and include the provi	, the facility clinical team to of Nursing, Assistant Director rdinator #1 and/or Unit ed the process of reviewing nits in a daily clinical meeting dision for bed mobility re it is completed and				
	documented in electronic presence of osteope ensure appropriate control of the co	ronic medical records, nia and/or osteoporosis, and are plan is in place. Any ied are corrected promptly.				
		nic change is documented neeting report form located neeting binder.				
	full-time, part-time, e staffing agencies cor employees complete Assistant Director of Coordinators (#1, #2 education includes b importance of comple	). The emphasis of this ut not limited to, the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D MANAGE				С
		345213	B. WING			04/	11/2023
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
IINIVEDS/	AL HEALTH CARE LILLIN	NGTON		·	1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON			LILLINGTON, NC 27546		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
			1		32.16.2.16.1		
F 600	Continued From page	e 13	F	600			
		lity status. Staff education					
		ty abuse prohibition policy					
	•	the requirements to use two					
	-	hen using mechanical lifts					
		cation was completed by					
	,	members not educated					
		wed to work until educated.					
		provided annually and has					
		w hire orientation for all new					
		agency employees effective					
	03/25/2023.						
	How the facility plans	to monitor its performance					
	to make sure that solu	•					
	to make sure that soil	utions are sustained.					
	Effective 03/25/2023	the Director of Nursing,					
		Nursing, MDS Coordinators					
	(#1, #2), Unit Coordin						
		complete abuse prohibition					
		his monitoring process is					
		erving residents to ensure					
		ling services in the facility					
		dent is free from abuse and					
	neglect, and to provid	le an environment that is					
	free from accidents a	nd hazards. The monitoring					
	process is accomplish	ned by observing five					
	randomly selected sta						
		ure two people are present					
	•	nis monitoring process will					
		r two weeks, weekly for two					
		onthly for three months, or					
	•	mpliance is established. Any					
		addressed promptly. This					
	monitoring process is						
		monitoring tool located in the					
	facility compliance bir	nder.					
	E##: 00/05/0000	Ale a Director of N					
	∟πестіνе 03/25/2023,	the Director of Nursing,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345213	B. WING			)4/11/2023
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP COI 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	(#1, #2), and/or Wee new admissions for the clinical meeting to en assessment has bee osteopenia/osteopord any) and plan or care intervention such as transfers when to min negative findings are monitoring process is weeks, weekly for two for three months or uncompliance is maintal monitoring process where we will be mobility assessionated in the facility.  Effective 03/25/2023. Assistant Director of (#1, #2), and/or Wee incident/accident monitoring process where we will say and sheets completed for last clinical meeting to injuries of unknown so a nurse and being accompliance in monitoring process is weeks, weekly for two for three months or uncompliance is maintal monitoring process as assessments audit to compliance binder.  Effective 03/25/2023.	Nursing, Unit Coordinators kend Supervisor review all he last 24 hours or from last usure that a bed mobility in completed, a diagnosis or posis has been identified (if e developed to include two people assistance with nimize risk if injuries. Any corrected promptly. This is completed daily for two in more weeks, then monthly intil the pattern of ined. Findings of this will be documented on the ment tool for new residents' compliance binder.  In the Director of Nursing, Nursing, Unit Coordinators kend Supervisor complete intoring process. This will be accomplished by sessments and shower the last 24 hours or from in the last 25 hours or from in the last 26 hours or from in the last 27 hours or from in the last 27 hours or from in the last 28 hours or from in the last 29 hours or from in t	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			1	C 11/2023
	ROVIDER OR SUPPLIER	NGTON		19	TREET ADDRESS, CITY, STATE, ZIP CODE 095 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Quality Assurance an Improvement Commirecommendations and for three months, or use compliance is archived Date of Completion: 3.  The facility provided at the incident that happed completion date of 3/2 was conducted on 4/3 departments and who were interviewed and training in using two presidents in a mechal residents were interviewed and the residents were interviewed and the residents had been asked if the and the residents had completed of the audieducational informatic the in-service and a rign-in logs. The in-service archives archive and the residents archive and a rign-in logs. The in-service and a rign-in logs.	pring process to the facility d Performance ttee (QAPI), for d/or modifications, monthly intil the pattern of ed.  8/25/23  a corrective action plan for pened on 3/18/23 with a 25/23. The onsite validation 10/23. Staff from different to worked different shifts verified they had received people when transferring inical lift. Alert and oriented ewed who indicated they had been abused by staff in oconcerns. A review was it logs that included the provided to staff during eview of in-service staff ervice logs were reviewed,	F	600			
F 641 SS=E	to have received train medical diagnoses, of for transfer with a me sheets and incident rubeen completed and injuries were identified tool revealed staff has of shower sheets and plans to include this meeting. The facility's validated as 3/26/23. Accuracy of Assessm	domly selected and verified sing. The audit of resident are plan to include two staff chanical lift, the shower eports were verified to have no additional unreported d. A review of the monitoring d completed daily monitoring l incident reports. The QAPI monitoring in their next is compliance date was	F	641			5/8/23

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			04/	11/2023
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	11/2020
				19	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLII	NGTON			ILLINGTON, NC 27546		
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F 641	Continued From page §483.20(g) Accuracy	of Assessments.	F 6	641			
	resident's status.	t accurately reflect the					
	Based on record rev	iew and staff interviews, the			F641		
	facility failed to accura	-			Address how corrective action will be		
		eas of wound care (Resident			accomplished for those residents found	d to	
		edication use (Residents			have been affected by the deficient		
	#373, #20 and #57), a				practice.		
		dents #57 and #111), for 5 of //inimum Data Set (MDS)			Minimum Data Cat (MDC) agardinator	41	
	assessments whose it	` '			Minimum Data Set (MDS) coordinator a completed a review of the medical reco		
	assessments were re	viewed.			for resident #62 and completed a	лu	
	Findings included:				modification of the 4/5/2023 MDS to		
	i mango moladoa.				reflect correct coding of section M, und	er	
	1. Resident #62 was	most recently re-admitted to			the current number of unhealed pressu		
		3. Diagnoses included, in			ulcers/injury at each stage section. The		
		al pressure ulcer and (1)			corrected MDS assessment was		
	deep tissue injury (D	ΓI) to his left heel.			transmitted on 4/5/2023.		
					Minimum Data Set (MDS) coordinator a	<b>#</b> 1	
	A significant change I	MDS assessment dated			completed a review of the medical reco	ord	
		d in Section M on Line			for resident #373 and completed a		
		ent #62 had (1) Stage 2			modification of the 4/4/2023 MDS to		
	pressure ulcer.				reflect correct coding of section N, und	er	
					the antipsychotic medication review		
		sion documentation dated			section. The corrected MDS assessme	nt	
		esident #62 had (1) Stage 4 is sacrum and (1) DTI to his			was transmitted on 4/5/2023.		
	left heel on admission	, ,			Minimum Data Set (MDS) coordinator i	# 1	
	left fieer off admission	1.			completed a review of the medical reco		
	In an interview with M	IDS Nurse #2 on 04/05/23 at			for resident #20 and completed a	u	
		she did not know why she			modification of the 4/6/2023 MDS to		
		sure ulcer on the MDS			reflect correct coding of section N, und	er	
		dent #62. She noted she			the antipsychotic medication review		
		oporting documentation that			section. The corrected MDS assessme	nt	
	indicated he had a St				was transmitted on 4/6/2023.		
		d (1) Stage 4 pressure ulcer					
	_	) DTI to his left heel at the			Minimum Data Set (MDS) coordinator	# 1	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 1/11/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	+/11/2023	
				1995 EAST CORNELIUS HARNETT BOU			
UNIVERSA	AL HEALTH CARE LILLII	NGTON		LILLINGTON, NC 27546			
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F 641	Continued From page	<b>∍</b> 17	F 64	41			
	coding error to: (1) cli the assessment, (2) b	ent. She contributed the cicking the wrong box within being new to the MDS g new to the computer e facility.		completed a review of the me for resident #57 and complete modification of the 4/6/2023 M reflect correct coding of section the medication received section correction included coding of antipsychotic medication us	ed a MDS to on N, under on. The seven days		
	02/06/23 and dischar 02/08/23. Diagnoses	s admitted to the facility on ged to the hospital on included, in part: senile rain, dementia, and visual		and zero days of anticoagular (N0410E) during the look bac The corrected MDS assessmentransmitted on 4/6/2023.	k period. ent was		
	02/08/23 documented NO410A that Resider antipsychotic medica stay at the facility). A	tion on 2 days (her length of also documented in Section as that Resident #373 had		Minimum Data Set (MDS) coccompleted a review of the me for resident #111 and complet modification of the 4/5/2023 N reflect correct coding of section the medication received section correction included coding zero anticoagulant use during the I period (N0410E). The correct assessment was transmitted of	dical record ated a MDS to on N, under on. The ro days of ook back ed MDS		
	Resident #373 reveal Seroquel 25 MG (Mill	ary physician orders for led the following order: igrams) twice a day by order (an antipsychotic		Address how the facility will id residents having the potential affected by the same deficient	to be t practice:		
	2:00 PM she stated the have been marked as antipsychotic medical concluded she had madestion to read, "did medication on a prevential was her first asseanswer as "no." She the question asked if	IDS Nurse #1 on 04/04/23 at the MDS assessment should as the resident did receive tion on a routine basis. She have a sistakenly interpreted the she receive antipsychotic ious assessment", and since the stated she now understood the resident had received tion on a routine basis, not		MDS coordinator #1 and/or M coordinator #2 completed 100 active residents with pressure ulcers/pressure injuries to ens MDS reflects coding of pressure ulcers/injuries in section M ap to include current stagging or wound. This audit was comple 05/01/2023. The audit results reflect any other discrepancie coding of pressure ulcers/inju MDS coordinator #1 and/or M	ow review of sure current ure propriately each eted on did not s in MDS ries.		

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			A. BOILDII			С	
		345213	B. WING _			11/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		11/2020	
				1995 EAST CORNELIUS HARNETT BO	OULEVARD		
UNIVERS	AL HEALTH CARE LI	LLINGTON		LILLINGTON, NC 27546			
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F 641	Continued From p	age 18	F 6	641			
	on a previous asse	essment. She indicated she		coordinator #2 completed 10	00% review of		
	would modify the	assessment to document that		active residents on an antips	sychotic,		
	Resident #373 had	d received antipsychotic		antiplatelet, anticoagulant m			
	medication on a ro	outine basis.		ensure current MDS reflects	coding of		
	3. Resident #20 w	as admitted to the facility on		medication use in section N	appropriately		
		noses that included		to include antipsychotic and			
	post-traumatic stre	ess disorder and anxiety.		This audit was completed or			
				The audit results did not refl	•		
		orders dated 10/14/22 Resident		discrepancies in MDS coding	g medication		
	•	ed aripiprazole (an antipsychotic		use.			
	medication)10 mill	ligrams twice daily.		A -l-l	to a moral trade		
	Decident #201s me	- 41: - 41:		Address what measures will			
		edication administration record revealed he received an		place or systemic changes r ensure that the deficient pra			
		during the 7-day lookback		recur:	Clice will flot		
	period.	during the 7-day lookback		recui.			
	period.			Regional MDS consultant re	-educated		
	Resident #20's au	arterly MDS assessment dated		facility MDS coordinate #1 a			
		ne did not receive antipsychotic		coordinator #2 on proper co			
	medication.	. ,		per RAI Manual, Chapter 3.			
				of this education includes, b	ut not limited		
	During an interview	w on 4/6/23 at 11:10 AM MDS		to, section N regarding codir	ng		
	Nurse #1 reported	Resident #20 received		medications, including antip	sychotic		
		ing the 7-day lookback period		medication, and anticoagula			
		S, and she made a coding		section M related to proper of	•		
	error. She report	ed she would make a correction		pressure ulcers. This educate	ion was		
	on the assessmen	nt.		completed on 5/1/2023.			
				Indicate how the facility plan	s to monitor		
	4. Resident #57 w	as admitted to the facility on		its performance to make sur			
		ses that included hypertension		solutions are sustained:			
	and heart failure.	<b>3.</b>					
				Effective 05/02/23, the Directive 05/02/23	tor of		
	Per the physician	orders, Resident #57 was		Nursing, Assistant Director of			
	prescribed Risper	dal (an antipsychotic medication		and/or Unit Coordinators (#1	, #2) will		
		ninking, mood and behavior) 5		complete MDS accuracy mo			
		vice daily on 2/15/23 and was		process. This monitoring pro			
		ogrel (an antiplatelet medication		accomplished by reviewing			
	used to prevent bl	ood clots) 75 milligrams daily		residents to ensure MDS is	coded		

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	ROVIDER OR SUPPLIER AL HEALTH CARE LILLIN	NGTON	,	STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULE  LILLINGTON, NC 27546				
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F 641	anticoagulant.  Resident #57's medic for February 2023 rev. Risperdal, an antipsyduring the 7-day look received an anticoagulant 6 da period. The MDS assonot receive antipsych lookback period.  On 4/6/23 at 11:10 Alt conducted with MDS coded the Clopidogre 2/22/23 MDS in error. an error that Residen receiving an antipsych Nurse #1 stated she with the state of the conducted with the c	ation administration record realed, she received chotic medication 7 days back period and she had not alant.  If Minimum Data Set (MDS) 22/23 revealed she received sys of the 7-day lookback ressment revealed she did otic medication during the  If as an anticoagulant on the She further stated it was ta #57 was not coded as notic on the MDS. MDS would make the corrections.  If admitted to the facility on noses included disease (thickening or ries caused by buildup of ing of an artery).  If ad 11/10/2022 included atelet medicine) 75 daily for a blood thinner.	F	641	correctly per RAI guidelines. This monitoring process will be completed of (Monday through Friday) for two weeks 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 a MDS accuracy monitoring tool located in the facility compliance binder.  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.  Completion date: 05/08/2023	s, hly re tor		
		nt #111 had not received						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY LETED
		345213	B. WING _				11/2023
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CO 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546			
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F 641	F 641 Continued From page 20		F6	641			
	#111 received anticoaduring the 7-day look  In an interview with M 7:46 a.m., she stated coded for receiving an Clopidogrel was listed physician's order, and of administration of C 2023 Medication Adm 7-day look back perio manual, she said Clop blood thinner in the M #111's MDS should no anticoagulants. She s antiplatelet medication have been called to c ordering Clopidogrel.  In an interview with th at 8:47 a.m., he state should not have been and MDS staff and no	17/2023 indicated Resident ingulants for seven days back period.  IDS Nurse #1 on 4/5/2023 at Resident #111's MDS was inticoagulants because if as a blood thinner on the interest was documentation dispidogrel on the January ininistration Record for the indicated. After reviewing the MDS pidogrel was not listed as a IDS manual, and Resident into thave been coded for intated Clopidogrel was an in, and the physician should thange the reason for the Administrator on 4/5/2023 and Resident #111's MDS incoded for anticoagulants, urses have been educated					
F 684 SS=J	on conducting adequate Quality of Care CFR(s): 483.25	ate MDS assessments.	F	684			
	applies to all treatmer facility residents. Base assessment of a residental residents receive accordance with professions.	ndamental principle that  nt and care provided to  ed on the comprehensive  dent, the facility must ensure  treatment and care in					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		345213	B. WING		04/11/2023
	ROVIDER OR SUPPLIER	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVAL  LILLINGTON, NC 27546	
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F 684	by: Based on record re practitioner, and me facility failed to have cognitively impaired an injury of unknown 3/18/23 nurse aide (bruising to Resident fourth toe. On 3/20/observed to have a described as the "si: and swollen knee. To Nurse #2 who ass results revealed Residisplaced complex f with angulation at the broken in more than fragments were at a		F 68	,	
	10/10/2018 with diag Tourette's disease (a involving repetitive r sounds) cognitive co abnormal posture, v behavioral disturbar osteoporosis.  The annual Minimur assessment dated 1 was severely cognit speech, and someti	dmitted to the facility on gnoses that included a nervous system disorder novements or unwanted ommunication deficit, ascular dementia with aces, convulsions, and			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER  AL HEALTH CARE LILLI	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEV  LILLINGTON, NC 27546	NELIUS HARNETT BOULEVARD		
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F 684	transfers and total as member for bathing. #22 had not taken an have any behaviors of have any physical/ve others.  The care plan dated had a focused area of inappropriate/disruptiout at times related to difficulty communicat attempt to redirect as communications.  A shower log and ski 3/15/23 showed Residocumented bruises sheet was signed by and the Unit Manage  A shower log and ski 3/18/23 (Saturday) sl bruising on her left th fourth toe. The show Nurse Aide #1 on 3/1 on 3/20/23.  Review of facility recessheet dated 3/18/23 (shift. The shift report assignment. The shift document changes in from previous shifts a shift, in addition the signed.	from two staff members for sistance from one staff The MDS showed Resident by anticoagulants, did not of refusing care, and did not rbal behaviors directed at  1/8/23 showed Resident #22 of socially live behaviors of screaming of Tourette's disorder and a ling. Interventions included a needed and use simple  In assessment sheet dated and the first form the first form the first from the first form the first f	F 68	84			

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	ROVIDER OR SUPPLIER  AL HEALTH CARE LILI	LINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEV  LILLINGTON, NC 27546	EVARD		
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F 684	Nurse #2 dated 3/2i giving bath notice le Physician was notifix-ray, writer called rimagining."  Review of an x-ray #22's left femur (this mineralization was osteopenia (reduce than osteoporosis) which bones becom loss of tissue). The had a grossly displadistal femur with an and soft tissue swemore than one plac were at an angle to Review of physiciar an order to send Redepartment for eval fracture.  Review of a nursing Unit Manager dated to ER for further eval for possible leg fem Review of the hospi 3/20/23 read "Left leg There is moderate shruising. No additio Resident #22's vital	progress note written by 0/23 read "nurse aide was eft knee was swollen.  ded, order for left leg to be mobile x-ray mobile  dated 3/20/23 of Resident gh bone) showed osseous decreased. This could reflect d bone mass lesser severity or osteoporosis (condition in the brittle and fragile from a report also read Resident #22 aced complex fracture of the gulation at the fracture site lling. (the femur was broken in the and the bone fragments each other).  In orders dated 3/20/23 showed esident #22 to the emergency that is a progress note written by the 13/20/23 read "Resident sent aluation and treatment per MD tur fracture."  Ital physical assessment dated beg has obvious deformity. Swelling to left thigh with the land obvious trauma on exam."  signs were stable, and she	F 68	4			
	Resident #22's vital was not in any distr signs of dementia, v extremities spontan						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 684	is broken in at least to (a procedure used to cutting the skin open) splinted after orthope Resident #22 was ad 3/20/23 with diagnosi fracture of distal end the thigh bone above readmitted to the faci.  A telephone interview 2:32 P.M. with NA #1 #22 on 3/18/23 and 3 A.M. shift. During the when she gave Resid 3/18/23, she observe left thigh, under her letoe. NA #1 indicated to have a deformed le reported the bruising Medication Aide #2 a Resident #22 with call shift. NA #1 indicated Resident #22's behave During the interview, shift had not reported #22.  A follow up telephone with NA #1 on 4/6/23 interview, NA #1 indicobserved on Residen reported to Medication observed on Residen reported to Medication observed on Residen bruise in the middle of about the width of "a"	(a fracture where the bone wo places) that was reduced set broken bones without in the emergency room and dic surgery consultation. mitted to the hospital on s that included closed of left femur. (a fracture of the knee). The resident was lity on 3/24/23.  If was conducted on 4/4/23 at who was assigned Resident /19/23 during the 7 P.M. to 7 interview, NA #1 indicated lent #22 a bed bath on d bruising on Resident #22's left knee, and on her fourth Resident #22 did not appear leg. NA #1 stated she on Resident #22 to not continued to provide the there was no change in viors from her baseline.  NA #1 indicated the previous any bruising on Resident  e interview was conducted at 11:19 A.M. During the cated the skin conditions she t #22 were immediately	F	584			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345213	B. WING			C 04/11/2023		
	ROVIDER OR SUPPLIER	NGTON	•	STREET ADDRESS, CITY, STATE, ZIP 1995 EAST CORNELIUS HARNETT LILLINGTON, NC 27546	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI DEFICIENCY)		(X5) COMPLETION DATE		
F 684	knee. During the interdescribe the length of #22's left knee. NA # the shower sheet and book at the nurses's indicated Resident # reported to the assig the interview, NA #1 educated prior to this both the medication and NA #1 did not indicated Resident #22's bruised A telephone interview 3:06 P.M. with Medication Aide indicated the went into Resident # incontinence care to a bruise on Resident # incontinence care t	ith the natural curve of the rview, NA #1 was unable to if the bruise on Resident 1 indicated she completed diput the sheet in the shower tation for review. NA #1 22's bruising was not med nurse on duty. During indicated she had been added to report changes to aide and the assigned nurse. The the tation Aide #2 assigned and 3/19/23.  If was conducted on 4/4/23 at the tation Aide #2 assigned 8/23 and 3/19/23 during the 7 During the interview, the cated when nurse aide #1 22's room to provide Resident #22, she observed #22's fourth toe and the Medication Aide #2 arted the bruises to her at that the #2 indicated the bruising dark in color and she were old. During the interview had a fall or was unsure what had the interview was conducted on with Medication Aide #2.	F	684				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 04/11/2023
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEV  LILLINGTON, NC 27546		7471112020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	a 24-hour shift reportunsure what time shift reportunsure what time shift. The Medication Ato have two bruises, right fourth toe and a knee. During the interiodicated Resident # side to observe the Medication Aide #2 wisize and appearance was "not sure how to Medication Adie #2 werbally told the nurse bruising.  A telephone interview, nurse aide complete nurse aide used the document any changes shower sheet was the nurse with any changes with a	rote the information down on t. The Medication Aide was a handed the report to Nurse Aide observed Resident #22 a bruise on the top of the a bruise on the back of the erview, Medication Aide #2 22 had to be turned onto her oruise on her left knee. It was unable to describe the erview of the bruise and stated she of measure bruises."  If was unable to recall if she are about Resident #22's  If was conducted on 4/5/23 at the #1 who was the nurse cation Aide on 3/18/23.  Nurse #1 indicated when a did a resident's shower, the shower sheet paperwork to ges in the resident's skin. The en provided to the assigned ges in the resident's skin for the analyses and the endicated she did not receive a cout any changes in Resident further indicated had she the would have assessed	F	684		
	11:45 A.M. with Nurse Nurse #1 indicated a 3/19/23, Medication Resident #22, gave The paper had the re	ner a scratch sheet of paper.				

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			l '	11/ <b>2023</b>
	ROVIDER OR SUPPLIER	NGTON		19	TREET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOULEVARD ILLINGTON, NC 27546	0-47	11/2020
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Nurse #1 indicated shin Resident #22's skir During the interview, during the shift verba on Resident #22's skir An interview was con P.M. with NA #3 who on 3/19/23 for the 7 Athe interview NA #3 in with Resident #22 to have nothing about Reside given during the shift observed a bruise on have immediately repassigned nurse.  An interview was con P.M. with Nurse Aide Resident #22 on 3/20 P.M. shift. NA #2 indicated a report Resident #22 When she went to Reprovide her with a bethat was light in color approximately the siz NA #2 indicated wher of the bed, NA #2 obsatished a swollen knee. NA # the assigned nurse.  An interview was con P.M. with Nurse #2 we resident #22 on 3/20 P.M. shift. Nurse #2 we received a report Resident Resident #22 on 3/20 P.M. shift. Nurse #2 in received a report Resident	Is blood glucose results. The did not see any changes of written on the sheet.  Nurse #1 indicated no one of the sheet in written on the sheet.  Nurse #1 indicated no one of the sheet in written on the sheet.  Nurse #1 indicated no one of the sheet in written on the sheet.  Nurse #1 indicated no one of the sheet in written on the sheet in written on the sheet in written of the sheet in sheet in sheet in written of the sheet in written of the sheet in sheet i	F	684			

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 _		0.0	C 4/11/2023	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, 2		77172020	
I INIVEDS	AL HEALTH CARE LILI	INGTON		1995 EAST CORNELIUS HARNE	TT BOULEVARD		
UNIVERS	AL HEALIH CARE LILI	LINGTON		LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 684	Continued From pa	ge 28	F 6	684			
	her shift on 3/20/23 moaning. During the indicated NA #2 repbruise on her thigh, her knee, and an in Nurse #2 assessed the bruise under he "about the size of a purple, red, with a "Nurse #2 indicated was only observed from the side. Durin indicated she felt R and reported the inj Nurse #2 further increported to her, who	sleeping when she arrived for with no calling out or e interview, Nurse #2 ported Resident #22 had a a bruise under her left leg by dentation above the left knee.  Resident #22 and described or leg at the knee as being softball". The bruise was dark little bit of tint on her thigh." the indentation at the left knee when the leg was looked at the interview, Nurse #2 esident #22 had a broken leg tury to the Unit Manager. dicated the x-ray technician en Resident #2's left thigh was #22 did not call out when her d.					
	P.M. with the Unit N indicated she was ubruising on her left #2 made her aware herself and Nurse #Resident #22. Durir Manger indicated R verbalize what caus head-to-toe assess following results: a the top of Resident to be a newer bruis bruise behind Resid bruise on a toe. The does not recall which interview, the Unit N #22 was unable to verbalize was unable to verbalize was unable to verbalize with the unit N #22 was unable to verbalize was unable to verbal	Anager. The Unit Manager unaware Resident #22 had any thigh until 3/20/23 when Nurse at The Unit Manager indicated #2 went and assessed by the interview, the Unit Manager unable to seed the bruise, so a ment was completed with the bruise the size of a softball on #22's left thigh that appeared be because it was not yellow, a dent #22's left knee, and a be Unit Manager indicated she can too had a bruise. During the Manager indicated Resident werbalize pain but did not show as of being in pain when she					

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>4/11/2023</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULE LILLINGTON, NC 27546				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 684	notified, and a mobile Physician gave order the hospital when the fracture. The Unit Ma staff should have rep #22's thigh to the nur A telephone interview 3:25 P.M. with the Nu NP indicated she was in she was alerted by ni needed to be assess observed a large bruithe side of her left thi under 24 hours old beher leg was a little swithe NP indicated she possible fracture. The completed an investig the injury occurred du Resident #22's comb #22's weak bones.  A telephone interview 8:22 A.M. with the Me interview, the Medica made aware Resident left thigh on 3/20/23. indicated an x-ray was discovered Resident the interview, the Me Resident #22 was se to express to staff the facility completed an determined the impro	2/23. The physician was a x-ray was ordered. The se to send Resident #22 to a x-ray results showed a sinager indicated on 3/18/22 orted the bruise on Resident se that worked that shift.  If was conducted on 4/6/23 at curse Practitioner (NP). The set the building on 3/20/23 when the building on 3/20/23 whe	F 6	84				

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345213	B. WING _			C <b>04/11/2023</b>
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP O 1995 EAST CORNELIUS HARNETT I LILLINGTON, NC 27546		3-7/11/2020
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	DATE
F 684	Nursing (DON) on 4/4 interview, the DON in reported the bruise of herself and the Admir was made aware of the was immediately star should have reported Administrator when it weekend, and she is reported the injury what The Administrator was Jeopardy on 4/6/23 at The facility provided at 4/8/23 which alleged 3/25/23. The correction The root cause analy noncompliance result facility staff (nurse aid unknown source to a	ducted with the Director of 4/23 at 3:42 P.M. During the dicated the Unit Manager in Resident #22's left thigh to histrator. When the facility he bruise, an investigation ted. The DON indicated staff the bruise to herself or the was discovered over the unsure why staff had not hen it was first discovered.  Is notified of the Immediate to 5:00 P.M.  In a corrective action plan on a date of completion of the action plan indicated:  It is identified that the alleged hed from the failure of the die #1) to report an injury of nurse on 3/18/2023 for and plan of care. Resident	F	584		
		n will be accomplished for I to have been affected by				
	On 3/25/2023, Nursin immediately suspend investigation of the al Resident #22.	~				
	and notified the atten	desident #22 on 03/20/2023 ding physician who ordered 22's leg. Unit coordinator #1				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		TE SURVEY MPLETED
		345213	B. WING	·		C )4/11/2023
	ROVIDER OR SUPPLIER  AL HEALTH CARE LILL	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOUL LILLINGTON, NC 27546	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	spoke to Xray technand received a prelihad a fracture. Unit Attending physician be sent to hospital for The unit coordinator responsible party of well as transfer to the On 03/25/2023, Director on the importance of accident, or any injufurther evaluation at How the facility will the potential to be a practice:  100% audit of all included a practice:  100% audit of all included and the potential to be a practice:  100% audit of all included and the potential to be a practice:  100% audit of all included and the potential to be a practice:  100% audit of all included and the potential to be a practice:  100% audit of all included and the potential to be a practice:  100% audit of all included and the potential to be a practice:  100% audit of all cure for the last 30 days by Director of Nursin MDS coordinator #2 Unit manager #2 to	ician who completed the Xray minary result that resident coordinator #1 contacted the who ordered resident #22 to or evaluation and treatment. In notified resident #22 the change in condition as the hospital on 3/20/2023.  Sector of nursing completed a con with nursing assistant #1 of reporting any incident, writes to a nurse on duty for and treatment.  Sidentify other residents having effected by the same deficient with the sted on March 25, 2023, by Unit coordinator #1, and/or identify any other incident or or a nurse on time. No other ents/accidents identified as the sted on an interest of the sted on an interest of the sted on an interest of the sted on 3/25/2023 and the sted on 3/	F 68	4		
	spoke to Xray technand received a prelihad a fracture. Unit Attending physician be sent to hospital for The unit coordinator responsible party of well as transfer to the On 03/25/2023, Director on the importance of accident, or any injufurther evaluation and How the facility will the potential to be a practice:  100% audit of all included a practice:  100% audit of all included and the potential to be a practice:  100% audit of all included and the potential to be a practice:  100% audit of all included and the potential to be a practice:  100% audit of all included and the potential to be a practice and the potential to be a practice:  100% audit of all included and the potential to a nurse for proper audit of all cure for the last 30 days by Director of Nursing MDS coordinator #2 Unit manager #2 to documentation of art to a nurse for proper and the proper proper and the proper proper proper and the proper proper proper and the proper proper and the proper proper proper and the proper proper proper and the proper p	ician who completed the Xray minary result that resident coordinator #1 contacted the who ordered resident #22 to or evaluation and treatment. In notified resident #22 the change in condition as the hospital on 3/20/2023.  Sector of nursing completed a con with nursing assistant #1 of reporting any incident, writes to a nurse on duty for and treatment.  Sidentify other residents having effected by the same deficient with the same deficient with the same on time. No other the same on time. No other the same on time. No other the same deficient with any other incident or to a nurse on time. No other the same deficient with any other incident or the same of the same deficient with any other incident or any other				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345213	B. WING _			C <b>04/11/2023</b>	
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP COL 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DE .	04/11/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	F 684 Continued From page 32		F 6	684			
	for proper follow-up. I documented on "show located in the facility of the fac						
	Measures will be put changes made to ens practice will not recur						
	Effective 03/25/2023, facility ensures each residents receives quality of care and treatment based on the comprehensive assessment of a resident and in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to ensuring any injury of a resident is reported to a nurse for proper assessment and follow ups.  Effective 03/25/2023 facility employees follow the company policy and procedures, when observing/identifying any injury to a resident, by notifying the nurse on duty for proper assessment and follow ups. Effective 3/25/2023 and moving forward nurse on duty assess any reported injury and document findings on each resident's medical records.						
	time, part time, employstaffing agencies comnursing employees we Director of Nursing, A Staff development concoordinators (#1, #2) education includes by importance of reportinurse on duty for profollow-ups. This education	Assistant Director of Nursing, ordinator, and/or Unit  The emphasis of this at is not limited to, the any incident/accident to a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C )4/11/2023
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	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 PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 684	for all new employee	allowed to work until ation will be provided d to the new hire orientation s effective 03/25/2023.	F6	84		
	to make sure that sol Effective 03/25/2023 Assistant Director of (#1, #2) and/or Unit (been completing qua process. This monito accomplished by rev and shower sheets of hours or from last clinary identified injuries nurse and being add negative findings are monitoring process had Monday through Frid two more weeks, the or until the pattern of Findings of this monital	the Director of Nursing, Nursing, MDS coordinators Coordinators (#1, #2) have lity of care monitoring ring process is ewing all skin assessments ompleted for the last 24 nical meeting to ensure that has been assessed by a ressed promptly. Any corrected promptly. This as been completed daily ay for two weeks, weekly for n monthly for three months compliance is maintained. toring process are Skin assessments audit tool" compliance binder.				
	process. This monito accomplished by rev and shower sheets of hours to ensure that been assessed by a promptly. Any negatif promptly. This monito every Saturday, and	quality of care monitoring				

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345213	B. WING _			04/	11/2023
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		ı	LILLINGTON, NC 27546		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	.,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B)	, ,	
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
F 684	Continued From page	<del>2</del> 34	F (	684			
		the pattern of compliance is					
		of this monitoring process					
	•	n the "Skin assessments					
	audit tool" located in t						
	binder.	are racinty compliance					
	Diridor.						
	Effective 03/25/2023.	the Director of Nursing					
	and/or Assistant Direc	_					
		oring process to the facility					
	Quality Assurance an	d Performance					
	Improvement Commit	ttee (QAPI), for					
	recommendations and	d/or modifications, monthly					
	for three months, or u	intil the pattern of					
	compliance is archive	ed.					
	Date of Completion: 3	3/25/23					
	The facility provided a	a corrective action plan for					
		ened on 3/18/23 with a					
		25/23. The onsite validation					
		ed on 4/10/23. Staff from					
		and who worked different					
	shifts were interviewe	ed and verified they had					
	received training to in	nmediately report injuries to					
	a nurse. A review was	s completed of the audit logs					
	that included the educ	cational information provided					
	•	service and a review of					
	_	logs. The in-service logs					
	were reviewed, staff r	•					
		to have received training.					
		er sheets and incident					
	•	to have been completed and					
	•	ted injuries were identified. A					
		ng tool revealed staff had					
		toring of shower sheets and					
		QAPI plans to include this					
		xt meeting. The facility's					
	compliance date was						
F 690	Bowel/Bladder Incont	inence, Catheter, UTI	F (	690			5/8/23
SS=D							

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345213	B. WING			04/	
NAME OF PR	ROVIDER OR SUPPLIER	0.02.0		S	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	11/2023
				1	995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	NGTON		L	ILLINGTON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 690	Continued From page	e 35	F	690			
	CFR(s): 483.25(e)(1)-(3)						
	resident who is continuadmission receives somaintain continence to condition is or become not possible to maintal §483.25(e)(2)For a reincontinence, based comprehensive assess	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical nes such that continence is ain. esident with urinary on the resident's					
	comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.						
	ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by:	on the resident's ssment, the facility must t who is incontinent of bowel treatment and services to			F690		

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.125.	_		، ا	С
		345213	B. WING				11/2023
NAME OF P	ROVIDER OR SUPPLIER		•	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 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
IAG	RESERVICION SIN		IAG		DEFICIENCY)		
F 690	Continued From page		F	690			
		the facility failed to attach an			Address how corrective action will be		
		heter tubing to a secure			accomplished for those residents found	l to	
		sion and possible injury and			have been affected by the deficient		
	•	essary care and services of			practice.		
		catheter when Nurse Aide				_	
		in the urinary catheter tubing			On 04/05/2023, the Assistant Director		
	when providing incon				Nursing re-attached an indwelling urina		
	residents reviewed for urinary catheters.  Catheter tubing to a secure device						
	(Resident #111)				to resident #111 leg, to prevent tension		
	Fig. discount in about a de-				and possible injury.		
	Findings included:				On 04/04/2022 Numae #2 alasmad		
	Danislant #444	dunith of to the facility on			On 04/04/2023, Nurse #3 cleaned		
		dmitted to the facility on noses included stage 3			Resident #111's urinary catheter tubing after being instructed by the director of		
	chronic kidney diseas				nursing.		
	Cilionic kiuney diseas	5 <b>c</b> .			nursing.		
	The care plan dated	11/10/2022 stated Resident			Address how the facility will identify oth	er	
		e of a urinary catheter due to			residents having the potential to be		
		ctive uropathy. Interventions			affected by the same deficient practice	:	
	included securing the	urinary catheter tubing to					
	Resident #111's thigh	to prevent pulling, ensuring			100% audit of all active residents in the	<del>;</del>	
	urinary catheter tubin	ig was secured, free of kinks			facility with an indwelling urinary cather	er.	
	or twisting to avoid ur	rethral tension or accidental			were completed on 04/06/23 by the		
	removal, providing ur	inary catheter care every			Director of Nursing and/or Assistant		
	shift and providing pe	eri-care away from meatus to			Director of Nursing, unit coordinator (#	1 or	
		igration into urethra and			#2) to identify any other resident with a		
	bladder.				indwelling urinary catheter, without sec	ure	
					device in place to prevent tension and		
	The quarterly Minimu				possible injury. No other resident with a	ì	
		17/2023 indicated Resident			foley catheter without a secure device		
	#111 was cognitively				identified. Findings of this audit is		
	indwelling urinary cat	neter for urination.			documented on the indwelling urinary	_	
	Dhysisian and a d	od 0/0/0000 in aluda di			catheter audit tool located in the facility		
		ed 2/2/2023 included using a			compliance binder.		
		bstructive uropathy and			Assistant director of nursing consulates	í	
	providing catheter ca	re daily and as needed.			Assistant director of nursing completed indwelling urinary catheter care for 100		
	On 4/3/2023 at 7:40 /	a.m. in an interview with			of all active residents with urinary cathe		
		tated she once had a secure			on 4/6/2023.	,tGI	
		La Lou Jillo Villou Hau a Jubilit			I VII I/U/EUEU.		

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	
NAME OF D	DOVIDED OD SUDDI IED	343213		CTDEET ADDRESS CITY STATE ZID COD		4/11/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
UNIVERSA	AL HEALTH CARE LILLI	NGTON		1995 EAST CORNELIUS HARNETT BOL	JLEVARD		
0111121107		10.0.1		LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 690	Continued From page	e 37	F 69	90			
	The secure strap was staff did not reapply a said when she moved	eatheter tubing on her leg. Is removed, and the nursing another secure strap. She din the bed, she surely heter tubing but have not felt		Address what measures will be place or systemic changes make ensure that the deficient practice.  Effective 05/01/2023, each re	ade to tice will not		
	On 4/3/2023 at 8:00 a.m., Resident #111 removed her linens to expose her thigh area. The indwelling urinary catheter tubing was observed exiting from underneath the adult brief and resting along the edge of the adult brief high on the left upper thigh area. There was no secure device observed on Resident #111's left or right thigh to attach the urinary catheter tubing.			an indwelling urinary catheter strap attached to each resider secure an indwelling urinary of tubing to prevent tension and injury.	nt⊡s leg and catheter possible		
				Effective 05/01/2023, License add an order to monitor leg st resident with an indwelling uri	trap for each inary		
	p.m., NA #3 was obse Resident #111 for incurinary catheter tubin secure device and whasked by the resident where the urinary cat Resident #111 answe tan-brown area was of	ervation on 4/4/2023 at 2:11 erved providing peri-care to continence of stool. The g was not observed in a men Resident #111 was t representative if the area heter entered her body hurt, ered "yes". A small dried light observed on the urinary aches from where the urinary		catheter on each resident so records. The order to monitor assure each resident so leg so in place to secure catheter tull prevent tension and possible Effective 05/01/2023, each rean indwelling urinary catheter indwelling catheter care durin of daily living care daily by cenursing aides and/or licensed	nonitor leg strap will s leg strap remains eter tubing to essible injury. each resident with atheter receives e during assistance y by certified		
	catheter exited the fo (opening of the urethic cleansing the urinary performing peri-care aroom at 2:26 p.m.  On 4/4/2023 at 2:30 p.#3, she stated she haperi-care to Resident washing the urinary on urses were responsicatheter tubing. She at	lded skin around the meatus ra). NA #3 was observed not		Director of Nursing (DON), As Director of Nursing (ADON) a development coordinator will 100% education for all nursing include full-time, part-time, an staff. The emphasis of this education to the importance of ensuring resident with an indwelling uricatheter has a leg strap in pla prevent tension and possible the catheter care is provided care and as needed. This education of the catheter care is provided to care and as needed.	essistant Ind/or Staff complete g staff, to ad as needed ducation will g each inary ace to injury, and during ADL		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C 4/11/2023	
NAME OF P	ROVIDER OR SUPPLIER	0.02.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL	•	4/11/2023	
NAME OF T	TOVIDER OR GOLF EIER			1995 EAST CORNELIUS HARNETT BO			
UNIVERSA	AL HEALTH CARE LIL	LINGTON		LILLINGTON, NC 27546	OLEVARD		
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 690	Continued From page	age 38	F 6	90			
	Resident #111's le	-		emphasized the importance	of writing an		
	Trobladin # 111 0 10	9.		order to monitor leg strap eve	-		
	On 4/4/2023 at 2:3	5 p.m., Nurse #4 reported		each resident with an order for	-		
		d to Resident #111 was not at		urinary catheter, and an orde	•		
the desk. When questioned al responsible for cleansing and		estioned about who was		care every shift. This educat	ion will be		
		ansing and securing Resident		completed by 05/08/2023. Ar			
		eter tubing, Nurse #4 stated		staff not educated by 05/08/2			
		check before she could answer		be allowed to work until educ			
	that question.			education is also be added to			
	On 4/4/2022 at 2:4	F n m NA #2 was shoomed		hires orientation process fo			
		5 p.m., NA #3 was observed dent #111 on her right side and		nursing staff effective 05/01/2	2023.		
		er tubing becoming tight. NA #3		Indicate how the facility plans	s to monitor		
		ositioning the urinary catheter		its performance to make sure			
		direction Resident #111 was		solutions are sustained:			
	turning.			Effective 05/01/2023, Directo	or of Nursing.		
	On 4/4/2023 at 2:4	7p.m., Nurse #3 was observed		and/or Assistant Director of H	_		
		t #111's urinary catheter tubing.		Nursing, will monitor complia	nce with		
		e urinary catheter tubing,		securing indwelling urinary ca			
	Nurse #3 was obs	erved asking NA #3 to move		by randomly observing three			
		er drainage bag from the center		with indwelling urinary cathet			
		own to the foot of the bed to		leg strap is in place to secure			
	·	catheter tubing from pulling		tubing from tension and/or po			
		nt. NA #3 and Nurse #3		injuries, and catheter care is			
		lent #111 up in the bed and the		during ADL care and as need	-		
	secured device.	mained unattached into a		issues identified during this n process will be addressed pr	-		
	secured device.			monitoring process will be co			
	On 4/4/2023 at 2:5	i1p.m. in an interview with		Monday to Friday for two wee			
		ed nurse aides cleansed the		for two more weeks, then mo			
		bing with morning care and		three months or until a patter	•		
		said she was instructed to		compliance is maintained.			
	•	ident #111's catheter care. She					
		cure device was usually applied		Effective 05/01/2023, Directo			
	_	atheter was changed to		and/or Assistant Director of H			
		he urinary catheter and did not		Nursing, will review all new a			
		at #111 did not have a secure		readmission, or any resident			
	∣ device to attach th	e urinary catheter and would		order for an indwelling urinar	y catheter for		

OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU  F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU  COMPLE		LETED				
	345213	B. WING _				C 11/2023
	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVARD			11/2023
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(	· ·		(X5) COMPLETION DATE
get a secure device for On 4/4/23 at 3:07 p.m Director of Nursing (D and Nurse #3 could p care, and NA #3 show when performing inconfurther stated both NA responsible for ensuring attached on Resident	or Resident #111.  In an interview with the DON), she stated both NA #3 erform urinary catheter all provide catheter care intinent care for stool. She A #3 and Nurse #3 were fing the urinary catheter was #111 to prevent pulling and	F 6		meeting to ensure that any resident with an indwelling urinary catheter had a monitoring of leg strap, and catheter calorders are included in resident's medicarecords. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday 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 monitoring process will be documented on the Urinary catheter monitoring tool for new residents located in the facility compliant binder.  Effective 05/01/2023, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensuthe facility remains in substantial	re al  y  or e  ce  ng  nce	
CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug	e(6)  ary Drugs-General.  regimen must be free from	F 7		Completion date 05/08/2023		5/8/23
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From page get a secure device for On 4/4/23 at 3:07 p.m. Director of Nursing (D and Nurse #3 could p care, and NA #3 show when performing incomplete for ensuring attached on Resident movement of urinary for  Drug Regimen is Free CFR(s): 483.45(d)(1)-  §483.45(d) Unnecess Each resident's drug for unnecessary drugs.	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 39 get a secure device for Resident #111.  On 4/4/23 at 3:07 p.m. in an interview with the Director of Nursing (DON), she stated both NA #3 and Nurse #3 could perform urinary catheter care, and NA #3 should provide catheter care when performing incontinent care for stool. She further stated both NA #3 and Nurse #3 were responsible for ensuring the urinary catheter was attached on Resident #111 to prevent pulling and movement of urinary catheter.  Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	TOUR REGIMENT IDENTIFICATION NUMBER:  A BUILDIN  345213  B. WING  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 39 get a secure device for Resident #111.  On 4/4/23 at 3:07 p.m. in an interview with the Director of Nursing (DON), she stated both NA #3 and Nurse #3 could perform urinary catheter care, and NA #3 should provide catheter care when performing incontinent care for stool. She further stated both NA #3 and Nurse #3 were responsible for ensuring the urinary catheter was attached on Resident #111 to prevent pulling and movement of urinary catheter.  Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	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 39 get a secure device for Resident #111.  On 4/4/23 at 3:07 p.m. in an interview with the Director of Nursing (DON), she stated both NA #3 and Nurse #3 could perform urinary catheter care, and NA #3 should provide catheter care when performing incontinent care for stool. She further stated both NA #3 and Nurse #3 were responsible for ensuring the urinary catheter was attached on Resident #111 to prevent pulling and movement of urinary catheter.  Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	ROUNDER OR SUPPLIER  345213  B. WIND  STREET ADDRESS, CITY, STATE, ZIP CODE  1998 EAST CORNELUS HARNETT BOULEVARD  LILLINGTON, NC. 27546  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY) MUST BE PRECEDED BY FULL  REQUILATORY OR I.S. IDENTIFYING INFORMATION)  Continued From page 39  get a secure device for Resident #111.  On 4/4/23 at 3:07 p.m. in an interview with the  Director of Nursing (DON), she stated both NA #3  and Nurse #3 could perform urinary catheter  care, and NA #3 should provide catheter care when performing incontinent care for stool. She further stated both NA #3 and Nurse #3 were responsible for ensuring the urinary catheter was attached on Resident #111 to prevent pulling and movement of urinary catheter.  Effective 05/01/2023, Director of Nursing process will be completed daily Monday through Friday for two weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the Urinary catheter monitoring tool for new residents located in the facility complian is maintained. Findings of this monitoring process will be documented on the Urinary catheter monitoring tool for new residents located in the facility complian is maintained. Findings of this monitoring process to the facility Complian is maintained. Findings of this monitoring process to the facility Complian is maintained. Findings of this monitoring process to the facility Complian is maintained. Findings of this monitoring process to the facility Complian compliance is maintained. The QAPI committee can modify this plan to ensu the facility remains in substantial compliance.  Completion date 05/08/2023	A BUILDING  345213  8. WING  STREET ADDRESS, CITY, STATE, 2IP CODE  1995 EAST CORNELIUS HARNETT BOULEVARD  LILLINGTON, NC 27546  SUMMARY STATEMENT OF DEPOISINGES (EACH ORDERCING) AND EMPERING PROPRIATE  (EACH ORDERCING WAS ITS EMPROPRIATE  (EACH ORDERCING AND SHORT OF THE PROPRIATE  (EACH ORDERCING AND SHORT OF THE ADDRESS OF THE ADDR

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		345213	B. WING _		C 04/11/2023
	ROVIDER OR SUPPLIER	NGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVA  LILLINGTON, NC 27546	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 757	duplicate drug therapy §483.45(d)(2) For ext §483.45(d)(3) Without set; or §483.45(d)(4) Without use; or §483.45(d)(5) In the consequences which reduced or discontinut §483.45(d)(6) Any constated in paragraphs section. This REQUIREMENT by:  Based on record revistaff interviews, the finantibiotic medication for 1 of 5 residents remedication administric Findings included:  Resident #62 was accomplete the consequence of the conseq	essive dose (including by); or cessive duration; or at adequate monitoring; or at adequate indications for its presence of adverse indicate the dose should be used; or sombinations of the reasons (d)(1) through (5) of this  It is not met as evidenced iew, physician interview and acility failed to discontinue an as ordered by the physician eviewed for antibiotic ation, Resident #62.  Imitted to the facility on sees that included, in part: in (UTI), traumatic brain interchange Minimum Data Set lated 02/22/2/3 documented	F 7	F757D Address how corrective action will accomplished for those residents for have been affected by the deficient practice.  On 04/11/2023, the licensed nurse practitioner assessed resident #62 determined that no adverse reaction negative outcomes noted. No fur actions needed.  Address how the facility will identify residents having the potential to be affected by the same deficient practice.	ound to t , and ons and urther y other
	on 02/22/23 docume	lan for Resident #62 revised nted a focal area of: At risk UTI related to incontinence.		100% audit of all active residents in facility with orders for antibiotics we completed on 05/01/2023 by the D of Nursing and/or Assistant Directors	ere irector

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(>	X3) DATE SURVEY COMPLETED
		345213	B. WING			C
NAME OF B	ROVIDER OR SUPPLIER	343213	1	STREET ADDRESS, CITY, STATE, ZIP (		04/11/2023
NAME OF F	ROVIDER OR SUFFLIER					
UNIVERS	AL HEALTH CARE LIL	LINGTON		1995 EAST CORNELIUS HARNETT I	BOULEVARD	
				LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 757	Continued From pa	age 41	F 7	757		
	The goal was for R skin irritation and L Interventions included adequate nutrition signs of a UTI, compadminister medicated National Review of a laborated 03/03/23 review of a laborated 03/03/23 review of the Marchis organism was Bactrim (Trimeth/S).  Review of the Marchis Review of the Marchis adequated Resident DS Tablet, take one (BID) for 7 days for	esident #62 to be free from ITI's through the next review. ded, in part: encourage and hydration, observe for aplete labs as orders, and ions as ordered.  tory report for a urine culture ealed Resident #62 had cia Stuartii growth in his urine. sensitive to the antibiotic ulfa).  ch 2023 physician orders #62 had an order for Bactrim establet by mouth twice a day UTI. The order was placed stop date of 03/11/23 (auto		Nursing, unit coordinator (a identify any other resident antibiotics to ensure a corr in place to ensure resident medication per physician or resident identified with an idea. Findings of this audit on the antibiotics medicatic located in the facility composite Address what measures we place or systemic changes ensure that the deficient precur:  Effective 05/01/2023, each an order for antibiotics has date in place based on the order.	with an order of rect stop date it receives order. No other incorrect stop it is documented on audit tool oliance binder.  Will be put into its made to ractice will not in resident with its a correct stop	is r d
	#62 had received E 03/04/23, 03/05/23 03/09/23, 03/10/23 days.  In an interview with 04/06/23 at 10:00 A order for Resident 03/10/23. She expautomatically gene were entered into the orders were en She noted the staff auto generated sto	ch 2023 Medication ord (MAR) revealed Resident Bactrim DS twice a day on , 03/06/23, 03/07/23, 03/08/23, and 03/11/23 for a total of 8 at the Infection Control Nurse on AM she stated the Bactrim DS #62 should have stopped on lained the computer rated stop dates when orders the system and the time of day tered effected the stop date. If were supposed to check the p dates to ensure they were rect, staff were to manually		Effective 05/01/2023, Licer enters orders in electronic records will manually coun doses ordered and enters each antibiotic ordered bas specified by the ordering p Director of Nursing (DON), Director of Nursing (ADON development coordinator v 100% education for all lice and medication aides, to in part-time, and as needed semphasis of this education importance of counting nur ordered and manually add date for each antibiotic ord the duration specified by the Physician. This education	medical at number of stop date to sed on duration obysician.  Assistant I) and/or Staff will complete ensed nurses include full-time staff. The in will be the mber of doses correct stop dered based or ine ordering	n

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUC		(X3) DATE SURVEY COMPLETED	
	345213	B. WING _			04/	11/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, ZIP CODE	1 04/	11/2020
			1995 EAST C	ORNELIUS HARNETT BOULEVARD		
UNIVERSAL HEALTH CARE LILLIN	IGTON			N, NC 27546		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	,	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B IOSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757 Continued From page	42	F 7	57			
In an interview with the 4/6/23 at 3:30 PM heroproblems were related auto generated stop dincorrectly. He noted supposed to count the the stop dates if need was a problem and the of transitioning to a new fix the problem with the stop dates.  In a telephone interview Director on 04/11/23 and aware of the problem the auto generated stop the auto generated stop the auto generated stop the interview as some flexibility were ported it could be given getting two extra dose to the resident; however, weeks it could be harroproblem with the compincorrect stop dates for	e facility Administrator on stated the medication do to a computer glitch that lates for medications the nursing staff were endoses and manually adjust endoses are program he hoped would be incorrect auto generated endose with the facility Medical endose with the computer and endose that were incorrect. In with the computer and endose that were incorrect. In with Resident #62, who day of Bactrim DS, there eith the medication. He were up to 10 days, so es would not be detrimental ever, if it were to go on for 3 mful. He concluded the puter auto generating or medications had to be finite problem he would		completed nurse all educated allowed education hires of the control of the contro	ted by 05/08/2023. Any License and/or Medication aide not at by 05/08/2023, will not be to work until educated. This on is also be added to the new orientation process for all new do nurse and/or Medication aide at 05/01/2023.  The how the facility plans to monite or mance to make sure that as are sustained:  The 05/01/2023, Director of Nursing Assistant Director of Health and any resident with an order to the same and the correct to the based on the duration specific to the same and the conducted daily Monda for two weeks, weekly for two mathem monthly for three months are then monthly for three months are the compliance is med. Findings of this monitoring will be documented on the icuse monitoring tool located in ity compliance binder.  The 05/01/2023, Director of Nursing and the monthly for three months are the compliance binder.  The 05/01/2023, Director of Nursing and the compliance binder.  The 05/01/2023, Director of Health and the compliance binder.  The 05/01/2023, Director of Health and the compliance binder.  The 05/01/2023, Director of Health and the compliance binder and the compliance binder.	or  ng, stop w 24  for onic ied ring y to ore or  n ng,	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345213	B. WING _				C / <b>11/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	11/2023
					995 EAST CORNELIUS HARNETT BOULEVARD		
UNIVERSA	AL HEALTH CARE LILLIN	IGTON			ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From page	• 43	F	757	electronic medical records to include the correct stop date based on the duration specified by the ordering physician. An negative findings will be corrected promptly by the DON/ADON. This monitoring process will be completed of Monday through Friday for two weeks, weekly for two more weeks, then month for three months or until the pattern of compliance is maintained. Findings of the monitoring process will be documented the Antibiotic use monitoring tool locate in the facility compliance binder.  Effective 05/01/2023, Director of Nursin will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensuthe facility remains in substantial compliance.  Completion date: 05/08/2023	aily hily his on ed  g	
F 812 SS=E		ore/Prepare/Serve-Sanitary 2)	F 8	312	•		5/8/23
	§483.60(i) Food safet The facility must -	y requirements.					
	state or local authoriti (i) This may include fo	ed satisfactory by federal,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	IPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
		345213	B. WING _			C <b>04/11/2023</b>
	ROVIDER OR SUPPLIER	NGTON	•	STREET ADDRESS, CITY, STATE, ZIP CO 1995 EAST CORNELIUS HARNETT BO LILLINGTON, NC 27546	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 812	facilities from using prograders, subject to desafe growing and food (iii) This provision do from consuming food §483.60(i)(2) - Store serve food in accord standards for food so This REQUIREMENT by:  Based on observation facility failed to label food items stored in (100 Hall Nourishment Room)  The findings included An observation of the was conducted on 40 Dietary Manager. The observed:  - A bag on the count a small take-out box paper.  - Two biscuits with me wrapped in clear plandard in clea	ulations. es not prohibit or prevent broduce grown in facility compliance with applicable od-handling practices. es not preclude residents ds not procured by the facility.  It is not met as evidenced  ons and staff interviews, the date, and/or remove expired 2 of 2 nourishment rooms ont Room and 500 Hall  d: e 500 Hall nourishment room (3/23 at 5:42 A.M. with the e following items were  er beside the refrigerator with and a biscuit wrapped in  neat between the bread, stic wrap. Ince container of fortified  ance package of cheese stainers were labeled with a	F8	Address how corrective act accomplished for those resi have been affected by the correctice:  On 4/3/2023, A bag on the of the refrigerator with a small and a biscuit wrapped in particular biscuits with meat between wrapped in clear plastic wra 32-ounce container of fortificing shake, One opened 11-ounce palmetto cheese, one opened package of cheese observed nourishment room were discimmediately by the dietary of watermelon with a use by 3/24/23, one opened 20-our general ale, one opened 20 of soda, one opened 28-our sports drink, one opened 24 of chocolate syrup observed.	dents found to deficient  counter beside take-out box per, two the bread, up, one opened ed nutritional ce container of ed 10-ounce d in 500 Hall carded manager.  32-ounce nal shake, one stic container of date of noce bottle of counce bottle noce bottle noce bottle noce bottle	

F 812 Continued From page 45 was conducted on 4/3/23 at 5:50 A.M. with the Dietary Manager. The following items were observed: - One opened 32-ounce container of fortified nutritional shake - One 15-ounce opened clear plastic container of watermelon with a use by date of 3/24/23 - One opened 20-ounce bottle of general ale - One opened 28-ounce bottle of a sports drink - One opened 24-ounce bottle of a sports drink - One opened 24-ounce bottle of chocolate syrup None of the food containers were labeled with a resident's name or the date of storage.  An interview was conducted on 4/3/23 at 5:42 A.M. with the Dietary Manager. During the interview, the Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated without a name and date needed to be discarded. The Dietary Manager indicated without a date on the food, she had no way to know how long the food had been in the refrigerator and she discarded the above listed items.  F 812  Address how the facility will identify other residents having the picatility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the ideating happing the food of a sports drink affected by the same deficient practice:  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the idetacy meaded to be affected by the same deficient practice:  Address was con		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		NSTRUCTION	(X3) DATE COMF	SURVEY
UNIVERSAL HEALTH CARE LILLINGTON  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  F 812  Continued From page 45 was conducted on 4/3/23 at 5:50 A.M. with the Dietary Manager. The following items were observed: - One opened 32-ounce container of fortified nutritional shake - One 15-ounce opened clear plastic container of watermelon with a use by date of 3/24/23 - One opened 20-ounce bottle of general ale - One opened 28-ounce bottle of a sports drink - One opened 28-ounce bottle of a sports drink - One opened 28-ounce bottle of opened with a resident's name or the date of storage.  An interview was conducted on 4/3/23 at 5:42 A.M. with the Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated all the food without a name and date needed to be discarded the above listed items.  1995 EAST CORDS PAPERIOR. PROFICENCY)  PREFIX TAG  PREFIX T			345213	B. WING _			1	
CALLILINGTON, NC 27548   ID   PREFIX   REGULATORY OR LISC IDENTIFYING INFORMATION)   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION NOT BE COMPLETO)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			NCTON			, , ,	•	
F 812  Continued From page 45 was conducted on 4/3/23 at 5:50 A.M. with the Dietary Manager. The following items were observed: - One opened 32-ounce container of fortified nutritional shake - One 15-ounce opened clear plastic container of watermelon with a use by date of 3/24/23 - One opened 20-ounce bottle of soda - One opened 20-ounce bottle of soda - One opened 22-ounce bottle of soda - One opened 24-ounce bottle of soda - One opened 28-ounce bottle of soda - One opened 29-ounce bottle of soda - One opened 29-ounce bottle of soda - One opened 29-ounce bottle of aboutle of a sports drink - One opened 29-ounce bottle of soda - One opened 29-ounce bottle of soda - One opened 29-ounce bottle of soda - One opened 29-ounce bottle of aboutle of a sports drink - One opened 29-ounce bottle of soda - One opened 29-ounce bottle of of chocolate syrup None of the food containers were labeled with a resident's name or the date of storage.  An interview, the Dietary Manager indicated staff had been educated to label all food brought into the nourishment room with the current dat	UNIVERSA	AL NEALIN CARE LILLI	NGTON		LILLI	NGTON, NC 27546		
was conducted on 4/3/23 at 5:50 A.M. with the Dietary Manager. The following items were observed:  One opened 32-ounce container of fortified nutritional shake  One 15-ounce opened clear plastic container of watermelon with a use by date of 3/24/23  One opened 20-ounce bottle of general ale One opened 20-ounce bottle of a sports drink One opened 24-ounce bottle of a sports drink One opened 24-ounce bottle of chocolate syrup None of the food containers were labeled with a resident's name or the date of storage.  An interview was conducted on 4/3/23 at 5:42 A.M. with the Dietary Manager indicated staff had been educated to label all food brought into the nourishment room with the current date and resident's room number. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated without a date on the food, she had no way to know how long the food had been in the refrigerator and she discarded the above listed items.  Inourishment room were discarded immediately by the dietary manager.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  Address how the facility will identify other residents having the potential to be affected by the same deficient practice:  An interview and potential to be affected by the same deficient practice:  An interview apropriately or stored beyond	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
An interview was conducted on 4/5/23 at 4:49 P.M. with the Director of Nursing (DON). During the interview, the DON indicated nursing staff were responsible to place a date and the resident's name on items when placed into the nourishment rooms refrigerators. The DON indicated dietary staff were responsible for cleaning out the nourishment rooms. Food items had to be discarded by their expiration date or three days after being opened.  Dietary Manager re-established a cleaning assignment for dietary staff on duty to ensure the food storage locations, to include nourishment rooms, refrigerators, freezers, and dry storage areas, are cleaned and all open food items include labels, dates, and are not stored beyond the use by and/or expiration dates. The new cleaning assignment will be used affective 05/01/2023.	F 812	was conducted on 4/Dietary Manager. The observed: One opened 32-our nutritional shake One 15-ounce oper watermelon with a us One opened 20-our One opened 20-our One opened 24-our None of the food con resident's name or the An interview was cor A.M. with the Dietary interview, the Dietary been educated to lab nourishment room wiresident's room numl indicated all the food needed to be discard indicated without a dway to know how lon refrigerator and she ditems.  An interview was cor P.M. with the Directo the interview, the DC were responsible to president's name on it nourishment rooms rindicated dietary staff cleaning out the nounhad to be discarded.	a3/23 at 5:50 A.M. with the e following items were ince container of fortified ined clear plastic container of se by date of 3/24/23 ince bottle of general ale ince bottle of soda ince bottle of a sports drink ince bottle of chocolate syrup stainers were labeled with a ine date of storage.  Adducted on 4/3/23 at 5:42 in Manager indicated staff had be all food brought into the ith the current date and in the distribution of the properties of	F	Are af Occest no too la the of are all all all are in front cl la the new the original are the original are cl la the new the original are the	ddress how the facility will identify of esidents having the potential to be effected by the same deficient practice on 4/6/2023, Certified Dietary Managonducted an inspection on all food coring areas to include 100 & 500 has purishment rooms, and the entire kith in identify any other open food items in identify any other open food items in identified appropriately or stored beyond their food items identified not labelled appropriately or stored beyond their food items identified not labelled appropriately or stored beyond the using inderest and in the facility complication of the food items in the facility complication of the food items in the facility complication of the food items in the facility complication of the food in the facility complication of the food in the facility complication of the food items in the facility Certified in the facility Certified in the facility Certified in the food items in the food items include items in the food items included items in the food items included in the food items included in the food items included items in the food items in the food items in the food items included items in the food item	e: er  Ils chen not d o il e by is ige ance to not do not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	343213	B. WING _		REET ADDRESS, CITY, STATE, ZIP CODE	04/	11/2023	
	AL HEALTH CARE LILLI	NGTON		19	95 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 812	Continued From page	÷ 46	F	312	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 food storage locations, to include nourishment rooms are cleaned and all open food items include labels, dates, and are not stored beyond the uby, and/or expiration dates. This education will be completed by 05/08/2023, any dietary employee not educated by 05/08/2023, will not be allowed to work until educated. This education will be provided annually and will be added on new hire orientation for all new dietary employee employees effective 05/08/2023.  Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.  Effective 05/01/2023, the Dietary Manage will complete kitchen monitoring process to ensure food storage locations, to include nourishment rooms, are clean all open food items include labels, date and are stored not to exceed a use-by, expiration dates. This monitoring proces will be completed daily Monday through Friday for two weeks, weekly for two money weeks, then monthly for three months of until the pattern of compliance is maintained. Findings of this monitoring process will be documented on Food storage monitoring tool located in the facility compliance binder.	ees ger. es, d se d or or or ss and es, or ess or ore or		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345213	B. WING			04/	11/2023
	ROVIDER OR SUPPLIER	IGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546			
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F 812	Continued From page	: 47	F	812	Effective 05/01/2023, the Dietary Mana 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 established.	ie	
F 867 SS=E			Completion date 05/08/2023		5/8/23		
	monitoring. A facility must establis policies and procedur collections systems, a adverse event monito	eedback, data systems and sh and implement written es for feedback, data and monitoring, including ring. The policies and ude, at a minimum, the					
	systems to obtain and from direct care staff, resident representativ information will be use	maintenance of effective If use of feedback and input other staff, residents, and res, including how such red to identify problems that tume, or problem-prone, and povement.					
	systems to identify, coinformation from all donot limited to the facility \$483.70(e) and include	maintenance of effective blect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C <b>04/11/2023</b>	
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON				STREET ADDRESS, CITY, STATE, ZI 1995 EAST CORNELIUS HARNET LILLINGTON, NC 27546		0-7/11/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG			(X5) COMPLETION DATE	
F 867	and evaluation of perincluding the methods development, monitor §483.75(c)(4) Facility including the methods systematically identify analyze and use data adverse events in the facility will use the darevent adverse events will use the darevent adverse events in the facility will use the darevent adverse events in the facility will use the darevent adverse events in the facility will use the darevent adverse events will be facility will use and track performance implementing those and track performance improvements are reasily and track performance improvements are reasily as a facility will use a determine underlying impacting larger systems (ii) How they will dever will be designed to efflevel to prevent quality safety problems; and	development, monitoring, formance indicators, plogy and frequency for such ring, and evaluation.  adverse event monitoring, aby which the facility will and information relating to facility, including how the tato develop activities to atts.  systematic analysis and cility must take actions improvement and, after actions, measure its success, the totel ensure that alized and sustained.  cility will develop and addressing: a systematic approach to causes of problems	F	367			
		provement activities to nents are sustained.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345213	B. WING			C /11/2023
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULE  LILLINGTON, NC 27546	·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 867	performance improve high-risk, high-volum consider the incidence of problems in those outcomes, resident s resident choice, and \$483.75(e)(2) Performactivities must track in resident events, analimplement preventive that include feedback facility.  §483.75(e)(3) As par improvement activitied distinct performance number and frequence conducted by the fact and complexity of the available resources, assessment required Improvement projects annually a project that problem-prone areas collection and analys (c) and (d) of this section section in the section of	cility must set priorities for its ement activities that focus on e, or problem-prone areas; ce, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care.  mance improvement medical errors and adverse yze their causes, and e actions and mechanisms of and learning throughout the est of their performance est, the facility must conduct improvement projects. The exp of improvement projects effacility's services and as reflected in the facility lat §483.70(e). It is must include at least at focuses on high risk or is identified through the data is described in paragraphs ention.  In a sessesment and errors to the facility's esignated person(s) erning body regarding its inplementation of the QAPI der paragraphs (a) through	F 86	67		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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UNIVERSAL HEALTH CARE LILLINGTON				1995 EAST CORNELIUS HARNETT BOULEVARI	)
UNIVERSAL HEALTH GARE EILLINGTON			LILLINGTON, NC 27546		
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F 867	Continued From page	e 50	F 86	7	
	action to correct iden (iii) Regularly review data collected under resulting from drug re available data to mak This REQUIREMENT by: Based on record rev interviews, nurse pra interview, the facility's Assurance Committe implemented procedu interventions that the put in place following complaint survey of 2 recited deficiencies of and complaint investi The deficiencies inclu Assessments (F641) use of antipsychotic a medications and Food Prepare and Serve, S continued failure duri record showed a patt sustain an effective of Findings included: This tag is cross refe  F-641 Based on record revi facility failed to accur (Resident #62), antip (Resident's #373, #26)	iew, observations, staff ctitioner and medical director so Quality Assessment and e failed to maintain committee had previously the recertification and entered to the current recertification and entered to the total and the current recertification and entered to the total and the current recertification and entered to the total and the current recertification and entered to the total and the current recertification and entered to the total and the current recertification and entered to the total and the current recertification and entered to the total and the current recertification and entered to the current recertific		F867 Address how corrective action will be accomplished for those residents for have been affected by the deficient practice:  As of 5/01/2023 facility Quality Assur Performance Improvement (QAPI) process has put in place measures the address the repeated deficient praction both F641 and F812. The plan implemented was approved by the Committee on 5/1/2023 to be effective prevent repeat citation.  Address how the facility will identify residents having the potential to be affected by the same deficient praction.  On 5/1/2023, the facility Administrate conducted a review annual and comsurveys for the prior 3 years to revie areas of repeat deficient practice. The review focus on the action plans implemented to identify whether the citation resulted from the same component of regulatory requirement other repeat citation identified under same component of regulatory	rance o ice for QAPI re to other ce: or plaint w all ne repat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		345213	B. WING				C 11/2023
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-4/	11/2020
UNIVERSAL HEALTH CARE LILLINGTON			19	995 EAST CORNELIUS HARNETT BOULEVARD			
		NGTON		L	ILLINGTON, NC 27546		
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F 867	Continued From page	e 51	F	867			
	Data Set (MDS) asse	essments were reviewed.			Address what measures will be put into	)	
					place or systemic changes made to		
		tion and complaint survey of was cited for failure to MDS assessment			ensure that the deficient practice will no recur:	ot	
	accuratory code and in	ind a decession.			Effective 5/1/2023, the facility		
	In an interview on 4/1	0/2023 at 4:58 p.m. with the			Administrator will discuss all cited		
	Administrator, he exp	lained there had been a			deficiencies from the last annual		
		in the MDS department.			inspection survey and/or from complain	nt	
	Although the MDS staff had received MDS				investigation sited in the previous 12		
	training, the MDS sta				months to ensure the area remains in		
	training to prevent ina	accuracy of the MDS			regulatory compliance.		
	assessment.				On 5/1/2023 Director of Operations has	6	
	F-812				re-educated the Administrator on the		
	_	as and staff intensions, the			facility QAPI procedures for monitoring areas of identified deficient practice an		
	I .	ns and staff interviews, the date, and/or remove expired			process of removing monitoring of area		
		2 of 2 nourishment rooms			due to patterns of compliance, to preve		
	(100 Hall Nourishmer				repeat deficiencies.	,,,,,	
	Nourishment Room).				1		
	,				100% education of all active/current		
	During the recertificat	tion and complaint survey of			facility members of QAPI committee to		
		was cited for failure to label,			includes Director of nursing Assistant		
		food items stored in the			Director of nursing (ADON), business		
	kitchen refrigerator ar	nd freezer.			office manager, activities director,		
		0/0000 1 1 50			housekeeping manager, maintenance		
	I .	0/2023 at 4:58 p.m. with the			director, admissions director, staff		
		ed the plan of correction			development coordinator, medical		
		Idressed only the area cited C needed to cover all			records, Rehab Director, MDS		
	, , , , , , , , , , , , , , , , , , ,	gulation which would include			Coordinators, and Central Supply Person), were completed by the facility		
	the nourishment refrig				Administrator. The emphasis of this		
		g =			education includes but is not limited to	the	
	In an interview with th	ne Administrator on			contents of QAPI committee and the		
		n., he explained how the			importance of developing and maintain	ing	
	1	erformance of Improvement			appropriate plans to correct identified	-	
		unctionable, and how the			quality deficiencies to prevent		
	issues of 2/4/2022 we	ere addressed in the plan of			re-occurrences. This education will be		
	corrections. He stated	d although there were			completed by 05/08/2023, any departm	nent	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION  ILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WING _			C <b>04/11/2023</b>	
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE LILLINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE  1995 EAST CORNELIUS HARNETT BOULEVARD  LILLINGTON, NC 27546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 867	survey 2/4/2022, and		F8	head not educated by 05/0 be allowed to work until ed education will be provided will be added on new hire all new Department heads 05/08/2023.  Indicate how the facility plaits performance to make sissolutions are sustained:  Effective 5/2/2023 Facility will review the Plan of Corn MDS accuracy (F641}, and procurement (F812) during QAPI meeting to ensure the process is effective to attain compliance and prevent notitation. This monitoring procupattern of compliance is marked weekly for eight monthly for three months of pattern of compliance is marked on Quality As monitoring tool located in the compliance binder.  Effective 05/02/2023, the fradministrator will report find monitoring process to the fradministrator will report find monitoring process to the fradministrator committee (or recommendations and/or recompliance is acceptablished.  Completion date: 05/08/20	ducated. This annually and orientation for effective  ans to monitor ure that  Administrator rections for d food g weekly ad hoc he monitoring in and maintain or future repeat rocess will be to weeks, then or until the haintained. In process will be surance the facility dings of this facility Quality ce QAPI), for modifications, or until the chieved		