	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3	B) DATE SURVEY COMPLETED	
		NH0444	B. WING		C 11/06/2023	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE		11/00/2023	
	CONDER OR SOLT EIER			HARNETT BOULEVARD		
JNIVERSA	AL HEALTH CARE LILLI	NGTON	TON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLET DATE	
D 000	Initial Comments		D 000			
	conduct a complaint exited on 11/2/23. At obtained on 11/3/23 a exit date was change TFNY11.	d the facility on 10/30/23 to investigation survey and dditional information was and 11/6/23. Therefore, the ed to 11/6/23. Event ID were investigated NC 7959.				
	Five of the five comp result in deficiency.	laint allegations did not				
D 338	10A NCAC 13F .0909	9 Resident Rights	D 338		11/24/23	
	all residents guarante	shall assure that the rights of eed under G.S. 131D-21, ents' Rights, are maintained				
	This Rule is not met Type B Violation:	as evidenced by:		Director of nursing completed a head to toes assessed for resident #14 on		
	staff interview the fact of a resident to be free continued to experier out of his wheelchair Resident # 15. Prior 14 demonstrated ver him vulnerable to abu the date of the incide 14 had been cursing 15 stated he "smacket wheelchair and hit hin Resident # 14 had be then cursed him. This residents reviewed for	ew, resident interview, and sility failed to protect the right the from abuse. Resident # 14 ance fear after being knocked and hit in the jaw by r to the incident, Resident # bal behaviors which make use by other residents. On nt, staff reported Resident # "all day" at staff. Resident # "all day" at staff. Resident # de (Resident # 14) out of his m upside the jaw" because been cursing the staff and is was for one of three or abuse. The findings		<ul> <li>11/06/2023, there were no signs of any injuries.</li> <li>On 11/06/2023, Director of nursing completed a one-on-one education with medication technician #1 on the importance of identifying, managing, and deescalating behaviors symptoms of the residents. The education also emphasize the importance of following-up on resident's post incident/event to ensure their physical and psychological wellbeing is not affected.</li> <li>On 11/22/2023, resident #15 was</li> </ul>		
	Ith Service Regulation DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE	
	ally Signed				11/22/23	

STATE FORM

6899

If continuation sheet 1 of 11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NH0444	B. WING		C 11/06/2023	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	AL HEALTH CARE LILLI	1995 EA	ST CORNELIUS	HARNETT BOULEVARD		
		LILLING	TON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLE	
D 338	Continued From page	e 1	D 338			
	included:			assessed by the licensed nurse		
				practitioner to ensure that resident #15	5 is	
		dmitted to the facility on		an appropriate setting. Nurse practition	ner	
		4's diagnoses in part		determine that resident #15 was in pro	per	
	included heart failure			placement.		
	pulmonary disease, and muscle wasting and atrophy.			Identification of Other Residents who Might Be Affected:		
	Resident # 14's care	plan, dated 6/3/23 noted the		ingit be / incolog.		
		14 was ambulatory with an		100% interview of all residents in the		
	aide or device, used	a wheelchair, and		assisted facility who are alert and orier	nted	
	sometimes was disor			completed by the facility social worker	#1,	
		plan included a section in		#2, and #3 on 11/06/23 to identify any		
		f a resident was "verbally		other resident with an allegation of	na i d	
		abusive" or displayed socially inappropriate"		abuse/neglect, or who voiced being aft of another resident. No other resident(		
		# 14's care plan did not have		voiced any allegation of abuse/neglect	· ·	
	any of these behavio	-		being afraid of another resident. Findir of this audit are documented on a		
	Resident # 15 was la	st admitted to the facility on		"resident abuse interview tool" located	in	
	chronic obstructive p	-		the facility compliance binder.		
		s, heart disease, seizure		100% interview of all residents in the		
	disorder, and hyperte	ension.		assisted living facility who are alert and		
	Popidont # 15's area	plan datad 7/1/22 pated		oriented completed by the facility social worker $#1, #2, and #2 an 11/06/22 to$	ai	
		plan, dated 7/1/23, noted tally independent in all his		worker #1, #2, and #3 on 11/06/23 to identify any other resident with behavior	or	
		g and was ambulatory		symptoms that may result onto physica		
		devices. Resident # 15 was		abuse. No other resident identified with		
		etimes disoriented and		behaviors that may result onto physica		
		he care plan included a		abuse to another resident.		
		checked if a resident was				
	"verbally abusive," "p			100% audit of current resident's medic		
	displayed "disruptive	•		records in assisted living facility compl		
		iors. Resident # 15's care		by director of Nursing, Unit coordinator		
	plan did not have any checked.	or these penaviors		and/or unit coordinator #2 on 11/06/20 to identify any other resident with beha		
				symptoms that may result onto		
	On 10/22/23 at 10.00	PM a medication technician		resident-to-resident abuse. No other		
		y into Resident # 15's record		resident identified to have behaviors the	4	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		NH0444	B. WING		C 11/06/2023
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
				HARNETT BOULEVARD	
NIVERS	AL HEALTH CARE LILLII	NGTON	TON, NC 27546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE
D 338	Continued From page	2	D 338		
	noting the following.	Another resident was		may result onto resident-to-resident	
		5 had assaulted him. The		abuse.	
	•	d called the police. Resident		Systemic Changes and Modification:	
	•	about the incident and			
		e other resident because		Effective 11/06/2023, the facility will	
		s yelling and cursing at the		ensure each resident retains the right	to
	nurses.			be free from abuse, neglect,	
				misappropriation of resident property,	
	Review of a facility in	-		and/or exploitation, to include freedon	n
		e resident who had been hit		from resident-to-resident abuse. This	
	-	Resident # 14. The incident		systemic change will be accomplished	ג 
	-	ent had occurred at 9:30 PM noted on the incident report,		through the implementation of the following measures:	
		and screaming coming from		Effective 11/06/2023 all new residents	s will
		er got there (Resident # 14)		have a behavior assessment complete	
	-	b) hit me." The incident		on admission, re-admission, annually	
		hour follow up notation		with any changes in their behavior sta	
		nentation that Resident # 14		by the licensed nurse. The appropriate	
	had no bruising from			measures will be implemented to mar	
	-	endently ambulatory and		identified behaviors and deescalated	-
		he incident report form also		behaviors to prevent resident to reside	ent
	included a section wh	•		abuse.	
	"additional follow-ups	" regarding the incident.			
	There were no furthe	r follow- ups noted on the		Effective 11/06/2023, all new resident	's
	incident report form for	blowing the 24 hour follow		medical records will be reviewed for a	ny
	up. The "additional fo	llow-ups" were blank.		behaviors that may result in	
				resident-to-resident abuse. Any reside	
		ent officer was interviewed		identified with any behavior symptoms	
	•	at 11:30 AM and reported		have appropriate interventions to redu	
		o the altercation on 10/22/23		escalation of behaviors that may resu	
	• •	as filed. The officer stated if		resident-to-resident abuse. This will b	
	-	ury, the responding officers		reviewed in the daily clinical meeting a	and
	would have made a r	eport.		be documented on each resident's medical records.	
	Resident # 14 was int	terviewed on 11/1/23 at 3:10			
		following. He had waited for		Effective 11/06/2023, the facility clinic	al
		ed made and was upset with		team to include the Director of Nursin	
		. He had cursed the nurses		assistant director of Nursing, Unit	-
		ent with Resident # 15		Manager #1 and/or Unit Manager #2	
		# 14 stated after he had		revised the process of reviewing new	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY LETED C
		NH0444	B. WING		06/2023	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
INIVERS	AL HEALTH CARE LILLIN	IGTON 1995 EAS	ST CORNELIUS	HARNETT BOULEVARD		
		LILLING	TON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
D 338	Continued From page	23	D 338			
	cursed the nurses, Re the ground and hit me stated the staff had se about the incident. Du # 14 repeated three d afraid of Resident # 1 Resident # 15 was me Resident # 15 was me PM and reported the been calling the nurses the incident. He aske cursing the nurses. At to stop cursing, Resid you," and then he ( him (Resident # 14) o him upside the jaw." MT # 1 had been the the incident on 10/22/ on 11/1/23 at 3:20 PM Resident # 14 often g would curse. Rather t wrong so they could t would routinely roll ar of 10/22/23 he had be the incident occurred Resident # 15, she dii occurred. She heard I yelling that Resident # to check on him. He h appeared to be okay. the time he reported i The Assisted Living R was interviewed on 17 reported the following witnessed the inciden Resident # 14 and Re	esident # 15 "knocked me to e in the jaw." Resident # 14 een it. He called the police uring the interview, Resident lifferent times that he was 5. Resident # 14 stated that uch younger than he was. terviewed on 11/1/23 at 1:15 following. Resident # 14 had es bad names on the date of ed Resident # 14 to quit fter he asked Resident # 14 lent # 14 responded, "F Resident # 15) "smacked but of his wheelchair and hit MT who had responded to (23. MT # 1 was interviewed A and reported the following. iot upset with the staff and han tell the staff what was ake care of it, Resident # 14 ound and curse. On the date een cursing all day. When between Resident # 14 and d not see what had Resident # 14 in the hallway # 15 had hit him. She went had no bruises and He was in the wheelchair at		admits/readmits in a daily clinical The revised process includes the provision for behavior assessme ensuring it is completed, docume with an appropriate care plan in discrepancies identified will be of promptly. Finding of this system is documented on the daily clinic meeting report form located on the clinical meeting binder. 100% education of all current as living staff to include full-time, pa and as needed employees will b completed by the Director of Nur Assistant Director of Nursing, an Coordinators (#1, #2). The empt this education includes but not li the importance of completing be assessment on admission, annu with changes of behavior status, prohibition policy and procedure include resident to resident abuse importance of identifying, manage deescalating resident behaviors resident to resident abuse, report incident/accident to a licensed in the requirements to follow up wit resident/residents post incident to their physical and psychosocial of is not affected. This education w completed by 11/24/2023. Any at living staff members not educate 11/24/2023, will not be allowed to until educated. This education w provided annually and will be ad new hire orientation for all new at living employees effective 11/24. Monitoring Process:	e ent, ented, place. Any orrected c change al he daily sisted art-time, e sing, d/or Unit hasis of mited to; havior ally, and abuse s to se, the ging and to prevent ting any urse, and th co ensure wellbeing ill be ssisted ad o work ill be	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		NH0444	B. WING		11/	06/2023
AME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
NIVERS	AL HEALTH CARE LILLIN	NGTON		HARNETT BOULEVARD		
_		LILLING	TON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLE DATE
D 338	Continued From page	9 4	D 338			
	Resident # 14 was no physical capability to the ground if he was of incident, she told both from each other. They prior altercations. Res shared with her that h 15. Resident # 16 was int 10/30/23 facility list of administrative staff ha interview purposes.) If Resident # 16 reporte to her about the incider Resident # 15. Resider about the incident, sh	ot hurt, and he had the have gotten himself up from on the ground. Following the n residents to stay away y did not have a history of sident # 14 had never ne was afraid of Resident # terviewed on 11/1/23 at # 16's name appeared on a f residents whom the facility ad reported to be credible for During the interview, ed Resident # 14 had spoken ent after he was hit by ent # 14 had let her know he nt # 15. When he told her ie could see that his hands ilking about it. She had not		Effective 11/06/2023, the Director Nursing, Assistant Director of Nur and/or Unit Coordinators (#1, #2) review all new admissions for the hours or from last clinical meeting ensure behavior assessment has completed, and appropriate interv are implemented to ensure that b are not escalating to cause reside resident abuse. Any negative find be corrected promptly. This moni process will be completed daily M through Friday for two weeks, we two more weeks, then monthly fo months or until the pattern of com is maintained. Findings of this mo process will be documented on th "behavior assessment tool for ner residents" located in the facility compliance binder.	rsing, will last 24 g to been vention ehaviors ent to lings will toring londay ekly for r three apliance onitoring	
	4:00 PM and reported aware of the altercation and Resident # 14. For staff tried to keep their not shared with any of of Resident # 15. If he would have addresse On 11/6/23 the facility following plan to immer Violation in order to p risk or additional harm Resident #15 was additional facility on 06/22/2020	Administrator presented the ediately remove the Type B rotect residents from further n. mitted to the assisted living and readmitted on e original admission and last		Effective 11/06/2023, the Director Nursing, Assistant Director of Nur and/or Unit Coordinators (#1, #2) monitor incident/accident reports ensure resident/residents involve been assessed to ensure their ph and/or psychosocial wellbeing are affected. Any negative findings w corrected promptly. This monitori process will be completed daily M through Friday for two weeks, we two more weeks, then monthly fo months or until the pattern of com is maintained. Findings of this mo process will be documented on th "incident report monitoring tool" to the facility compliance binder. Person(s) Responsible to implem	tor of Nursing, s (#1, #2) will nt reports to ts involved have te their physical libeing are not indings will be a monitoring ed daily Monday veeks, weekly for nonthly for three ern of compliance of this monitoring nted on the ng tool" located in	

STATE FORM

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TFNY11

If continuation sheet 5 of 11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		NH0444	B. WING	11	/06/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
JNIVERS	AL HEALTH CARE LILLIN	NGTON	ST CORNELIUS FON, NC 27546	HARNETT BOULEVARD		
(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)	I SHOULD BE	(X5) COMPLET DATE
D 338	Continued From page	9 5	D 338			
	nursing facility from 1 The most recent read with diagnoses that in brain injury, Chronic C Disease, Hypertensio disorder of puberty, a Resident #14 was add facility on 04/20/2022 diagnoses that includ Obstructive Pulmonar Heart Failure, Dyspha Gastro-esophageal re- muscle weakness. Review of incident rep 10/22/2023, indicated resident #14 on 10/22 #14 to fall out of his w injuries. Root Cause Analysis The Governing body I Director, Director of N resident care Coordin selected members of Assurance and Perfor (QAPI) committee cor analysis on 11/06/202 factor for this alleged implemented appropr and prevent the reoco The root cause analys noncompliance result to implement appropr manage residents' be	0/15/2021 up to 06/30/2022. mission, he was readmitted included (in parts), traumatic Distructive Pulmonary in, seizures, Hyperlipidemia, and muscle weakness. mitted to the assisted living . He was admitted with ed (in parts), Chronic ry Disease, Hypertension, agia, Dementia, egurgitation disease, and port completed on that resident #15 hit 2/2023 and caused resident wheelchair with no apparent (RCA): led by the facility Executive lursing, Assisted Living lator in collaboration with the the facility Quality rmance Improvement inducted the root cause 23, to identify the causative noncompliance and iate measures to correct		Corrective Plan of Care: Effective 11/06/20232, the Exe Director, Director of Nursing, a Assisted living Resident care of will be responsible for the imp of this plan to immediately rem Type B Violation in order to pr residents from further risk or a harm.	and/or coordinator lementation nove the otect	

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
		NH0444	B. WING		C 11/06/2023	
			ADDRESS, CITY, STATE		11	106/2023
	ROVIDER OR SUPPLIER					
INIVERS	AL HEALTH CARE LILLI	NGTON	TON, NC 27546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From page	e 6	D 338			
	alleged noncomplian of the facility staff to o up to ensure resident well being is not affect facility. This was evic said he continues to when interviewed by Immediate Action Imp Director of nursing co assessment for resid were no signs of any On 11/06/2023, Director one-on-one educatio #1 on the importance and deescalating beth residents. The education incident/event to ensist psychological wellbeit Identification of Other Affected:	ompleted a head to toe ent #14 on 11/06/2023, there injuries. ctor of nursing completed a n with medication technician of identifying, managing, naviors symptoms of the tion also emphasized the ng-up on resident's post ure their physical and				
	facility who are alert the facility social wor 11/06/23 to identify a allegation of abuse/n	and oriented completed by ker #1, #2, and #3 on ny other resident with an eglect, or who voiced being				
	voiced any allegation afraid of another resi are documented on a	dent. No other resident(s) of abuse/neglect or being dent. Findings of this audit a "resident abuse interview cility compliance binder.				
	living facility who are	residents in the assisted alert and oriented completed vorker #1, #2, and #3 on				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY
			A. BUILDING:			
		NH0444	B. WING		11	C / <b>06/2023</b>
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
		1995 EA	ST CORNELIUS HA	RNETT BOULEVARD		
	AL HEALTH CARE LILLI	LILLING	TON, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From page	e 7	D 338			
	abuse. No other resid	ny other resident with hat may result onto physical lent identified with behaviors physical abuse to another				
	in assisted living facil Nursing, Unit coordin coordinator #2 on 11/ other resident with be result onto resident-to	06/2023, to identify any ehavior symptoms that may p-resident abuse. No other have behaviors that may				
	Systemic Changes ar	nd Modification:				
	resident retains the rinneglect, misappropria and/or exploitation, to resident-to-resident a	the facility will ensure each ght to be free from abuse, ation of resident property, o include freedom from buse. This systemic change through the implementation ures:				
	behavior assessment re-admission, annual their behavior status appropriate measures manage identified be	all new residents will have a t completed on admission, ly, and with any changes in by the licensed nurse. The s will be implemented to haviors and deescalated event resident to resident				
	records will be review may result in resident resident identified wit	all new resident's medical ved for any behaviors that t-to-resident abuse. Any h any behavior symptoms interventions to reduce rs that may result in				

STATEMENT	of Health Service Regu of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY		
		NH0444	NH0444 B. WING			C / <b>06/2023</b>		
	ROVIDER OR SUPPLIER	STREET	STREET ADDRESS, CITY, STATE, ZIP CODE					
				RNETT BOULEVARD				
UNIVERS	AL HEALTH CARE LILLI	NGTON	TON, NC 27546					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET		
D 338	Continued From page	e 8	D 338					
		abuse. This will be reviewed eeting and be documented edical records.						
	include the Director of	, the facility clinical team to of Nursing, assistant director ager #1 and/or Unit Manager						
	admits/readmits in a revised process inclu behavior assessmen	daily clinical meeting. The ides the provision for t, ensuring it is completed,						
	place. Any discrepan corrected promptly. F	appropriate care plan in icies identified will be Finding of this systemic ed on the daily clinical						
	meeting report form I meeting binder.	ocated on the daily clinical						
	to include full-time, p	ll current assisted living staff art-time, and as needed mpleted by the Director of						
	Nursing, Assistant Di Unit Coordinators (#1	irector of Nursing, and/or 1, #2). The emphasis of this						
	· · ·	eting behavior assessment						
	behavior status, abus	lly, and with changes of se prohibition policy and e resident to resident abuse,						
	the importance of ide	entifying, managing and t behaviors to prevent						
		a licensed nurse, and the						
	post incident to ensu	w up with resident/residents re their physical and ng is not affected.This						
	education will be con	npleted by 11/24/2023. Any nembers not educated						
	11/24/2023, will not be educated. This educa	be allowed to work until ation will be provided						
	annually and will be a a a structure and the service Regulation	added to the new hire						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		С	
		NH0444	B. WING			/06/2023
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
JNIVERSA	AL HEALTH CARE LILLI	NGTON 1995 EA	ST CORNELIUS HA	RNETT BOULEVARD		
		LILLING	TON, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From page	e 9	D 338			
	orientation for all new effective 11/24/2023.	- · ·				
	orientation for all new assisted living employees					
		Director of Nursing and/or nt care coordinator will				

TATEMEN	of Health Service Regi OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		С	
		NH0444	B. WING	B. WING		/06/2023
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
NIVERS	AL HEALTH CARE LILLI	INGTON	ST CORNELIUS HA TON, NC 27546	RNETT BOULEVARD		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pag	e 10	D 338			
	facility Quality Assura Improvement Comm recommendations ar for three months, or compliance is achiev Person(s) Responsite Plan of Care: Effective 11/06/2023 Director of Nursing, a Resident care coordi the implementation of remove the Type B	nd/or modifications, monthly until the pattern of				