11(14(11)

PRINTED: 10/31/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION (	(X3) DATE SUF COMPLETI	
		345213	B. WIN	G	- Will	10/2	5/2012
	ROVIDER OR SUPPLIER	NGTON		1:	EET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOULEVA ILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	∑ ZJ.[D PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION ĐATE
F 280 SS=D	The resident has the incompetent or other incapacitated under t participate in planning changes in care and  A comprehensive car within 7 days after the comprehensive asses interdisciplinary team physician, a registere for the resident, and disciplines as determined, to the extent pratter resident, the resident, the resident legal representative;	right, unless adjudged wise found to be he laws of the State, to g care and treatment or treatment. re plan must be developed	F	280	Submission of this response to to of Deficiencies by the undersigned constitute an admission that the dexisted and/or were correctly cited require correction.  1. Corrective action for Resident been accomplished. The resident oral/dental status has been assess supervisor. The care plan and C. Guide has been updated & oral of delivered by the assigned C.N.A assessment.  2. Oral/dental assessments for a residents completed on 11/5/201 plans & care guides updated to residents current oral care needs partial plates that need removal for the constitution of the con	ed does not deficiencies and/or t # 103 has 's led by a RN N.A. Care are is being as per this tl current 2 and Care effect the including	
	by: Based on staff interveview the facility faile plan for a resident will of 1 residents review dental appliance. Findings include: Resident #103 was a 3/28/2008. Her diagn stroke and generalize	riews and facility record and to update a working care the allower dental partial for 1 allower dental partial for 1 and (resident #103) with a admitted to the facility on loses included dementia, and muscle weakness.			3. Measures/systems in place to continued compliance: All resid have an oral/dental assessment c licensed nurse on admission, qua with changes in dental status inc dental appliances.  All dental consult reports will be by the Interdisciplinary team (ID daily clinical meetings. All chan reflected in the resident's care place.  Licensed nurses and C.N.A.'s in by the staff development coordinates.	ents will completed by arterly, and duding new e reviewed art) in the ges will be an & on the	(X8) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	:	345213	B. WIN	IG_		10/25/2		5/2012
		ATEMENT OF DEFICIENCIES	ID	1: L	REET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOUL ILLINGTON, NC 27546 PROVIDER'S PLAN OF COR	RECTIO	ın (	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)			COMPLETION DATE
T# in dip confil T as 9, ep. liv "r m A di de D di lo N ev an in over the black we dit the C	and dated May 2011 adicated she was concection making and bersonal hygiene such oded to have any deting dentures or gurthe care plan for resignd updated on 12/10/8/11 and 10/18/11 in extensive to total assigning. Approaches on provide oral care eventual care eventual section.  The transport of a lower defined to the extension of a lower defined and lower partial were defined to the defined lower partial fit will walk at the extension of the ext	et assessments for resident I and January 2012 gnitively impaired for daily was dependent on staff for h as oral care. She was not ental problems such as loose in problems.  dent #103 dated 7/30/10 0/10, 2/22/11, 5/11/11, indicated she needed istance with activities of daily in the care plan included ery shift", there was no ental partial in the care plan.  care card for resident #103 ipartial listed under the  in the cart for resident #103 indicated resident #103, indicated resident #103, indicated resident #103 ist and her upper dentures ell. Notes from 1/13/12 03 had gingival overgrowth partials and the partials The note indicated when red it caused pain and e103. The Dentist's note val were so inflamed that it emove her lower partial. It e teeth had been cleaned or	F	280	on 11/5/2012 regarding proposincluding removing and clear plates at least daily and ensur care guide is updated.  The licensed nurses & transp in-serviced on 11/5/2012 to for consult reports to IDT for revisiting in medical record.  Residents and responsible paranotified of all dental appoints requested to turn in any writte communication or verbal conto the licensed nurse.  Director of Nursing (DON), A Director of Nursing (ADON) supervisor will review dental daily for 4 weeks, weekly for and monthly for 3 months.  4. The findings will be review monthly QA meeting for 6 methen quarterly.	ning paring the cortation forward view parties was ments ten mmuni Assistation and/olivers week a week week a consumer 8	artial artial artial artial artial article and article	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345213	B. WING	з		10/25	5/2012
*****	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON		19	EET ADDRESS, CITY, STATE, ZIP CODE 895 EAST CORNELIUS HARNETT BOULEVAR ILLINGTON, NC 27546	₹D	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 312 SS=D	are assessed in persidental appliances or assessment. She sai resident #103 had a cindicated the MDS not at quarterly and annocould also be update brought up in the monursing. MDS nurses was a specific order a resident having derplan stated "oral care."  On 10/25/12 at 2:25 (DON) indicated it was expectation of the nuread the consult note update the resident conursing assistant of dental partial care. 483.25(a)(3) ADL CADEPENDENT RESIDATE A resident who is unadaily living receives the maintain good nutriticand oral hygiene.  This REQUIREMENT by: Based on family and record reviews the factean a dental partial	on for complications with oral health on the MDS of she was never aware dental partial. MDS nurse #1 curses updated the care plans all MDS reviews but they of from care concerns rning meetings held by #1 and #2 said unless there by a physician regardless of nurse or partials the care etc.  PM the Director of Nursing as the responsibility and arse on the resident's hall to be update the care plan, care card and inform the changes in care such as			1. Corrective action for Resident abeen accomplished. The resident's oral/dental status has been assessed supervisor. The care plan and C.N. Guide has been updated & oral cardelivered by the assigned C.N.A.s assessment.  2. Oral/dental assessments for all residents completed on 11/5/2012 plans & care guides updated to refresidents current oral care needs in partial plates that need removal for	d by a RN A. Care re is being per this  current and Care lect the acluding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345213	B. WIN	G		10/25/2012	
	OVIDER OR SUPPLIER	NGTON	<b>1</b>	11	EET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOULEVAR ILLINGTON, NC 27546	RD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		.D BE	(X5) COMPLETION DATE	
F 312	Resident #103 was a 3/28/2008. Her diagr stroke and generalized. The minimum data s #103 dated May 201 indicated she was conducted the was conducted to the was conducted to the was decision making and personal hygiene surface plan for result and updated on 12/1 9/8/11 and 10/18/11 extensive to total assoliving. Approaches o "provide oral care evention of a lower day."	admitted to the facility on moses included dementia, ed muscle weakness.  et assessments for resident 1 and January 2012 ognitively impaired for daily was dependent on staff for	F 312  3. Measures/systems in place to en continued compliance: All resident have an oral/dental assessment con licensed nurse on admission, quart with changes in dental status includental appliances.  All dental consult reports will be resident by the Interdisciplinary team (IDT daily clinical meetings. All change reflected in the resident's care plan C.N.A. care guide.  of daily  of daily  ed  on 11/5/2012 regarding proper denincluding removing and cleaning propers.		nts will impleted by iterly, and ding new eviewed i) in the es will be in & on the serviced iter (SDC) intal care partial		
	dated 10/15/10 revelower partial were de Notes dated 1/14/11 evaluated by the der and lower partial fit vindicated resident # over her lower dentawere hard to remove the partial was remobleeding to resident stated "Patients ging was very difficult to did not appear that the	ult notes in the cart for resident #103 /10 revealed upper dentures and a were delivered to resident #103. i 1/14/11 indicated resident #103 was y the dentist and her upper dentures artial fit well. Notes from 1/13/12 sident #103 had gingival overgrowth rer dental partials and the partials o remove. The note indicated when ras removed it caused pain and resident #103. The Dentist's note ents gingival were so inflamed that it ficult to remove her lower partial. It ear that the teeth had been cleaned or emoved in quiet a while."  The Dentist			The licensed nurses & transportation-serviced on 11/5/2012 to forward consult reports to IDT for review filing in medical record.  Residents and responsible parties notified of all dental appointments requested to turn in any written communication or verbal communication to the licensed nurse.  The oral dental care provided to rewith partial plates by the C.N.A.	rd dental prior to will be s and nication esidents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		345213	B. WA	IG	······	10/	25/2012
	ROVIDER OR SUPPLIER	NGTON	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 995 EAST CORNELIUS HARNETT BOULEVAN ILLINGTON, NC 27546		
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F 312	also noted he had plain 2007 and would promoted in 2007 and would promote in 2007 and would promote in 2012 at 3:10 findicated that resident dentist in early 2012 at 2:25 fower her lower dental.  On 10/24/12 at 9:25 fowerved in her room clean and well groom teeth, her mouth was odor noted.  On 10/25/12 at 9:25 fower partial. NA #1 stake the residents low occasion because shoresident had a full set lower area would not was a permanent der was not told by the president #103 that should have a head a she brushed and had wash daily. (The Adm 10/25/12 at 3:00 PM to assigned to resident #November 18, 2011.)  On 10/25/12 at 2:25 F(DON) indicated it was	anned to extract all her teeth occeed with the plan.  PM family member #1 at #103 had visited the and her gums had grown partial.  AM resident #103 was after breakfast, she was led. She did not have any clean and there was no  AM nursing assistant (NA) assigned to resident #103 proximately one year ago at that the resident had a lead she had attempted to liver teeth out on one are was surprised that the come out she assumed it lead system. NA #1 said she revious NA assigned to be had a lower partial and gon the residents care card lower partial. NA #1 said resident #103 use mouth sinistrator indicated on that NA #1 was consistently #103 for morning care since  PM the Director of Nursing s the responsibility and	F		monitored by nurse supervisor dail weeks and then weekly times 4 we bimonthly x 4 weeks, then monthly months.  4. The findings will be reviewed a monthly QA meeting for 6 months then quarterly.	eks, y x 3 t the	
	expectation of the nur	s the responsibility and rise on the resident 's hall to s, update the care plan,					lulud.

STATEMENT AND PLAN OF	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345213	B. WIN	G		10/25/2012	
	OVIDER OR SUPPLIER	NGTON		1995	ADDRESS, CITY, STATE, ZIP CODE EAST CORNELIUS HARNETT BO INGTON, NC 27546	3	
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F 312	nursing assistant of c dental partial care. The was that any resident the partial removed a	are card and inform the hanges in care such as he DON said her expectation with a partial would have and cleaned daily and as eare card and care plan	F	312			

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STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345213	B. WING		441	4 F (004 0
UNIVER	PROVIDER OR SUPPLIER	JLLINGTON		TREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOI LILLINGTON, NC 27546		15/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	∆llin aF	(X5) COMPLETION DAYE
K 000	INITIAL COMMENT	rs	K 000			
K 012 SS=D	conducted as per T at 42 CFR 483.70(a Health Care section publications. This far construction and is automatic sprinkler spaces are protected.  CFR#: 42 CFR 483 NFPA 101 LIFE SAI Building construction of the following, 19.19.3.5.1	de (LSC) survey was he Code of Federal Register ); using the 2000 existing of the LSC and its referenced hot equipped with an system Only hazardous d with sprinkler coverage, .70 (a) FETY CODE STANDARD In type and height meets one 1.6.2, 19.1.6.3, 19.1.6.4,  not met as evidenced by:	K 012	1. Ceiling located in A-hall corroom will be cut out and replace new fire rated dry wall followin leak repair by 12/30/12 2. Facility tour completed to identify possible unidentified unsealed penetrations in the rate ceilings due to water damage. 3. Quarterly inspection of roof ceiling will be conducted by maintenance staff.	ed with ng roof ed	
K 029 SS=D	Based on the obsert on 11/15/2012 the for observed as noncominclude: The "A" hall unsealed penetration water damage.  CFR#: 42 CFR 483. NFPA 101 LIFE SAF One hour fire rated c fire-rated doors) or a extinguishing system and/or 19.3.5.4 prote the approved automatic option is used, the another spaces by smoothers.	vations and staff interviews illowing Life Safety item was appliant, specific findings is conference room had as in the rated ceiling due to 70 (a)  ETY CODE STANDARD onstruction (with 1/4 hour in approved automatic fire in accordance with 8,4.1 cts hazardous areas. When altic fire extinguishing system eas are separated from the resisting partitions and	K 029	4. Inspection results will be mo quarterly at QA meeting.  1. Ceiling in soiled linen room on Band C hall will be repaired rated dry wall by 12/30/12.  2. Facility tour completed to identify possible unidentified unsealed penetrations in the rate ceilings.  3. Quarterly inspection of roof a ceiling will be conducted by	located   with fire	12/30/17
BORATORY	TRECTOR'S OR BROVIDE	risupplier representative's sign/	ATURE	TITLE	)	XG) DATE
··· [· ·· /	West Drow	<u> </u>		· Homenistratur		414/17

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		& MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·			и approve <u>), 0938-03</u> 9	
STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE COMPL		
		345213	B, WING		11/	/15/2012	
	PROVIDER OR SUPPLIER	LILLINGTON	s	TREET ADDRESS, CITY, STATE, ZIP CO 1995 EAST CORNELIUS HARNETT LILLINGTON, NC 27546	DDE	10/2012	
(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	COMPLETIO DATE	
K 029	doors. Doors are s field-applied protec	elf-closing and non-rated or tive plates that do not exceed bottom of the door are	K 02:	maintenance staff.  4. Inspection results will be n quarterly at QA meeting.	nonitored		
SS=D:	Based on the obse on 11/16/2012 the f observed as noncorinclude; There were the rated ceilings of "B" and "C" hallways around the exhaust CFR#: 42 CFR 483 NFPA 101 LIFE SA A fire alarm system installed, tested, and with NFPA 70 Natio 72. The system has and testing program requirements of NFI This STANDARD is Based on the observance.	FETY CODE STANDARD required for life safety is d maintained in accordance nal Electrical Code and NFPA an approved maintenance complying with applicable	K 052	1. All dust and lint will be refrom the smoke sampling tub detectors by 12/30/12. 2. All duct detectors were expossible buildup. 3. Duct detectors in the meet room will be monitored quart 4. Inspection results will be n quarterly at QA meeting.	es of duct camined for canical erly.		

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	NO FORTHIEDION INC	& MEDICAID SERVICES				CINID IAC	), 0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI,IA IDENTIFICATION NUMBER:	1	IULTIPLE	CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMPL	
		345213	B. Wil	/G	· · · · · · · · · · · · · · · · · · ·	11/	15/2012
	ROVIDER OR SUPPLIER SAL HEALTH CARE L	ILLINGTON		1995	TADDRESS, CITY, STATE, ZIP CODE EAST CORNELIUS HARNETT BO INGTON, NC 27546	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO OATE
K 052	include: The duct of rooms were not we	ige 2 mpllant, specific findings letectors in the mechanical Il maintained as there was a Ilnt on the smoke sampling	K	052			
	CFR#: 42 CFR 483,70 (a)	3.70 (a)	   	!			***************************************
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Problem or to desire		: !	: !				
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FORM CMS-2507(02-99) Previous Versions Obsolete

Event ID: 8YLP21

Facility ID; 943230

If continuation sheet Page 3 of 3



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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION REDING 02 - BUILDING 02	(X3) DATE	
		345213	B. WIN	•		
NAME OF P	ROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP CO		15/2012
UNIVER	SAL HEALTH CARE L	ILLINGTON		1995 EAST CORNELIUS HARNETT LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG		I SHOULD BE	(X5) COMPLETION DATE
. The second sec	This Life Safety Co conducted as per Ti at 42 CFR 483.70(a Health Care section publications. This fa construction and is a automatic sprinkler spaces are protecte. There were no Life to noted during the sur CFR#: 42 CFR 483	de (LSC) survey was he Code of Federal Register i); using the 2000 existing of the LSC and its referenced icility is Type II protected not equipped with an system. Only hazardous d with sprinkler coverage. Safety Code Deficiencies vey.  70 (a)	K 0			
ANTINA P	ALECTORIZE OK LKONIDEI	RUSUPPLIER REPRESENTATIVE'S SIGNA	HUKE	TITLE	(	XG) DATE

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