STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to notify the responsible party regarding 1 of 1 sampled	F 157	Resident #103 was transferred to emergency room on August 6, 2013.	11/22/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/22/2013

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F 157	Continued From page 1 resident was being send out of the facility to the emergency room with signs of pneumonia(resident # 103) Findings included: Resident # 103 was admitted to the facility on 4/30/2013 with diagnoses of Coronary Artery Disease, Chronic Airway Obstruction, Convulsions, Hyperlipidemia and Dehydration. The resident ' s Minimum Data Set (MDS) dated 9/6/2013 indicated the resident ' s cognitive status was intact. The resident had no short or long term memory problems. Review of the nurse's note dated 8/6/2013 revealed Resident # 103 was sent out of the facility to the emergency room with signs of wheezing. The nurse's note also revealed that the doctor was notified but the responsible party was not notified. During the phone interview on 11/5/2013 at 1:30 PM, Nurse # 1 reported that she did not recall notifying the responsible party that Resident # 103 was being send out of the facility to the emergency room with signs of pneumonia. During the interview on 11/5/2013 at 3:20 PM, The Director of Nursing(DON) reported that her expectations of the staff was to notify the responsible party immediately, if a resident was being send out of the facility to the emergency room. The DON also added that the facility did not have any documentations indicating that Resident # 103's responsible party was notified that the resident was sent out to the emergency room on 8/6/2013.	F 157	A review of all resident transfers to the emergency room from August 6, 2013 to November 7, 2013 was completed by Director of Nursing (DON) on 11/22/13. No other residents were found to be affected by the alleged deficient practice. All licensed nurses were in-serviced by the Staff Development Coordinator (SDC)as of 11/21/13 regarding the importance of family notification of resident transfer to emergency room A review of the 24 hour reports to be accomplished daily by DON/Designee for daily audit of family notification of residents transferred to the Emergency room. For those identiied as not being notified previously notification will be completd by DON/Designess after review of 24 hour report DON/Designee will report to QA committee the findings of these audtis monthly x 3 months. The QA committee will determine effectiveness of plan with revisions made as deemed necessary.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		11/22/13

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F 272	Continued From page 2 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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F 272	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to accurately assess a resident with impaired vision for 1 of 3 sampled residents reviewed for visual function (Resident #31). The findings included: Resident #31 was admitted into the facility on 3/29/10. Diagnoses included cataract, nuclear sclerosis (both eyes) and presbyopia (both eyes). Nuclear sclerosis refers to a gradual cloudiness, hardening and yellowing in the center of the eye lens. Presbyopia is a condition, wherein, the crystalline lens of one's eye loses its flexibility; therefore, making it difficult for one to focus on close objects. The annual minimum data set (MDS) completed on 5/15/13 indicated vision was impaired with no corrective lenses. The care area assessment summary dated 5/15/13 listed vision as a triggered care area with a visual function plan. The problem area section for vision function indicated "no" for user of visual appliances. The resident was assessed "at risk for worsening visual ability." The quarterly MDS completed on 8/14/13 indicated that Resident #31 cognitive status was moderately impaired. Vision was indicated as "impaired sees large print, but not regular print in newspapers/books." No corrective lenses were listed. The most recent care plan dated 9/12/13 did not indicate visual function as an identified problem. During an observation on 11/5/13 at 10:40 am Resident #31 was observed in his room in the bed with no eye glasses on. During an observation on 11/6/13 at 3:47 pm	F 272	Corrective action for resident #31 was accomplished by completing a new quartely MDS on 11/13/13. B100 was coded "1" based on exam by MDS and eye doctor. A review of all current residents triggering for visual impairments on last assessment will be audited to check for correct coding of need for visual appliances by MDS nurse with modifications of MDS as indidcated. MDS nurses in-serviced by Regional MDS Nurse regarding need for accurate coding for residents triggering for visual impairments. MDS Coordinator to do weekly audits x 4 and monthly x 3 months of assessments to ensure accuarate coding for visually impaired residents with modications as indidcated. MDS Coordinator to reprot to QA Committee the findings of these audits monthly x 3 months. The QA Committee will determine effectiveness of plan with revisions made as deemed necessary.	

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F 272	Continued From page 4	F 272		

Resident #31 was observed outside smoking accompanied by the facility staff with no eyes glasses on.

In an interview on 11/7/13 at 9:45 am accompanied by Nurse #2 Resident #31 indicated that he enjoyed playing bingo and that he had difficulty seeing the writing on the bingo card and this affected his ability to successfully perform at the game, due to it was difficult for him to see the letter/numbers on the card. He added that because he could not see the numbering clearly on the card, it affected his ability to win, due to he was seeing the numbers incorrectly.

In an interview on 11/7/13 at 9:50 am Nurse #2 when questioned regarding Resident #31 reliability stated the resident was reliable and capable of conveying his needs to the staff; he just spoke softly and had trouble getting his words out due to a history of stroke. Nurse #2 concluded she had been Resident #31's nurse for one year and had not observed the resident with eye glasses on throughout the day.

In an interview on 11/7/13 at 11:42 am, the MDS nurse when questioned why the comprehensive MDS assessment did not capture vision devices utilized stated that she was not employed in the facility during the completion of the annual MDS on 5/15/13 and the quarterly on 8/14/13. She added that her expectation was that the vision section should have been assessed correctly to include any vision devices prescribed and a plan of care.

In an interview on 11/7/13 at 1:41 pm, the optometrist indicated that she had not seen Resident #31 since the last evaluation on 7/27/10.

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F 272	Continued From page 5 She stated "at the time of Resident #31's last eye exam, my assessment findings revealed diagnoses of cataract and presbyopia. At the time of the eye exam the resident was not a candidate for cataract surgery." She added "in the years to come since the last evaluation, the resident would become a candidate for cataract survey and it was my expectation to have seen the resident annually to monitor the progression of the cataract in both eyes." The optometrist concluded eye glasses were prescribed during the last visit. In an interview on 11/7/13 at 1:51 pm, the regional MDS consultant after reviewing the clinical record acknowledged that there was a coding error on the comprehensive assessment dated 5/15/13 which indicated "no" for corrective lenses that should have indicated "yes."	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		11/22/13

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F 279	Continued From page 6 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to develop a plan of care for impaired vision for 1 of 3 sampled residents reviewed for visual function (Resident #31). The findings included: Resident #31 was admitted into the facility on 3/29/10. Diagnoses included cataract, nuclear sclerosis (both eyes) and presbyopia (both eyes). Nuclear sclerosis refers to a gradual cloudiness, hardening and yellowing in the center of the eye lens. Presbyopia is a condition, wherein, the crystalline lens of one's eye loses its flexibility; therefore, making it difficult for one to focus on close objects. The annual minimum data set (MDS) completed on 5/15/13 indicated vision was impaired with no corrective lenses. The care area assessment summary dated 5/15/13 listed vision as a triggered care area with a visual function plan. The problem area section for vision function indicated "no" for user of visual appliances. The resident was assessed "at risk for worsening visual ability." The quarterly MDS completed on 8/14/13 indicated that Resident #31 cognitive status was moderately impaired. Vision was indicated as "impaired sees large print, but not regular print in newspapers/books." No corrective lenses were listed. The most recent care plan dated 9/12/13 did not indicate visual function as an identified problem. In an interview on 11/7/13 at 9:45 am	F 279	Corrective action for resdient #31 was accomplished by developing a plan of care for impaired vision on 11/13/13 by MDS nurse. An audit of all current residents triggering for visual impairments on last asseessment for a plan of care for impaired vision was completed by MDS by 11/22/13 with plan of care updated as necessary. MDS nurses to be in-serviced by Regional MDS Nurse on the importance of developing a plan of care for all residents triggering for visual impairments by 11/19/13. MDS Coordinator to do weekly audits x 4 and monthly x 3 of assessments to ensure all plans of care are in place for resients triggering for visual impairments. MDS Coordintatr to report findings of audits x 4 months with revisions made as deemed necessary.	

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F 279	Continued From page 7	F 279		

accompanied by Nurse #2 Resident #31 indicated that he enjoyed playing bingo and that he had difficulty seeing the writing on the bingo card and this affected his ability to successfully perform at the game, due to it was difficult for him to see the letter/numbers on the card. He added that because he could not see the numbering clearly on the card, it affected his ability to win, due to he was seeing the numbers incorrectly.

In an interview on 11/7/13 at 9:50 am Nurse #2 when questioned regarding Resident #31 reliability stated the resident was reliable and capable of conveying his needs to the staff; he just spoke softly and had trouble getting his words out due to a history of stroke. Nurse #2 concluded she had been Resident #31's nurse for one year and had not observed the resident with eye glasses on throughout the day.

In an interview on 11/7/13 at 11:42 am, the MDS nurse when questioned why there was not a care plan for vision function stated that she was not employed in the facility during the completion of the annual MDS on 5/15/13 and the quarterly on 8/14/13. She indicated "a care plan should have been completed for vision due to the resident was identified with impaired vision. As a result of impaired vision, the resident was at risk for falls and physically limited with activities of daily living."

In an interview on 11/7/13 at 12:10 pm, the director of nursing accompanied by the administrator indicated that she expected there to be a care plan for vision because the resident was identified with impaired vision according to the MDS assessment and was prescribed eye glasses by the eye doctor per review of the

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F 279	Continued From page 8 clinical record. In an interview on 11/7/13 at 1:41 pm, the optometrist indicated that she had not seen Resident #31 since the last evaluation on 7/27/10. She stated "at the time of Resident #31's last eye exam, my assessment findings revealed diagnoses of cataract and presbyopia. At the time of the eye exam the resident was not a candidate for cataract surgery." She added "in the years to come since the last evaluation, the resident would become a candidate for cataract survey and it was my expectation to have seen the resident annually to monitor the progression of the cataract in both eyes." The optometrist concluded eye glasses were prescribed during the last visit.	F 279		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to arrange or coordinate follow up vision services for a resident with impaired vision. The facility also failed to ensure a resident prescribed eye glasses were available for use as ordered by the physician for 1	F 313	Corrective action for resient #31 was accomplished by obtaining a follow up visit with opthalmologist on November 12, 2013. Consult from opthalmologist stated resident with 20/25 vision with no need for prescription eye glasses.	11/22/13

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F 313	Continued From page 9 of 3 residents reviewed for vision (Resident #31). The findings included: Resident #31 was admitted into the facility on 3/29/10. Diagnoses included cataract, nuclear sclerosis (both eyes) and presbyopia (both eyes). Nuclear sclerosis refers to a gradual cloudiness, hardening and yellowing in the center of the eye lens. Presbyopia is a condition, wherein, the crystalline lens of one's eye loses its flexibility; therefore, making it difficult for one to focus on close objects. The quarterly minimum data set completed on 8/14/13 indicated that Resident #31 cognitive status was moderately impaired. Vision was indicated as "impaired sees large print, but not regular print in newspapers/books." The most recent care plan dated 9/12/13 did not indicate visual function as an identified problem. During an observation on 11/5/13 at 10:40 am Resident #31 was observed in his room in the bed with no eye glasses on. During an observation on 11/6/13 at 3:47 pm Resident #31 was observed outside smoking accompanied by the facility staff with no eyes glasses on. In an interview on 11/7/13 at 9:45 am accompanied by Nurse #2 Resident #31 indicated that he enjoyed playing bingo and that he had difficulty seeing the writing on the bingo card and this affected his ability to successfully perform at the game, due to it was difficult for him to see the letter/numbers on the card. He added that because he could not see the numbering clearly on the card, it affected his ability to win, due to he was seeing the numbers incorrectly.	F 313	A chart audit of all residents for need of vision exams was accomomplished by central supply clerk on 11/14/13. Administrative nurses will be in-serviced by Staff Development Coordinator by 11/22/13 regarding the need to ensure that all residents will have a ophthalmological follow up exam as indicated. Director of Nursing/Designee will obtain order for residents needing vision exam with transportation aid setting up follow up visits. Medical records to complete quarterly audits for residents need for vision exam. Audit will be reviewed by DON. All Ophthalmology consults will be given to DON/designee to ensure follow up appointments are made and prescription glasses are available for use as ordered by the physician. DON/Designee to do random checks of residents to ensure prescribed eye glasses are available for use as ordered by the physician daily x 2 weeks then weekly x 4 weeks then monthly x 2 months. DON/Designee will report to the QA Committee findings of these audits monthly x 3 months with revisions made as deemed necessary by QA Committee.	

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In an interview on 11/7/13 at 9:50 am Nurse #2 when questioned regarding Resident #31 reliability stated the resident was reliable and capable of conveying his needs to the staff; he just spoke softly and had trouble getting his words out due to a history of a stroke. Nurse #2 concluded she had been Resident #31's nurse for one year and had not observed the resident with eye glasses on throughout the day.

In an interview on 11/7/13 at 10:15 am, the activity director revealed she was not aware that Resident #31 had visual deficits; she thought the resident vision was fine.

In an interview on 11/7/13 at 10:18 am, the activity assistant stated that on 11/5/13 during "bingo activity" she placed a bingo card before Resident #31 and he did not participate during the entire game. She added that she was not sure why he did not participate, and assumed it was mood related.

In an interview on 11/7/13 at 12:10 pm, the director of nursing (DON), accompanied by the administrator revealed per her review of the clinical record she stated she did not see where Resident #31 refused the offer of follow up vision services. The DON indicated considering the resident diagnosis of cataract, she expected the resident to have been evaluated by the eye doctor since 2010. The DON concluded that the resident had not been evaluated by the eye doctor in the last two years.

In an interview on 11/7/13 at 1:41 pm, the optometrist indicated that she had not seen Resident #31 since the last evaluation on 7/27/10. She stated "at the time of Resident #31's last eye

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exam, my assessment findings revealed diagnoses of cataract and presbyopia. At the time of the eye exam the resident was not a candidate for cataract surgery." She added "in the years to come since the last evaluation, the resident would become a candidate for cataract survey and it was my expectation to have seen the resident annually to monitor the progression of the cataract in both eyes." The optometrist indicated that the process for her evaluating residents is that the facility provided a list of residents when onsite that needed to been seen and the residents were evaluated accordingly. She added that she did not choose which residents were to be seen, but the facility provided a list of residents during the onsite visits. The optometrist concluded that Resident #31's vision should have been revaluated by her one year after the last eye exam.

In an interview on 11/7/13 at 2:33 pm, the administrator when questioned regarding the location of Resident #31 prescribed eye glasses, stated she was not sure were the glasses were. She concluded that she would have the staff to check the resident's room to see if the eye glasses could be located.