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 03/19/2015

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to assure two (Residents #1 and # 5) of seven sampled residents received care in a manner which maintained their personal dignity. The facility failed to assure Resident # 5 was provided assistance to prevent her from lying in a bed saturated with urine to the extent that there was a foul odor and the resident needed to be transferred out of the bed for the mattress to dry. The facility failed to assure Resident # 1 received personal care to prevent body odor. The facility also failed to assure Resident # 1 resided in a room where he could voice his pain and care needs without being called derogatory names by his roommate. The findings included: 1. Record review revealed Resident # 5 was admitted to the facility on 10/8/08 with a readmission date of 9/30/11. The resident was documented as having multiple diagnoses which included but were not limited to the following: Alzheimer ' s Disease, Contractures, Dysphagia with Gastrostomy Placement. The resident ' s Minimum Data Set (MDS) assessment, dated 2/2/15, revealed the resident was coded as having severely impaired cognitive abilities. Nurse Aide (NA) # 1 was interviewed on 3/18/15 at 2:05 PM as she prepared to enter and provide	F 241	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F241 1.Corrective action accomplished for those residents found to have been affected by the alleged deficient practice: Incontinent care and bed bath were provided to Resident #5 by CNA on 3/18/15. Bed bath was provided to Resident #1 by CNA on 3/18/15. Room change was provided to Resident #4 on 3/18/15. 2.How corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the same alleged deficient practice. Check of all current residents was completed by administrative nurses on 3/20/15 to identify residents in need of	4/15/15

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

Electronically Signed | 04/06/2015

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 03/19/2015

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 241	Continued From page 1 personal care for Resident # 5. The NA stated that her last opportunity to provide incontinent care prior to 2:05 PM for Resident # 5 was at 9:30 or 10:00 AM. The resident was observed on 3/18/15 at 2:05 PM as the NA provided care. The following was noted during this observation. The resident ' s adult brief was saturated. The draw sheet and the flat sheet were also wet and stained yellow. As the NA began to remove the soiled linens to provide care, it was also observed that the mattress was wet. There was a strong odor. An administrative nursing staff member also observed the above and instructed the NA to transfer the resident into a chair so that the mattress could dry. Review of the resident ' s care plan, which was last reviewed on 2/11/15, revealed the facility ' s goal for this resident would be that she was clean, dry, and odor free. 2. Record review revealed Resident # 1 had an admission date of 10/31/13 and a readmission date of 9/18/14. Record review revealed the resident had multiple diagnoses which included but were not limited to the following: Spinal Stenosis, Arthritis, mild intellect disability, General Muscle Weakness, and Chronic leg swelling. The resident ' s last Minimum Data Set (MDS), dated 12/16/14, coded the resident as requiring total assistance from the staff with his bathing. This same MDS coded the resident as needing extensive assistance with his hygiene. The resident was initially observed on 3/18/15 at 9:05 AM lying in bed and appeared unkempt. The resident had a heavy beard growth, dirty fingernails and a body odor. The resident was alert and able to clearly voice concerns to the surveyor, and during this initial observation he complained of pain when the nurse aides repositioned him and also of inadequate hygiene assistance. On 3/18/15 at 12:10 PM the resident	F 241	incontinent or bathing care or experiencing pain during care. Any resident identified in need of incontinent care or bathing needs were attended to by resident□s certified nursing assistant. Any resident noted to be experiencing pain during care was addressed by resident□s nurse for administration of pain medication prior to care provided. All residents were reviewed by the interdisciplinary management team for verbal altercations with roommates. The nurse practitioner from NCEPS was consulted by the Administrator regarding any residents with complaints about verbal altercations with their roommate. There were no other residents who had verbal altercations with their current roommate identified. 3.Measures put into place to ensure that the alleged deficient practice will not occur: All nursing staff will be in-serviced by Director of Nursing/administrative nurses on promoting care for residents in a manner and in an environment that maintains resident□s dignity and respect to include grooming of residents, incontinent care and resident respect related to verbal altercations between residents by 4/14/15. In addition all certified nursing assistants will be in-serviced to notify licensed nurse of any resident experiencing pain while receiving ADL care at which time licensed nurse will evaluate and provide pain management per physician order. Any employee not receiving in-service by above date will not be allowed to work until they have	

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 03/19/2015

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 241	Continued From page 2 was observed as two NAs provided personal care for him. The resident was observed to cry " oh-oh-oh " as the NAs repositioned and provided care for him. NA # 2 stated the resident always had pain when he was repositioned and received care. As care continued it was observed that at any movement of his body or change in the elevation of the head of his bed the resident grunted and moaned. It was also observed that his body odor, which had been noted 3 hours and five minutes prior, was still present although the resident ' s disposable brief was dry. NA # 2 validated that the brief was dry and the body odor was not attributed to a recent incontinent episode. These observations in combination with the record review revealing the diagnosis of spinal stenosis provided credibility to the resident ' s concerns of pain and unmet care needs. The resident ' s Medication Administration Record (MAR) was reviewed on 3/19/15. This revealed the resident ' s last dose of pain medication prior to his 12:10 PM care the previous day had been at 9 AM. The resident did not receive pain medication again following the 12:10 PM care until 8 PM. In the following observation it was found that Resident # 1 was not able to voice his pain and care concern without initiating derogatory comments from his roommate (Resident # 4). On 3/19/15 at 9:10 AM, Resident # 1 was again observed lying in the bed and had a food stained sheet lying over him. The resident was asked how he was, and again expressed that he still continued to hurt when the staff members turned him and that he never received any help with brushing his teeth the previous day. As noted in the above observations the resident had been observed to have pain and had a body odor. As he expressed his concerns, the Resident ' s	F 241	received in-service. Ambassador Rounds will be conducted daily by assigned employees. Any identified resident in need of grooming or incontinent care will be addressed with resident□s certified nursing assistant. All Ambassador Rounds report sheets will be reviewed daily (Monday □Friday) by the Administrator. Any discrepancies noted at that time will be reviewed with employee with appropriate intervention as deemed necessary by the Administrator/Director of Nursing. Verbal altercations will be reported to the Social Worker, Administrator, Director of Nursing and/or administrative nurse for immediate intervention. In-servicing of all employees regarding verbal altercations will be completed by DON/Administrator/Department Managers by 4/14/18.The Social Worker will discuss roommate compatibility at least quarterly with each resident who has a roommate according to MDS schedule and as situation arises. The nurse practitioner from NCEPS will advise the Social Worker, Administrator and/or Director of Nursing of any verbal altercations reported to her during her interactions with residents with facility visits prior to leaving the facility. Director of Nursing/Assistant Director of Nursing/RN will audit 24 hour report daily Monday through Friday for any further identified altercations. Director of Nursing/Social Worker/Administrator will address situation with appropriate intervention. Social Worker/Administrator will conduct follow up visits daily Monday through Friday x1 week, 3x a week	

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 03/19/2015

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 241	Continued From page 3 roommate (Resident # 4) commented from behind a drawn curtain which separated the two roommates that the resident was a " cry baby. " This prompted Resident # 1 to loudly deny to Resident # 4 that he was not a cry baby, which in turn prompted Resident # 4 to start yelling that he was a " cry baby " and a " son of a _____ " Resident # 4 also shouted if Resident # 1 would just come over there he was going to " whoop his _____. " Record review revealed a mental health professional ' s recommendation had been made for a room change for either Resident # 1 or his roommate (Resident # 4) on 2/25/15 and no action had been taken.	F 241	x1week, then weekly x2 weeks to ensure no further altercations. Any further issues identified during this time will be discussed with Administrator/Director of Nursing and resident□s attending physician for further orders. 4.How the facility plans to evaluate the effectiveness of the corrective action: The Administrator will submit summary of Ambassador Rounds to monthly Quality Assurance and Performance Improvement meeting. Social Worker/Administrator will submit audit information related to verbal altercations between residents monthly x6 months at which time revisions to this plan will be determined by the QA Committee.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to accommodate one out (Resident #1) of one sampled residents identified to have individualized bathing and hygiene needs. The findings included: Record review revealed Resident # 1 had an	F 246	F246 1.Corrective action accomplished for those residents found to have been affected by the alleged deficient practice: Care was provided to Resident #1 by providing resident with a bed bath, shave and nail care by resident□s certified	4/16/15

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 03/19/2015

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 246	Continued From page 4 admission date of 10/31/13 and a readmission date of 9/18/14. Record review revealed the resident had multiple diagnoses which included but were not limited to the following: Spinal Stenosis, Arthritis, mild intellect disability, General Muscle Weakness, Generalized Abdominal Pain, History of Back Surgery, and Chronic leg swelling. The resident ' s last MDS, dated 12/16/14, coded the resident as needing total assistance from the staff for his bathing needs. This same MDS coded the resident as needing extensive assistance with his personal hygiene needs. The resident was also coded as being always incontinent of bowel and bladder The resident was initially observed on 3/18/15 at 9:05 AM lying in bed. The resident appeared to be both very large and unkempt. The resident had a body odor which could be detected by just standing at the bedside. He had a heavy beard growth and his fingernails were noted to have brown matter under them. The resident was observed to be in the same condition on 3/18/15 at 10:30 AM and 11:50 AM. On 3/18/15 at 12:10 PM NA # 2 was observed with another NA as they prepared to check Resident # 1 for incontinent needs and provide perineal care. At this time the resident ' s body odor could still be detected by standing at the bedside. As noted above the resident was observed to be a very large individual and he was lying in what appeared to be a standard size single bed. Due to his large body build the resident was observed to also have large skin folds needing care. His body was observed to take up most of the area on the mattress due to his large body. Therefore as the NAs turned the resident to provide care to the posterior side of his body there was limited room available on either side of the mattress to	F 246	nursing assistant. A bariatric bed was delivered on March 31, 2015 for resident□s comfort and positioning. Order received from physician by resident□s nurse to change pain medication administration to coincide with resident bathing times. Bariatric shower chair is being used for showers. 2.How corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the same alleged deficient practice. Check of all current residents was completed by DON/administrative nurses/unit coordinator on 3/20/15 to identify residents in need of incontinent or bathing care or experiencing pain during care. Any resident identified in need of incontinent care or bathing needs were attended to by resident□s certified nursing assistant. Any resident noted to be experiencing pain during care was addressed by resident□s nurse for administration of pain medication prior to care provided. DON will meet by 4/16/15 with the certified nursing assistants to identify other residents in need of special accommodations for showers.CNAs in-serviced to report to the DON/administrative nurse/licensed nurse any resident needing special accommodations for showers. Licensed nurse to communicate the need for special accommodations on the 24 hour report. DON to ensure special accommodations are made.	

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 03/19/2015

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 246	Continued From page 5 turn the resident completely to his side in order to allow access to his large body frame. The resident was observed to cry out in pain as the NAs attempted to position and move his large body frame for care within the limited confines of his bed area. In order to fully get the resident over to his side for care, the resident ' s face came in very close proximity to the wall which was directly adjacent to one side of his bed. Also it was observed and validated with NA # 2 that the resident ' s disposable brief was dry and the body odor, which had been observed 3 hours and five minutes prior, was not coming from a recent incontinent episode. On 3/19/15 at 1:40 PM the NAs (NA # 3 and NA # 4) who routinely provide resident showers as part of the " shower team " were interviewed. The NAs stated that Resident # 1 usually was only able to receive one to two showers per month because he could not tolerate having a shower without pain. Review of a skin assessment sheet revealed a nurse noted on 3/18/15 that the shower team " state that the beds and chairs are so small to roll him over to clean him properly. "	F 246	3.Measures put into place to ensure that the alleged deficient practice will not occur: Ambassador Rounds will be conducted daily by assigned employees. Any identified resident in need of grooming or incontinent care will be addressed with resident□s certified nursing assistant. Any resident identified experiencing pain during care will be addressed by resident□s floor nurse or administrative nurse for evaluation with medication provided prior to care or notification of resident□s attending physician for further orders. Director of Nursing to review 24 hour report daily (Monday-Friday) to follow up with resident□s identified as experiencing pain during care for effectiveness of administered pain medication and to ensure special accommodations are made for identified residents. Ambassador Rounds sheets will be reviewed daily (Monday □Friday) by the Administrator. Any discrepancies noted at that time will be reviewed with employee with appropriate intervention as deemed necessary by the Administrator/Director of Nursing. 4.How the facility plans to evaluate the effectiveness of the corrective action: The Administrator will submit summary of Ambassador Rounds to monthly Quality Assurance and Performance Improvement meeting. Director of Nursing to submit summary of resident□s pain management during care. Revisions to this plan will be determined by the QA	

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 03/19/2015

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 246	Continued From page 6	F 246	Committee.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility failed to provide medically related social services for three Residents (#1, #4 & #7) of three sampled residents reviewed for social service needs. The facility failed to manage verbal altercations and follow up between Residents #1 and #4, failed to provide social service assistance with clinical areas for gastrostomy tube, physicians and scheduler so a plan could be made to obtain medical treatment and consent for Resident #7. Findings include: 1-Record review revealed Resident # 1 had an admission date of 10/31/13 and a readmission date of 9/18/14. Record review revealed the resident had multiple diagnoses which included but were not limited to the following: Spinal Stenosis, Arthritis, Mild Intellect Disability, General Muscle Weakness, and Chronic leg swelling. The resident ' s last MDS (Minimum Data Set) assessment provided to the surveyor was dated 12/16/14. This MDS coded the resident as requiring total assistance from the staff for his bathing. This same MDS coded the resident as needing extensive assistance with his	F 250	F250 1.Corrective action accomplished for those residents found to have been affected by the alleged deficient practice: A) Resident #4 was moved to a room on a different unit. B) The Medical Director contacted the court appointed legal guardian for Resident #7 and obtained consent for medical treatment .Resident was hospitalized on 3/19/15 for gastrostomy tube replacement. He had a permanent gastrostomy tube inserted on 3/21/15. 2.How corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the same alleged deficient practice. A) All residents were reviewed for verbal altercations with roommates by the interdisciplinary management team on 4/3/15. The nurse practitioner from NCEPS was consulted by the	4/15/15

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 03/19/2015

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 250	Continued From page 7 hygiene needs. Under section E (entitled Behavior) of this MDS assessment, the resident was not checked as displaying any verbal, physical, or other behavioral symptoms toward others. The resident was initially observed on 3/18/15 at 9:05 AM lying in bed and appeared unkempt. The resident had a heavy beard growth, dirty fingernails and a body odor. The resident was alert and able to clearly voice concerns to the surveyor, and during this initial observation he complained of hurting when the nursing assistants repositioned him and also of inadequate hygiene assistance. On 3/19/15 at 9:10 AM the resident was again observed lying in the bed and had a food stained sheet lying over him. The resident was asked how he was, and again expressed that he still continued to hurt when the staff members turned him and that he never received any help with brushing his teeth the previous day. As Resident # 1 relayed this, the Resident ' s roommate (Resident # 4) commented from behind a drawn curtain which separated the two roommates that the resident was a " cry baby. " This prompted Resident # 1 to loudly deny to Resident # 4 that he was not a cry baby, which in turn prompted Resident # 4 to start yelling that he was a " cry baby " and a " son of a b .... " Resident # 4 also shouted if Resident # 1 would just come over there he was going to " whoop his a .... " A brief observation of Resident # 4 revealed he was lying in bed and neither of the two residents appeared to be able to get out of bed independently, but continued from their side of the room with their verbal altercation. The surveyor exited as NA (nursing assistant) # 2 entered to offer intervention. The NA was briefly asked as she was entering the door if this had happened before	F 250	Administrator on 3/19/15 regarding any residents with complaints about verbal altercations with their roommate. There were no other residents who had verbal altercations with their current roommates. B) All appointments for medical treatment were reviewed by the Administrator with scheduler on 3/18/15to determine if consent for medical treatment needed to be obtained from responsible party. No other residents were affected. 3. Measures put into place to ensure that the alleged deficient practice will not occur: A) All employees will be in-serviced by Administrator/Director of Nursing/Social Worker/administrative nurse regarding verbal altercations between residents. All altercations will be reported to the Social Worker, Administrator/Director of Nursing and/or licensed nurse for immediate intervention. The Social Worker will discuss roommate compatibility at least quarterly with each resident who has a roommate according to MDS schedule and as situation arises. The nurse practitioner from NCEPS will advise the Social Worker, Administrator and/or Director of Nursing of any verbal altercations reported to her during her interactions with residents with facility visits before leaving facility. Director of Nursing/Assistant Director of Nursing/administrative nurse will audit 24 hour report daily for any further identified verbal altercations. Director of Nursing/Social Worker/Administrator will address situation with appropriate intervention. Social Worker/Administrator	

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 03/19/2015

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 250	Continued From page 8 and commented that " this is an everyday occurrence. " On 3/19/15 at 1:40 PM the NAs who routinely provide resident showers as part of the " shower team " were interviewed. They were questioned regarding verbal altercations between Resident # 1 and # 4 and stated that approximately once per month the residents would start cursing each other. The shower team NAs stated they did not want to repeat the language exchanged between the two, and stated they had let a nurse know. A direct care staff nurse was interviewed on 3/19/15 at 9:20 AM and stated the residents had resided together for about four months and for about the first initial three weeks they appeared okay before the altercations began. The nurse stated the altercations occurred intermittently. Review of Resident # 4 ' s medical record revealed he was diagnosed with Dementia among other diseases. He was most recently readmitted to the facility on 12/6/14. Review of the resident ' s care plan, last reviewed on 3/6/15, revealed the resident was identified to have multiple behavioral problems. Specifically the resident was identified to have a history of verbally aggressive behavior, refusal of care, incompliance with his diet, and a history of inappropriately touching female staff members. Review of the resident ' s social services notes revealed he had moved into the room he shared with Resident # 1 on 1/5/15. The (SW) social worker had noted on this date that she had spoken to Resident # 4 on the date he was to be transferred to his new room. The SW did not note any assessment regarding the compatibility of Resident # 4 with his new roommate although there was documentation in previous history that Resident # 4 had been calling another resident a demeaning name. The SW did note that she had	F 250	will conduct follow up visits daily Monday through Friday x1 week, 3x/week x1 week, then weekly x2 weeks to ensure no further altercations. Any further issues identified during this time will be discussed with Administrator/Director of Nursing and resident□s attending physician for further orders. Any staff not in-serviced by 4/14/15 will not be allowed to work until employee has received in-service. B) The scheduler will contact the responsible party if a medical consent is needed for a medical appointment. If the scheduler is unable to reach the responsible party on the first call, they are to notify the Social Worker, Administrator and/or Director of Nursing at which time the Social Worker, Administrator and/or Director of Nursing will continue attempts to reach the responsible party. If Social Worker, Administrator and/or Director of Nursing continue to be unable to reach the responsible party they will receive further instructions from the resident□s attending physician. Social Worker/Administrator or Director of Nursing to log responsible party notification, consent obtained and further instructions received from Administrator and physician notification. Social Worker/Administrator to review log daily Monday through Friday with Administrator x4 weeks then 3x/week x4 weeks, and then monthly x4 months. Any discrepancies noted will be addressed with appropriate action as deemed necessary by the Administrator. Scheduler, Social Worker and Director of	

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 03/19/2015

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 250	Continued From page 9 spoken to the new roommate and would " continue to provide support as needed. " As of the record review on 3/19/15 there were no further social worker notes on Resident # 4 ' s record following her entry of 1/5/15. The first and only nursing notation in Resident # 4 ' s departmental notes regarding verbal altercations between Resident #4 and his roommate since they began residing together was dated shortly after they became roommates and was dated 1/24/15. The nurse noted on that date that Resident # 4 was calling staff members " hoes, motherf ....s " and telling them to " suck his d ..... " The nurse also noted Resident # 4 was cursing his roommate and telling him to " shut the h .... up and suck his d ... ... " Record review revealed Resident # 4 had been seen by a mental health NP (nurse practitioner) on the dates of 1/30/15, 2/6/15; 2/20/15; and 2/25/15 and the NP had made changes in Resident # 4 ' s psychoactive medications to deal with his behaviors. She had made multiple notations during her visits regarding the verbal altercations between Resident # 4 and # 1. Specifically on 1/30/15 the NP documented, " Since recently changing rooms, he has had some verbal altercations with his roommate. " On 2/6/2015 the NP noted Resident # 4 had been " ..verbally abusive to bed staff and his roommate.. " and that he denied any conflict with his roommate although the staff continued to report verbal aggression between both residents. On 2/20/15 the NP documented, " Recently, he and his roommate have been increasingly verbally aggressive towards one another. " On 2/25/15 the NP noted that Resident # 4 and his roommate had been having persistent verbally aggressive conversations and arguments and that " this has been going on for several weeks. " The NP noted	F 250	Nursing will be in-serviced by the Administrator by 4/3/15 regarding process of obtaining responsible party consent as needed for resident medical treatment. Any staff not in-serviced on above processes by 4/14/15 will not be allowed to work until employee has attended in-service. 4.How the facility plans to evaluate the effectiveness of the corrective action: Social Worker/Administrator to report information from audits to the QA Committee x 6 months at which time further audits to be obtained as deemed necessary by the QA Committee.	

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 03/19/2015

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 250	Continued From page 10	F 250		

examples of the name calling to be " d ... sucker, " " f ...head " and " cry baby. " On her visit of 2/25/15 the NP noted she " had recommended a potential room change to staff. " There was no further documentation regarding follow up to this recommendation of a room change. There were no further NP notes after the date of 2/25/15.
Resident # 1 ' s record was also reviewed again to determine if staff had documented any assessment or interventions on his record of efforts to resolve the verbal altercations. Review of Resident # 1 ' s record revealed three social service entries since 11/25/14. The last one was dated 3/17/15. None of the three addressed the verbal altercations between Resident # 1 and # 4.
Review of the resident ' s departmental notes revealed only one notation regarding the verbal altercations which was dated 2/22/15 at 1:53 PM. The nurse noted, " Rsdt (Resident) noted cursing and calling roommate a cry baby all throughout morning. "
Resident # 4 ' s care plan, last reviewed on 3/6/15, revealed social services was to evaluate and visit with Resident # 4 PRN (as needed). As noted above the SW had not documented she had identified nor addressed the residents ' verbal altercations.
Interview with an administrative nursing staff member and the administrator on 3/19/15 at 4:55 PM revealed they had not been made aware of the verbal altercations between Resident # 4 and #1 nor of the recommendations for a room change. The records were reviewed with the administrative nursing staff member at this time and no further documentation was found within the departmental notes or social worker notes regarding assessment and intervention of the reoccurring altercations. Interview with the administrator at this time revealed the facility had

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 03/19/2015

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 250	Continued From page 11	F 250		

one social worker. The administrator stated the social worker had been out of work for personal reasons from 1/13/15 through 2/19/15. In the current month of March the SW was absent again on six days (3/3; 3/5; 3/6; 3/9; 3/18 and 3/19/15) due to personal need. The administrator stated they were attempting to find someone to fill her role and in the interim her job responsibilities were being done by various staff members.
2) Record review revealed Resident # 7 was admitted to the facility on 9/14/07 with a readmission date of 7/31/13. The resident had multiple diagnoses which included but were not limited to the following: Profound intellect Disability, History of Hepatic Encephalopathy, Dysphagia, and Gastrostomy Tube Placement.
The resident was observed on 3/19/15 at 6:45 AM as Nurse Aide #6 prepared to give care. The resident ' s bed sheet was noted to be wet with a clear like fluid. The NA stated that the bedsheet was wet because the resident pulled and gnawed on his G-tube (gastrostomy tube) and fluid would leak out of it. The resident was observed to have redness around the insertion site of the gastrostomy tube and be lying in a semi fetal position.
Review of the record revealed Resident # 7 ' s current leaking G-tube was a temporary foley catheter which is a flexible catheter commonly used as a urinary catheter. According to the record the resident had pulled out his G-tube on 3/1/15 at 3:38 AM and was sent to the ER (emergency room) per physician ' s order to have it replaced. Also according to the record, the hospital called a report to a facility staff nurse on 3/1/15 at 6:12 AM and informed the nurse that the resident needed to be seen as soon as possible by a physician because the foley catheter was only a temporary replacement.

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 03/19/2015

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 250	Continued From page 12	F 250		

According to the record and following interviews to be noted below the resident had three appointments to have his G-tube replaced, but as of the date of 3/19/15 he still retained the temporary foley G-tube. Also the following interviews and record review revealed incomplete documentation of efforts made from 3/1/15 through 3/19/15 to coordinate this care with the surgical physician and the resident ' s responsible party and resolve any problems that might be hindering the resident from obtaining this medical procedure. Specific details are as follows: A nurse noted in the departmental notes on 3/2/15 at 4:18 PM that an order had been received to send the resident out to a particular physician for the G-tube replacement. This same nurse noted within this entry that she had " contacted the RP (responsible party) and left call back information to give RP update on resident.. " Following this entry of 3/2/15, there were only five more entries in the resident ' s departmental notes through the date of 3/19/15; the date on which the resident was observed by the surveyor to still have the temporary tube. The first of these five was dated 3/4/15 and entered by the social worker at 2:36 PM. The SW documented, " SW called Dr. ... ...office to find out more information regarding resident ' s previous apt. Office manager stated that RP refused to give consent via telephone at last apt (appointment). Dr ... .requires legal guardian to be present with resident at all appts. SW informed hall nurse. SW will continue to provide support as needed. " The next note was entered on 3/13/15 at 4:50 PM by an administrative nursing staff member. The administrative nursing staff member noted at this time that the resident remained with a temporary tube because there " was no consent to treat. " This staff member also noted the resident had

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 03/19/2015

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 250	Continued From page 13	F 250		

another appointment for March 19th but the RP had informed the administrative staff nurse that she herself had an appointment on that date. The administrative staff member noted she requested the RP make an appointment and then notify the facility of the date. This administrative nurse further noted that the RP agreed and the administrative nurse requested that the facility scheduler call the RP back and provide her with the Dr ' s office number so she could make the appointment. Following this entry of 3/13/15 there was no further documentation of efforts to coordinate the G-tube replacement with the surgical physician and the RP. Two of the remaining entries were documented on 3/15/15 and had notations that the resident was sent to the ER again at 12:37 PM for a non- functioning G-tube (the tube would not flush). The resident was noted as returning at 6:51 PM on 3/15/15 with the same temporary tube. Upon his return the nurse also noted that the resident ' s physician was notified and the physician stated he would take care of it the next day. There was no further documentation in the record of efforts made to coordinate the procedure. The 5th entry in the departmental notes was entered by a pharmacist and was not related to this issue. The last physician ' s progress note was documented on 1/21/15 before the issue began.

On 3/19/15 at 8:40 AM the administrator and the NA transporter were interviewed. The administrator stated the SW had turned the coordination of the G-tube replacement to the nursing staff. The NA transporter stated the resident had an appointment on March 4th at 1 PM at a surgical center to have the tube replaced and the resident was actually transported to the surgical center, but the surgeon would not do the procedure without the RP being present and thus

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 03/19/2015

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 250	Continued From page 14	F 250		

the resident was returned to the facility with a new appointment of March 12th, 2015. The transporter stated that this appointment was also canceled because the RP wasn ' t available and neither was a transport service. The NA transporter stated that a third appointment was made again for March 19th but that when the surgical center called on March 18th to confirm the appointment, it also had to be canceled because the RP was not going to be available.
Interview with an administrative nursing staff member on 3/19/15 at 9:40 AM revealed she had not been made aware there was a problem until the resident missed his second scheduled appointment on the 12th. This administrative nurse stated she was then informed that the resident had missed his initial appointment also. She stated she called and talked to the RP and that the RP had also had surgery and there were days she also had appointments; thus this administrative nurse stated she left it to the RP to make an appointment which was convenient for her and then call the facility staff back with the date. The resident ' s record was reviewed with the administrative nurse and she verified that she had last spoken to the RP on March 13th.
The resident ' s physician approached the surveyor at 10:25 AM at 3/19/15 and stated he was aware the resident needed the replacement but there was a problem with communicating with and obtaining consent from the RP. The physician decided to attempt to call the RP at that time and it was observed that he was able to communicate with her and obtain verbal consent for the procedure which he stated would work for the needed procedure. The physician documented a note and delivered to the surveyor on 3/19/15 in which he noted that he would send the resident to the hospital that day and that he

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 03/19/2015

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 250	Continued From page 15	F 250		

had attempted to rectify the situation " but could not due to RP problems. "
A staff nurse was interviewed on 3/19/15 at 8:50 AM. She stated that she had attempted to call the RP regarding the need to get the consent signed three times. She stated that the RP worked at what she thought was some type of factory and when she called the work number the RP would never pick up the phone. The nurse was asked if she had tried other numbers and stated she had tried her cell phone but there was no voice mail set up to receive messages.
Review of the Resident ' s medical record face sheet revealed there were three numbers listed for the RP. One was noted to be a daytime number. Another was noted to be an evening number and the third was noted to be a cell phone number. The surveyor called the RP ' s cell phone on 3/19/15 at 4:10 PM. Initially the call started to go to the RP ' s cell phone voice mail, but before a message could be left it was noted that the RP was trying to call back on the phone used by the surveyor. The RP in turn stated she had experienced trouble in getting in touch with the correct staff member with whom she was supposed to discuss Resident # 7 ' s care. She stated that she did work during the day and she could not always leave her job to answer the facility ' s call to her but they would leave a message. She stated she would try to call back and she commented, " It ' s hard to get in touch with people there. " She said there is one number for the facility and once you call and tell them you need to speak to a certain person that she has had to hold for extended periods of time and finally had to get back to her job. She stated she wished there was a direct number to the social worker. The RP stated she had some surgery on March 11th and was permitted to drive

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 03/19/2015

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 250	Continued From page 16 again on the 16th. She stated she had visited Resident # 7 on the week-end prior to the 11th and recalls speaking to a nurse while there because she needed to pick up some papers. The RP stated the facility had asked her to schedule an appointment that worked for her and that the last conversation she had with anyone regarding the situation was when they gave her an office number to make the appointment for Resident # 7 ' s G-tube replacement. She further stated she had tried the number the facility staff gave her and that she got an unusual sound like it was a fax machine. She stated she had tried to call the number several times. The RP was asked if the physician had tried to call her also and she stated that he had called one work day while she was at lunch with a message that he would like to try to talk to her and if she could call back in the next 7 to 10 minutes he would be available. The RP stated that by the time she received the message that it was too late, and as noted earlier when she tried to call other staff members she would have to wait for prolonged time periods. The RP stated that in previous times she had been able to give verbal consent over the phone for procedures but that this had not been the case for the surgical center. On 3/19/15 at 5:50 PM the administrative nurse and the NA transporter were given the number which the RP had reported as given to her by facility staff. These two staff members verified that the number the RP reported as having was actually the fax number for the surgical center and was not the appointment number.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		4/15/15

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 03/19/2015

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 309	Continued From page 17 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and resident interviews the facility failed to evaluate the current pain management for one (Resident #1) of seven sampled resident ' s and revise interventions to better manage Resident #1 ' s pain. The findings included: Record review revealed Resident # 1 had an admission date of 10/31/13 and a readmission date of 9/18/14. Record review revealed the resident had multiple diagnoses which included but were not limited to the following: Spinal Stenosis, Arthritis, with mild intellect disability, General Muscle Weakness, Generalized Abdominal Pain, History of Back Surgery, Chronic leg swelling, and Morbid Obesity. The resident ' s last Minimum Data Set, dated 12/16/14, coded the resident as needing total assistance from the staff for bathing. This same Minimum Data Set coded the resident as needing extensive assistance with hygiene. The resident was initially observed on 3/18/15 at 9:05 AM lying in bed. The resident was alert and voiced concerns of hurting when the nurse aides repositioned him. On 3/18/15 at 12:10 PM the resident was observed as two nurse aides (NAs) provided personal care for him. As the head of the bed was lowered so that the resident could be positioned for care, the resident cried aloud in pain, " oh-oh-oh. " It was observed that the	F 309	F309 1.Corrective action accomplished for those residents found to have been affected by the alleged deficient practice: A bariatric bed was delivered on March 31, 2015 for resident□s comfort and positioning. Order received from physician by resident□s nurse to change pain medication administration to coincide with resident bathing times. 2.How corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. A pain review will be completed by licensed nurse for all residents by 4/14/15. Licensed Nurse will notify resident□s attending physician for new or changes needed in resident□s pain management. 3.Measures put into place to ensure that the alleged deficient practice will not occur: Pain screening, evaluation and care will be conducted upon admission, quarterly, annually and with significant change in condition and upon newly identified onset of pain during ADL care. Licensed nurse	

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 03/19/2015

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 309	Continued From page 18 resident ' s body torso was so large that there was very little mattress room on either side of the resident. Thus for the resident to be turned adequately to a side lying position so he could receive care to all portions of his posterior body, the resident needed to be moved to the far part of one mattress side. As noted above the resident was documented as obese in additional to having spinal stenosis. With all repositioning the resident cried out loudly " Oh, oh " or grunted with pain. At times when the resident was allowed to be still he was observed to become quieter, but at any further movement of his body or change in the elevation of the head of his bed the resident again began grunting and moaning. Following the observation of care, one of the NAs (NA# 2) was interviewed and stated she cared for this resident two to three times a week and every time he was repositioned he complained of pain. The resident was observed the following day of 3/19/15 at 11 AM as the resident ' s NA prepared to position the resident for care along with another fellow NA. An administrative nursing staff member was present at this time. The resident was observed to cry out in pain with movement again. The resident ' s NA was the same NA who was observed the previous day caring for Resident # 1 when he was observed to be in pain. The NA (NA #2) was asked if she had reported to the nurse that the resident was in pain the previous day with his care and she replied that she had been so busy the previous day that she didn ' t know if she had or not. The resident ' s nurse was interviewed on 3/19/15 at 11:30 AM and stated she could not recall if the NA had reported the resident ' s pain with movement, but that she had the concern that he might sleep more in between assistance if his pain medication was increased.	F 309	will evaluate and implement pain management per physician order. Licensed nurse will re-evaluate the resident for the effectiveness of pain management and follow up with resident□s attending physician as needed. Director of Nursing/Assistant Director of Nursing to audit 3 resident pain reviews daily x4 weeks and then 3 times a week for 4 weeks and then weekly x4 weeks for compliance. Director of Nursing/Assistant Director of Nursing to audit 24 hour report daily (Monday-Friday) to identify residents experiencing pain during care, pain management strategies implemented with effectiveness of pain. Ambassador rounds will be completed daily by assigned staff to identify residents experiencing pain during care with licensed nurse follow up for pain management as necessary. 4.How the facility plans to evaluate the effectiveness of the corrective action: The Assistant Director of Nursing/Director of Nursing will submit summary from pain assessments to include pain management during care to monthly Quality Assurance and Performance Improvement meeting x3 months. Revisions to this plan will be determined by QA Committee.	

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 03/19/2015

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 309	Continued From page 19 On 3/19/15 the NAs who routinely provide resident showers as part of the " shower team " were interviewed. The NAs stated that Resident # 1 usually was only able to receive one to two showers per month because he could not tolerate having a shower without pain. They stated they provided a bed bath on his other shower days instead, but that he also had pain with repositioning and movement with all of his bed baths. Review of the nursing notes from 2/19/15 through the date of 3/18/15 revealed no documented assessment of the resident ' s increased pain with movement nor any attempts to better manage his pain he experienced with repositioning and care. Furthermore the resident was documented as having no pain on multiple days although the above interviews revealed he experienced pain with all repositioning. Specifically review of the resident ' s medication administration record (MAR) on 3/19/15 revealed an area where the nurses were to document a pain assessment every shift and make a notation of a pain score for both the 7A to 7PM shifts. The number " 0 " was entered for both shifts from 3/1/15 through 3/18/15 and again for the 7A-7PM shift on 3/19/15. Further review of the resident ' s MAR revealed the resident was scheduled to receive 650 milligrams of Tylenol twice daily at 8 AM and 8PM. He was also scheduled to receive Ultram 50 mg twice daily at 9 AM and 9 PM. The resident did have PRN (as needed) pain medication orders on the MAR for both Ultram and Tylenol but he was only documented as receiving his regularly scheduled Ultram and Tylenol and no PRN doses from 3/1/15 to 3/19/15. Thus, eleven hours would elapse between scheduled pain medications according to the March 2015 MAR.	F 309		

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 03/19/2015

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 309	Continued From page 20 Review of the resident ' s care plan, last reviewed on 12/14/15, revealed the staff members were to "observe for effectiveness of pain meds for control of pain " and notify the doctor as needed.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to assure two (Residents # 5 and # 6) of seven sampled residents who required assistance with activities of daily living received necessary services to maintain good personal hygiene. The facility failed to assure Resident # 5 and # 6 received incontinent care per the residents ' plan of care. The facility also failed to assure Resident # 5 received adequate assistance with oral care to prevent dry scaly lips and a dry coated tongue. The findings included: 1) Record review revealed Resident # 5 was admitted to the facility on 10/8/08 with a readmission date of 9/30/11. The resident was documented as having multiple diagnoses which included but were not limited to the following: Alzheimer ' s Disease, Contractures, Dysphagia with Gastrostomy Placement. The resident ' s last MDS (Minimum Data Set) assessment, dated 2/2/15, revealed the facility had assessed the resident to be severely cognitively impaired. The	F 312	F312 1.Corrective action accomplished for Resident #5 for this alleged deficient practice was accomplished on 3/18/15. Certified Nursing Assistant provided incontinent care, bed bath, and oral care for Resident #5. Resident #5 mattress was removed from bed, cleaned and sanitized by housekeeping. Corrective action accomplished for Resident #6 for this alleged deficient practice was accomplished on 3/18/15. Certified Nursing Assistant provided incontinent care for resident. 2.All residents have the potential to be affected by this same alleged deficient practice. Check of all current residents was completed by administrative nurses on 3/20/15 to identify residents in need of grooming including incontinent care or bathing needs, shaving, and oral care.	4/15/15

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 03/19/2015

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 312	Continued From page 21 resident was assessed as requiring total assistance from staff members for her all of her activities of daily living. Review of the resident ' s care plan, which was last reviewed on 2/11/15, revealed the facility ' s goal for this resident would be that she was clean, dry, and odor free. An intervention was noted as " incontinent care q (every) 2-3 h (hours) and PRN (as needed). " NA (Nursing Assistant) # 1 was interviewed on 3/18/15 at 2:05 PM as she prepared to enter and provide personal care for Resident # 5. The NA stated that her last opportunity to provide incontinent care prior to 2:05 PM for Resident # 5 was at 9:30 or 10:00 AM, and she had not had the time to provide any oral care for Resident #5 during her shift. An earlier interview with NA # 1 at 1:45 PM on 3/18/15 revealed she was assigned 17 residents with whom to provide care. Resident # 5 was observed on 3/18/15 at 2:05 PM as NA # 1 provided care. The following was noted during this observation. The resident ' s mouth was open and her tongue was coated with dried white matter. Scaly dried skin was hanging from her lips. The resident ' s adult brief was saturated. The draw sheet and the flat sheet were also wet and stained yellow. As the NA began to remove the soiled linens to provide care, it was also observed that the mattress was wet. There was a strong odor. An administrative nursing staff member also observed the above and instructed the NA to transfer the resident into a chair so that the mattress could dry. An administrative staff member was interviewed on 3/19/15 at 2:30 PM regarding the facility ' s incontinent protocol, and this staff member stated it was her expectation that incontinent residents be checked every two hours and as needed. 2) Record review revealed Resident # 6 was	F 312	Any resident identified in need of incontinent care, bathing needs, shaving, or oral care were attended to by resident□s certified nursing assistant upon observation. 3.Measures put into place to prevent this alleged deficient practice from recurring include: All nursing staff to be in-serviced on care and services for residents unable to carry out activities of daily living to ensure resident receives necessary services to maintain good grooming and personal and oral hygiene by Director of Nursing/administrative nurse by 4/14/15. Any employee not receiving in-service by above date will not be allowed to work until they have received in-service. Ambassador Rounds will be conducted daily by assigned employees. Any identified resident in need of grooming, to include incontinent care and personal and oral hygiene, will be addressed with resident□s certified nursing assistant. Director of Nursing/Assistant Director of Nursing will randomly check 5 residents per week x 4 weeks and then 5 residents 3 x a week for 4 weeks, 5 residents weekly x 4 weeks for grooming needs. Any resident noted to be in need of grooming will be addressed by the Director of Nursing with resident□s certified nursing assistant with follow-up for validation of care. Any discrepancy found will be addressed with appropriate nursing staff by the Director of Nursing with appropriate intervention as deemed necessary. Ambassador Round sheets will be reviewed daily (Monday-Friday) by	

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 03/19/2015

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 312	Continued From page 22 admitted on 1/6/15 with multiple diagnoses; some of which delayed the resident ' s intellectual development. The resident also had diagnoses of Dysphagia with PEG (percutaneous endoscopic gastrostomy) tube placement. The resident was coded on her last MDS assessment, dated 1/13/15, as needing total assistance with all of her activities of daily living. Review of the resident ' s care plan, dated 1/19/15, revealed the resident was incontinent. According to the resident ' s care plan the resident was to be turned and repositioned as needed and per facility protocol. The resident was also to receive incontinent care after each incontinent episode. Resident # 6 was observed on 3/18/15 at 2:25 PM as NA # 1 provided incontinent care. The resident was soiled with both urine and stool. As the NA cleaned the stool away from Resident # 6 ' s skin, it was observed that the resident ' s buttocks were reddened in the area where the stool had been against her skin. The NA was questioned regarding when she was last able to check and provide care for Resident # 6 and responded that it was around 11 AM. An earlier interview with NA # 1 at 1:45 PM on 3/18/15 revealed she was assigned 17 residents for whom to provide care. An administrative staff member was interviewed on 3/19/15 at 2:30 PM regarding the facility ' s incontinent protocol, and this staff member stated it was her expectation that incontinent residents be checked every two hours and as needed.	F 312	the Administrator. Any discrepancies noted at that time will be reviewed with employee with appropriate intervention as deemed necessary by Administrator/Director of Nursing. 4.How the facility plans to evaluate the effectiveness of the corrective action: The Assistant Director of Nursing/Director of Nursing will submit summary from resident rounds to monthly Quality Assurance and Performance Improvement meeting x 3 months. Administrator to submit summary from Ambassador Rounds to QA Committee Meeting x 3 months. Revisions to this plan will determined by QA Committee.	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --	F 322		4/15/15

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 03/19/2015

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 322	Continued From page 23 (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to assure 1 of 3 sampled residents with gastrostomy feeding tubes (Resident # 7) received necessary services to prevent complications. The facility failed to provide a care planned abdominal binder and assess its effectiveness in helping prevent the Resident from pulling on his gastrostomy tube. The finding included: Record review revealed Resident # 7 had multiple diagnoses which included but were not limited to the following: Profound intellect Disability, Dysphagia, and Gastrostomy Tube Placement. Review of the Resident ' s last Minimum Data Set (MDS) assessment, dated 1/5/15 revealed the resident was coded as having severely impaired cognitive abilities. The resident was also coded as having range of motion limitations in his lower	F 322	F322 1.Corrective action for Resident #7 was accomplished by placing abdominal binder on resident by licensed nurse on 3/19/15. 2.How corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice: All residents with gastrostomy tubes have the potential to be affected by the same alleged deficient practice. All residents fed by gastrostomy tube were observed by the Director of Nursing/Unit Coordinator on 3/19/15. No other resident was identified to be affected. 3.Measures put into place to ensure that	

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 03/19/2015

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 322	Continued From page 24 extremities. Review of the resident ' s interdisciplinary care plan revealed it was last reviewed on 1/6/15. A care plan problem was noted as " chewing and sucking on GT (gastrostomy tube). " There was a notation by this problem signifying it had been added to the resident ' s care plan on 6/6/14. Under the care plan approaches a staff member had entered on 6/11/14, " received abdomen binder. " The March 2015 monthly physician orders also noted that the resident ' s care plan had been approved by the physician. Review of the resident ' s " departmental notes " revealed the resident had been sent to the emergency room on 3/1/15 at 3:38 AM after he pulled out his gastrostomy tube. The following observations and interview revealed the resident was observed not to have the abdominal binder in place on multiple observations and that a direct care staff member had noted that it was not always effective in deterring the resident from pulling on the G-tube. The resident was observed on 3/19/15 at 6:45 AM as Nurse Aide (NA) # 6 prepared to give care. The resident ' s bed sheet was noted to be wet with a clear like fluid to the degree that the NA did a complete linen change. NA # 6 stated that the bedsheet was wet because the resident pulled and gnawed on his G-tube (gastrostomy tube) and fluid would leak out of it. The resident was observed to have redness around the insertion site of the G-tube. NA # 6 was questioned regarding interventions to help deter the resident from pulling on his tube. The NA stated the resident was supposed to have an abdominal binder but that when she came onto her shift at 11 PM the binder was soiled with " milk. " Therefore, the NA stated she sent it to be laundered and placed another one on the	F 322	the alleged deficient practice will not occur: All Licensed Nurses will be in-serviced by Director of Nursing/administrative nurse by 4/14/15 regarding residents with gastrostomy tubes to receive the appropriate treatment and services to prevent complications as well as to evaluate effectiveness of measures in place. All CNAs will be in-serviced by Director of Nursing/administrative nurse by 4/14/15 to notify licensed nurse when there is a need to change abdominal binder due to being soiled. Any Licensed Nurse or CNA not in-serviced by above date will not be allowed to work until employee has received in-service. Licensed Nurse to check residents fed by gastrostomy tube to ensure resident is not pulling or chewing on tubing and that measures ordered by attending physician for residents with gastrostomy tubes are in place and effective every shift. If measures are not in place and/or are not found to be effective in preventing potential complications, Licensed Nurse will notify Director of Nursing/ Assistant Director of Nursing/ RN/Unit Coordinator as well as notifying resident□s attending physician for further orders and document on 24 hour report. Director of Nursing/Assistant Director of Nursing/RN/ Unit Coordinator will review 24 hour report daily for reported potential complications as well as observing all residents fed by gastrostomy tube to ensure measures to prevent potential complications are in place daily x 4 weeks, 3 x a week x 4 weeks , and then	

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 03/19/2015

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 322	Continued From page 25 resident but it also had been noted by her to be soiled at 4 AM rounds. NA # 6 stated she removed the second binder and also sent it to the laundry and there were no other binders to place on him. NA # 6 stated sometimes the resident would work his hands to the tube and pull on it even with the binder in place. The resident was observed again on 3/19/15 at 5:40 PM with an administrative nurse. The resident was observed to be in bed and there was no abdominal binder on the resident. Immediately following this observation the administrative nurse went to determine why the binder was not in place, and at 6:02 PM returned to the surveyor to say that the resident ' s abdominal binder had been sent to the wrong resident ' s room by laundry staff. Further record review revealed no assessment of how consistent the binder was being applied to the resident or an evaluation of its effectiveness in deterring him from pulling and chewing on the tube.	F 322	weekly x 4 weeks. Any discrepancies noted will be followed up with employee with appropriate interventions as deemed necessary by the Director of Nursing. 4.How the facility plans to evaluate the effectiveness of the corrective action: Director of Nursing to submit information from audits to the QA Committee x 3 months at which time further audits to be obtained as deemed necessary by the QA Committee.	
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353		4/16/15

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 03/19/2015

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 353	Continued From page 26 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to assure it had sufficient nursing staff to provide nursing services to meet activities of daily living needs for two (Residents #5, and # 6) of seven sampled residents needing assistance with activities of daily living. The findings included: Cross refer to F 312 Based on observations, record review, and staff interviews the facility failed to assure two (Residents # 5 and # 6) of seven sampled residents who required assistance with activities of daily living received necessary services to maintain good personal hygiene. The facility failed to assure Resident # 5 and # 6 received incontinent care per the residents ' plan of care. The facility also failed to assure Resident # 5 received adequate assistance with oral care to prevent dry scaly lips and a dry coated tongue. NA # 5 was interviewed on 3/18/15 at 2:52 PM. This NA stated she was assigned 17 residents to care for their needs. The NA was questioned if she could provide for all of her residents ' care needs and noted that she was not able to get to the residents " like she was supposed to " in order to provide incontinent care.	F 353	F353 1.Corrective action accomplished for Resident #5 for this alleged deficient practice was accomplished on 3/18/15. Certified Nursing Assistant provided incontinent care, bed bath, and oral care for Resident #5. Resident #5 mattress was removed from bed, cleaned and sanitized by housekeeping. Corrective action accomplished for Resident #6 for this alleged deficient practice was accomplished on 3/18/15. Certified Nursing Assistant provided incontinent care for resident. A review of the residents most current MDS for ADL acuity level were reviewed by the MDS nurse and Director of Nursing. Resident #5 has an ADL score of 15 and Resident #6 has an ADL score of 10. The residents' care was adjusted to meet their needs. 2.All residents have the potential to be affected by this same alleged deficient practice. Check of all current residents was completed by Director of Nursing/administrative nurse on 3/20/15 to identify residents in need of grooming	

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 03/19/2015

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 353	Continued From page 27 NA # 2 was interviewed on 3/18/15 at 12:05 PM as she was making preparations to check on one of her residents for incontinent needs. This NA stated she had 17 residents for whom to provide care and it was her first opportunity to check on the resident since " right after breakfast. " An administrative nurse was interviewed on 3/19/15 at 2:30 PM and stated her expectation was that the incontinent residents would be provided care every two hours and as needed. The administrative nurse stated there was a shower team to help the other NAs who had specific resident assignments. The administrative nurse provided a shower schedule to the surveyor on 3/18/15 at 11:30 AM. This nurse stated the shower team was expected to do the resident showers, nail trimming, and provide shaving assistance to the residents on the schedule. The shower schedule was reviewed to determine the number of responsibilities delegated to the shower team. According to the schedule, the dayshift shower team was accountable for 20 to 22 resident showers per day depending upon the day of the week.	F 353	needs including incontinent care or bathing needs, shaving, and oral care. Any resident identified in need of incontinent care, bathing needs, shaving, or oral care were attended to by residents certified nursing assistant upon observation. A review of all current residents most recent MDS for ADL acuity level was completed by the Director of Nursing and Administrator. CNA assignments were adjusted according to resident acuity and 24 hour report and adjusted to accommodate resident□s needs. 3.Measures put into place to prevent alleged deficient practice from reoccurring include: The Director of Nursing/Administrative Nurse will monitor resident s medical acuity and ADL direct care needs daily by reviewing the resident 24 hour report starting 4/6/15. In addition, communication between CNAs and licensed nurses regarding the time needed to accommodate residents' needs will be done each shift. CNA assignments will be re-directed daily to meet the needs of the resident. If more staff is needed, CNAs from the shower team, restorative nursing, administrative nurses and/or staff called in from home will be used to meet residents' needs. DON will maintain daily staffing sheets to reflect any changes in assignments starting 4/6/15. Upon admission the licensed nurse will assess the residents medical acuity and ADL direct care needs and assign CNA as appropriate to meet the residents needs. Director of Nursing/Assistant Director of	

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 03/19/2015

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 353	Continued From page 28	F 353	Nursing/RN/Unit Coordinator to conduct daily rounds x 4 weeks and then 3 x a week for 4 weeks and then weekly x 4 weeks to ensure staff are responsive to residents needs for assistance, call bells answered promptly as well as dependent residents observed for safety, comfort, positioning, and provision of care. If discrepancies noted in sufficient staff, Director of Nursing/Assistant Director of Nursing/RN will report to Administrator for any changes in staffing as deemed necessary. 4.How the facility plans to evaluate the effectiveness of the corrective action: Director of Nursing will submit a summary of staffing to the monthly Quality Assurance and Performance Improvement meeting x3 months. Revisions to this plan will be determined by QA Committee.	