PRINTED: 08/21/2019
FORM APPROVED
OMB NO. 0938-0391

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 ______	07/18/2019

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
E 000	Initial Comments An unannounced recertification/complaint suvey was conducted on 07/15/19 through 07/18/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# KZV911.	E 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		8/15/19

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

Electronically Signed | | 08/07/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interviews and record review, the facility failed to notify the physician of a resident's change of condition which resulted in the resident not being sent for treatment for 13 hours (Resident #113). Findings included: A review of the medical record revealed Resident #113 was admitted 5/15/2019 with diagnoses including Urinary Tract Infection, sacral pressure ulcer, and obstructive uropathy. The medical record review noted Resident #113 to have a chronic indwelling urinary catheter, a colostomy and a peripherally inserted central catheter (PICC is a tube inserted into a large vein carrying blood to the heart to administer long term medications, such as antibiotics.)	F 580	F-580 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root cause: The Executive Director and Director of Nursing discussed on 8/2/19 to identify the root cause of this alleged	

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F 580	Continued From page 2 The Quarterly Minimum Data Set (MDS) dated 6/20/2019 noted Resident #113 to be moderately intact for cognition and needed extensive assistance for all care given with the assistance of two persons. On 7/15/2019 Resident #113 was observed in her room being assisted with breakfast by staff at 10:00 AM. At 11:30 AM on 7/15/2019 Resident #113 was observed sitting in bed which was raised to a 90-degree angle. Resident #113 did not respond verbally when spoken to but did move her eyes. On 7/16/2019 at 8:20 AM Resident #113 was observed to be sitting straight up with head of the bed at a 90-degree angle. Resident #113 did not respond verbally and did not blink her eyes or move. At 8:25 AM on 7/16/2019 Nurse #1 was at the medication cart in the hallway and stated Resident #113 was a new resident to her. Nurse #1 stated Resident #113 was not alert verbally but was alert to tactile stimulation. A review of the progress notes revealed on 7/16/2019 at 9:36 AM, the Speech Therapist (ST) notified the nurse of decreased alertness. The ST noted the Nurse reported will contact Medical Doctor (MD) due to worsening lethargy. On 7/17/2019 at 2:39 PM, in a telephone interview the ST stated Nurse #1 was who she informed of Resident #113's condition. The ST stated she went in to try and assist Resident #113 with breakfast and found the Resident to be unresponsive and after about ten minutes the	F 580	noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from when Nurse #1 failed to properly inform the physician of a change in condition (Residents #113). For affected residents: Resident #113 attending physician was notified during the survey on 7/16/19 about the change in resident # 113 condition. For other residents with the potential to be affected: By 8/9/19 a 100% audit of current resident□s notes, 24 hours reports and incident reports for last 30 days will be completed by the Director of Nursing (DON), Asst. Director of Nursing (ADON) and unit managers to determine if any other residents had experienced a change in condition that the Resident Representative (RR) or the Physician (MD) would needed to have been notified. Appropriate additional notifications were made by 8/9/19. Facility plan to prevent re-occurrence: Effective 8/9/2019, and moving forward, licensed nursing staff will ensure residents□ change in condition notifications will be made to the Resident Representative (RR) and the Physician (MD). Starting 8/9/2019, the Director of Nursing, Assistant Director of Nursing, and/or Unit managers will complete 100% education for all licensed nursing staff and	

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F 580	Continued From page 3 Resident indicated she did not want to try and eat anymore. The ST stated Resident #113 had been that way when she was first admitted but ST had not seen her in that condition since then. In a telephone interview on 7/17/2019 at 3:43 PM, Nurse #1 stated she had never been assigned to Resident #113 before 7/16/2019. Nurse #1 indicated after she spoke to the ST, the Nurse told the Nursing Assistant (NA) not to feed Resident #113 because of aspiration danger. Nurse #1 stated she did tell the ST she would call the physician but did not call the physician and decided to read some nurses notes to try and determine if Resident #113 had been this way previously and had become more responsive. Nurse #1 stated Resident #113 did eat some supper about 4:30 PM. On 7/17/2019 at 8:03 PM, in a telephone interview, Nurse #2 stated she worked the 7PM to 7AM shift on 7/16/2019 and was assigned to Resident #113. Nurse #2 stated she received report from Nurse #1 who stated Resident #113 was lethargic earlier in the day and had not taken her medications and had no intake. Nurse #2 indicated Resident #113 did not want to take her medications and Nurse #2 told the Resident the antibiotic was important and Resident #113 took her medications in applesauce and drank ¼ of a container of nectar thickened liquid. Nurse #2 stated the NA called her to Resident #113's room about 9:45 PM and Resident #113 was not responding to verbal cues but was asked if she wanted to go to the hospital and responded "yes." Nurse #2 stated she felt the arms and hands of Resident #113 and they were warm, but Nurse #2 could not get a blood pressure reading, did get a manual pulse and could not get an oxygen	F 580	Medication Aides, to include full time, part time and as needed employee. The education will include, notification of a change in condition will be reported to the Resident Representative (RR) and the Attending Physician. Any licensed nurse or certified medication aide not educated by 8/16/19 will not be allowed to work until educated. Effective 8/12/2019, the Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will review the previous days notes, 24-hour report and incident reports during the morning clinical meeting to ensure if a change in a residents condition was reported to RR and MD. This review will be stored in the Daily Clinical Binder. Monitoring: Effective 8/9/2019, the Director of Nursing, Assistant Director of Nursing or designee to monitor the nurse□s notes, 24 hour report and incident logs daily, five days a week for four weeks, then three days a week for four additional weeks to ensure notification of RR and the residents MD of any change in condition. The weekend Supervisor will audit all orders, 24 hours reports and incident logs to ensure all items have the appropriate follow-up for Saturday and Sunday for eight weeks. This monitoring will be documented on the Notification of change Monitoring Tool. Effective 9/20/2019, Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and	

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F 580	Continued From page 4 saturation reading. Nurse #2 noted she immediately called the physician and Emergency Medical Services (EMS). Nurse #2 stated she had never seen Resident #113 like that. On 7/17/2019 Resident #113 was noted to be discharged to the hospital 7/16/2019 at 10:20 PM. In a telephone interview on 7/18/2019 at 11:15 AM, the physician stated Resident #113 went to the Emergency Department and was diagnosed with sepsis secondary to Urinary Tract Infection and left lower lobe pneumonia. The physician stated he had spoken with the Hospitalist who did not say anything about aspiration. The physician stated he would expect to be notified earlier when Resident #113 was identified as lethargic by the ST. The NA that was assigned to Resident #113 was interviewed 7/18/2019 at 3:20 PM and stated on 7/16/2019 the Resident did not eat anything for the evening meal. On 7/18 2019 at 3:55 PM, the facility Administrator stated his expectation was the physician would be notified as soon as possible when a resident has a change of condition.	F 580	Performance Improvement Committee for any additional monitoring or modification of this plan. This reporting will occur monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: The Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance. Compliance Date: 8/15/19	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		8/15/19

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F 644	Continued From page 5 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to initiate a Level II PASARR (Preadmission Screening and Resident Review) screening for 1 of 2 residents (Resident #17) reviewed for Level II PASRR. Findings included: Resident #17 was admitted to the facility 4/16/13 and his last re-admission was 1/11/18. Review of a quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 7/9/19 revealed Resident #17 was moderately cognitively impaired and had active diagnoses which included, but were not limited to, cerebral palsy, non-Alzheimer's dementia, depression, psychotic disorder, unspecified psychosis not related to a substance or known physiologic condition, and mood (affective) disorder. He was not coded for Level II PASARR. Resident #17 had a care plan, last updated 7/9/19, which focused on a diagnosis of depressive disorder, mood disorder, psychosis, and dementia with behavioral disturbances. The	F 644	F-644 Root cause: The Executive Director and Director of Social Services discussed on 8/2/19 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from a failure to properly conduct a preadmission screening and review (Residents #17). For affected residents: A Level II PASRR for Resident #17 has been applied for. The attending physician was notified of the Level of change as well as the Resident Representative (RR). For other residents with the potential to be affected: By 8/9/19 a 100% audit of current residents on psychotropic drugs, qualifying diagnoses, behaviors and change in condition will occur. All new admissions and readmissions will be	

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F 644

Continued From page 6

stated goal read "mood will be redirected with encouragement and interventions included psychiatric services and follow up with recommendations as ordered.

Physician orders for July 2019 included, but were not limited to, Divalproex SOD (sodium) DR (delayed release) (a medication used to treat manic episodes related to bipolar disorder) 500mg (milligrams)-take 1 tablet by mouth twice daily for psychosis.

A review of the MAR (Medication Administration Record) dated 7/1/19 through 7/31/19 revealed Divalproex SOD DR was administered each day, twice per day.

An interview was conducted on 7/18/19 at 9:40AM with the Regional Director of Operations. She stated Resident #17 was diagnosed with unspecified psychosis in 2014 after his 2011 admission. She stated on admission the facility conferred with the hospital and the Admission Coordinator, or designee, initiated the screening process for mental or intellectual disability diagnoses. She also stated, "We failed to do a Level II PASARR screening with a new onset diagnosis. He (Resident #17) also received psych (psychiatric) services later on and there was still no Level II PASARR screening. The new diagnosis hasn't affected his care, everything is in place such as the care plan and psych services, we just didn't do the paperwork."

F 644

reviewed during morning clinical meeting to determine triggers. This will include review of the discharge summary, medication regiment, medical history and behaviors.

Facility plan to prevent re-occurrence:

Effective 8/9/2019, and moving forward, the Director of Nursing, Assistant Director of Nursing, and/or Unit managers and Social Services will review all new admissions and readmissions during morning clinical meeting to determine triggers. This will include review of the discharge summary, medication regiment, medical history and behaviors. This review will be stored in the Daily Clinical Binder.

Starting 8/9/2019, the Executive Director will educate the Director of Social Services, Director of Nursing, Assistant Director of Nursing, Unit Managers, Director of Admissions and MDS Nurses on proper protocol to identify Level II PASRR Candidates. This education will include: Reviewing all new admissions and readmissions during morning clinical meeting to determine triggers. This will include review of the discharge summary, medication regiment, medical history and behaviors.

Monitoring:

Effective 8/9/2019, the Director of Nursing, Assistant Director of Nursing or designee will monitor all admissions,

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F 644	Continued From page 7	F 644	readmissions and significant change during clinical meeting. This monitoring will occur five days a week for four weeks, then three days a week for four additional weeks to ensure proper PASRR levels are obtained. This monitoring will be documented on the PASRR Monitoring Tool. Effective 9/20/2019, Executive Director and/or Director of Social Services will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. This reporting will occur monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: The Executive Director and the Director of Social Services will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance. Compliance Date: 8/15/19	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		8/15/19

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F 657	Continued From page 8 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to hold a care plan meeting and invite the resident to participate in the care plan meeting for two consecutive care plan meetings after the quarterly assessments (Resident #36). Findings included: A review of the medical record revealed Resident #36 was admitted 8/6/2017 with diagnoses that included osteoarthritis, difficulty walking, Diabetes Mellitus and chronic pain.	F 657	F-657 Root cause: The Executive Director and Director of Social Services discussed on 8/2/19 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from when the former Social Services failed to properly notify (Residents #36) of a scheduled care planned meeting.	

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F 657	Continued From page 9 The Annual Minimum Data Set (MDS) dated 5/1/2019 noted Resident #36 to be cognitively intact and needed supervision for some Activities of Daily Living with the help of one person. In an interview on 7/16/2019 at 10:45 AM, Resident #36 stated she had not been invited to a care plan meeting that she could recall. The Social Worker stated, in an interview on 7/16/2019 at 2:30 PM, he was not familiar with Resident #36 but would check to see if she had a care plan meeting since he came to work at the facility. A review of progress notes revealed documentation of a care plan meeting October 18, 2018. The signature sheet for the October care plan meeting had Resident #36' signature to document her attendance. A review of the Quarterly assessments noted assessments were completed on 1/10/2019 and 4/9/2019. There were no notes documenting care plan meetings. On 7/18/2019 at 12:07 PM, the facility Administrator was interviewed and stated the care plan meetings should be every 90 days or when there was a significant change in a resident's condition. The Administrator stated his expectation was the resident and the responsible party would be notified and invited to participate in the care plan meetings.	F 657	For affected residents: Resident #36 was hand delivered a care planning invitation on 7/17/19 and a Care Planning Meeting was conducted with Resident #36 on 7/24/19. For other residents with the potential to be affected: By 8/9/19 a 100% audit of the care plan invitations for the quarter ending July 2019 will be conducted. Any Residents that is identified as to not receiving an invitation will immediately be notified along with their Resident Representative. A care planning meeting with then is set up within the next calendar week or when feasible for the all parties to meet. Facility plan to prevent re-occurrence: Effective 8/9/2019, and moving forward, the Director of Social Services will utilize the MDS Care Planning schedule produced in AHT to schedule and send Care Planning invitations On 8/9/2019, the Executive Director educated the Director of Social Services on the importance of proper care planning scheduling and proper protocol of care planning scheduling. The education will include reviewing the MDS Care Planning schedule and timely mailing Resident Representative and hand delivering invitations to Resident. All supporting documentation will be stored in the Social Services Scheduling Binder that will be kept in the Director of Social Services	

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F 657	Continued From page 10	F 657	office. Monitoring: Effective 8/9/2019, the Executive Director will perform weekly monitoring of the Care Planning invitation calendar. This monitoring will occur weekly for four weeks, and then bi-weekly for an additional four weeks to ensure to ensure that invitation are being sent and sent in a timely manner. This monitoring will be documented on the Care Planning Monitoring Tool. Effective 9/20/2019, Executive Director and/or Director of Social Services will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. This reporting will occur monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: The Executive Director and the Director of Social Services will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance. Compliance Date: 8/15/19	