STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0444	A. BUILDING: _____ B. WING _____	C 11/06/2023

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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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D 000	Initial Comments The surveyor entered the facility on 10/30/23 to conduct a complaint investigation survey and exited on 11/2/23. Additional information was obtained on 11/3/23 and 11/6/23. Therefore, the exit date was changed to 11/6/23. Event ID TFNY11. The following intakes were investigated NC 205255 and NC00207959. Five of the five complaint allegations did not result in deficiency.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Type B Violation: Based on record review, resident interview, and staff interview the facility failed to protect the right of a resident to be free from abuse. Resident # 14 continued to experience fear after being knocked out of his wheelchair and hit in the jaw by Resident # 15. Prior to the incident, Resident # 14 demonstrated verbal behaviors which make him vulnerable to abuse by other residents. On the date of the incident, staff reported Resident # 14 had been cursing "all day" at staff. Resident # 15 stated he "smacked (Resident # 14) out of his wheelchair and hit him upside the jaw" because Resident # 14 had been cursing the staff and then cursed him. This was for one of three residents reviewed for abuse. The findings	D 338	Director of nursing completed a head to toes assessed for resident #14 on 11/06/2023, there were no signs of any injuries. On 11/06/2023, Director of nursing completed a one-on-one education with medication technician #1 on the importance of identifying, managing, and deescalating behaviors symptoms of the residents. The education also emphasized the importance of following-up on resident's post incident/event to ensure their physical and psychological wellbeing is not affected. On 11/22/2023, resident #15 was	11/24/23

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D 338	Continued From page 1 included: Resident # 14 was admitted to the facility on 4/20/22. Resident # 14's diagnoses in part included heart failure, chronic obstructive pulmonary disease, and muscle wasting and atrophy. Resident # 14's care plan, dated 6/3/23 noted the following. Resident # 14 was ambulatory with an aide or device, used a wheelchair, and sometimes was disoriented and needed reminders. The care plan included a section in which staff checked if a resident was "verbally abusive," "physically abusive" or displayed "disruptive behavior/socially inappropriate" behaviors. Resident # 14's care plan did not have any of these behaviors checked. Resident # 15 was last admitted to the facility on 6/30/22 with diagnoses of traumatic brain injury, chronic obstructive pulmonary disease, generalized weakness, heart disease, seizure disorder, and hypertension. Resident # 15's care plan, dated 7/1/23, noted Resident # 15 was totally independent in all his activities of daily living and was ambulatory without any assistive devices. Resident # 15 was also noted to be sometimes disoriented and needed reminders. The care plan included a section in which staff checked if a resident was "verbally abusive," "physically abusive" or displayed "disruptive behavior/socially inappropriate" behaviors. Resident # 15's care plan did not have any of these behaviors checked. On 10/22/23 at 10:00 PM a medication technician (MT) entered an entry into Resident # 15's record	D 338	assessed by the licensed nurse practitioner to ensure that resident #15 is an appropriate setting. Nurse practitioner determine that resident #15 was in proper placement. Identification of Other Residents who Might Be Affected: 100% interview of all residents in the assisted facility who are alert and oriented completed by the facility social worker #1, #2, and #3 on 11/06/23 to identify any other resident with an allegation of abuse/neglect, or who voiced being afraid of another resident. No other resident(s) voiced any allegation of abuse/neglect or being afraid of another resident. Findings of this audit are documented on a “resident abuse interview tool” located in the facility compliance binder. 100% interview of all residents in the assisted living facility who are alert and oriented completed by the facility social worker #1, #2, and #3 on 11/06/23 to identify any other resident with behavior symptoms that may result onto physical abuse. No other resident identified with behaviors that may result onto physical abuse to another resident. 100% audit of current resident’s medical records in assisted living facility completed by director of Nursing, Unit coordinator #1, and/or unit coordinator #2 on 11/06/2023, to identify any other resident with behavior symptoms that may result onto resident-to-resident abuse. No other resident identified to have behaviors that	

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D 338	Continued From page 2 noting the following. Another resident was claiming Resident # 15 had assaulted him. The assaulted resident had called the police. Resident # 15 was questioned about the incident and admitted he had hit the other resident because the other resident was yelling and cursing at the nurses. Review of a facility incident report, dated 10/22/23, revealed the resident who had been hit by Resident # 15 was Resident # 14. The incident report noted the incident had occurred at 9:30 PM on 10/22/23. MT # 1 noted on the incident report, "Writer heard yelling and screaming coming from top of hall. Once writer got there (Resident # 14) stated (Resident # 15) hit me." The incident report contained a 24 hour follow up notation which included documentation that Resident # 14 had no bruising from the altercation and continued to be independently ambulatory and use his wheelchair. The incident report form also included a section where staff could make "additional follow-ups" regarding the incident. There were no further follow- ups noted on the incident report form following the 24 hour follow up. The "additional follow-ups" were blank. A local law enforcement officer was interviewed via phone on 11/3/23 at 11:30 AM and reported officers did respond to the altercation on 10/22/23 but no police report was filed. The officer stated if there had been an injury, the responding officers would have made a report. Resident # 14 was interviewed on 11/1/23 at 3:10 PM and reported the following. He had waited for two days to get his bed made and was upset with the nurses about that. He had cursed the nurses right before the incident with Resident # 15 happened. Resident # 14 stated after he had	D 338	may result onto resident-to-resident abuse. Systemic Changes and Modification: Effective 11/06/2023, the facility will ensure each resident retains the right to be free from abuse, neglect, misappropriation of resident property, and/or exploitation, to include freedom from resident-to-resident abuse. This systemic change will be accomplished through the implementation of the following measures: Effective 11/06/2023 all new residents will have a behavior assessment completed on admission, re-admission, annually, and with any changes in their behavior status by the licensed nurse. The appropriate measures will be implemented to manage identified behaviors and deescalated such behaviors to prevent resident to resident abuse. Effective 11/06/2023, all new resident's medical records will be reviewed for any behaviors that may result in resident-to-resident abuse. Any resident identified with any behavior symptoms will have appropriate interventions to reduce escalation of behaviors that may result in resident-to-resident abuse. This will be reviewed in the daily clinical meeting and be documented on each resident's medical records. Effective 11/06/2023, the facility clinical team to include the Director of Nursing, assistant director of Nursing, Unit Manager #1 and/or Unit Manager #2 revised the process of reviewing new	

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D 338	Continued From page 3 cursed the nurses, Resident # 15 "knocked me to the ground and hit me in the jaw." Resident # 14 stated the staff had seen it. He called the police about the incident. During the interview, Resident # 14 repeated three different times that he was afraid of Resident # 15. Resident # 14 stated that Resident # 15 was much younger than he was. Resident # 15 was interviewed on 11/1/23 at 1:15 PM and reported the following. Resident # 14 had been calling the nurses bad names on the date of the incident. He asked Resident # 14 to quit cursing the nurses. After he asked Resident # 14 to stop cursing, Resident # 14 responded, "F ...you," and then he (Resident # 15) "smacked him (Resident # 14) out of his wheelchair and hit him upside the jaw." MT # 1 had been the MT who had responded to the incident on 10/22/23. MT # 1 was interviewed on 11/1/23 at 3:20 PM and reported the following. Resident # 14 often got upset with the staff and would curse. Rather than tell the staff what was wrong so they could take care of it, Resident # 14 would routinely roll around and curse. On the date of 10/22/23 he had been cursing all day. When the incident occurred between Resident # 14 and Resident # 15, she did not see what had occurred. She heard Resident # 14 in the hallway yelling that Resident # 15 had hit him. She went to check on him. He had no bruises and appeared to be okay. He was in the wheelchair at the time he reported it. The Assisted Living Resident Care Coordinator was interviewed on 11/1/23 at 3:18 PM and reported the following. None of the staff had witnessed the incident. She had talked to both Resident # 14 and Resident # 15. Resident # 15 had acknowledged he had hit Resident # 14.	D 338	admits/readmits in a daily clinical meeting. The revised process includes the provision for behavior assessment, ensuring it is completed, documented, with an appropriate care plan in place. Any discrepancies identified will be corrected promptly. Finding of this systemic change is documented on the daily clinical meeting report form located on the daily clinical meeting binder. 100% education of all current assisted living staff to include full-time, part-time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to; the importance of completing behavior assessment on admission, annually, and with changes of behavior status, abuse prohibition policy and procedures to include resident to resident abuse, the importance of identifying, managing and deescalating resident behaviors to prevent resident to resident abuse, reporting any incident/accident to a licensed nurse, and the requirements to follow up with resident/residents post incident to ensure their physical and psychosocial wellbeing is not affected. This education will be completed by 11/24/2023. Any assisted living staff members not educated 11/24/2023, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new assisted living employees effective 11/24/2023. Monitoring Process:	

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D 338	Continued From page 4 Resident # 14 was not hurt, and he had the physical capability to have gotten himself up from the ground if he was on the ground. Following the incident, she told both residents to stay away from each other. They did not have a history of prior altercations. Resident # 14 had never shared with her that he was afraid of Resident # 15. Resident # 16 was interviewed on 11/1/23 at 10:45 AM. (Resident # 16's name appeared on a 10/30/23 facility list of residents whom the facility administrative staff had reported to be credible for interview purposes.) During the interview, Resident # 16 reported Resident # 14 had spoken to her about the incident after he was hit by Resident # 15. Resident # 14 had let her know he was afraid of Resident # 15. When he told her about the incident, she could see that his hands were shaking while talking about it. She had not witnessed the incident. The Administrator was interviewed on 11/1/23 at 4:00 PM and reported the following. He was aware of the altercation between Resident # 15 and Resident # 14. Following the incident, the staff tried to keep them apart. Resident # 14 had not shared with any of the staff that he was afraid of Resident # 15. If he had done so, then they would have addressed his fears. On 11/6/23 the facility Administrator presented the following plan to immediately remove the Type B Violation in order to protect residents from further risk or additional harm. Resident #15 was admitted to the assisted living facility on 06/22/2020 and readmitted on 06/30/22. Between the original admission and last readmission, he was admitted to the Skilled	D 338	Effective 11/06/2023, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all new admissions for the last 24 hours or from last clinical meeting to ensure behavior assessment has been completed, and appropriate intervention are implemented to ensure that behaviors are not escalating to cause resident to resident abuse. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the “behavior assessment tool for new residents” located in the facility compliance binder. Effective 11/06/2023, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor incident/accident reports to ensure resident/residents involved have been assessed to ensure their physical and/or psychosocial wellbeing are not affected. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the “incident report monitoring tool” located in the facility compliance binder. Person(s) Responsible to implement	

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D 338	Continued From page 5 nursing facility from 10/15/2021 up to 06/30/2022. The most recent readmission, he was readmitted with diagnoses that included (in parts), traumatic brain injury, Chronic Obstructive Pulmonary Disease, Hypertension, seizures, Hyperlipidemia, disorder of puberty, and muscle weakness. Resident #14 was admitted to the assisted living facility on 04/20/2022. He was admitted with diagnoses that included (in parts), Chronic Obstructive Pulmonary Disease, Hypertension, Heart Failure, Dysphagia, Dementia, Gastro-esophageal regurgitation disease, and muscle weakness. Review of incident report completed on 10/22/2023, indicated that resident #15 hit resident #14 on 10/22/2023 and caused resident #14 to fall out of his wheelchair with no apparent injuries. Root Cause Analysis (RCA): The Governing body led by the facility Executive Director, Director of Nursing, Assisted Living resident care Coordinator in collaboration with the selected members of the facility Quality Assurance and Performance Improvement (QAPI) committee conducted the root cause analysis on 11/06/2023, to identify the causative factor for this alleged noncompliance and implemented appropriate measures to correct and prevent the reoccurrences. The root cause analysis identified that the alleged noncompliance resulted from an employee failure to implement appropriate measures necessary to manage residents' behaviors, as a result, resident #15 got angry and hit resident #14 on his jaw which resulted with a fall from the wheelchair on 10/22/2023.	D 338	Corrective Plan of Care: Effective 11/06/20232, the Executive Director, Director of Nursing, and/or Assisted living Resident care coordinator will be responsible for the implementation of this plan to immediately remove the Type B Violation in order to protect residents from further risk or additional harm.	

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D 338	Continued From page 6 The root cause analysis also identified that the alleged noncompliance resulted from the failure of the facility staff to complete post incident follow up to ensure resident physical and psychological well being is not affected by any incident in the facility. This was evident by Resident # 14 who said he continues to be afraid of Resident # 15 when interviewed by the surveyor while on site. Immediate Action Implemented: Director of nursing completed a head to toe assessment for resident #14 on 11/06/2023, there were no signs of any injuries. On 11/06/2023, Director of nursing completed a one-on-one education with medication technician #1 on the importance of identifying, managing, and deescalating behaviors symptoms of the residents. The education also emphasized the importance of following-up on resident's post incident/event to ensure their physical and psychological wellbeing is not affected. Identification of Other Residents who Might Be Affected: 100% interview of all residents in the assisted facility who are alert and oriented completed by the facility social worker #1, #2, and #3 on 11/06/23 to identify any other resident with an allegation of abuse/neglect, or who voiced being afraid of another resident. No other resident(s) voiced any allegation of abuse/neglect or being afraid of another resident. Findings of this audit are documented on a "resident abuse interview tool" located in the facility compliance binder. 100% interview of all residents in the assisted living facility who are alert and oriented completed by the facility social worker #1, #2, and #3 on	D 338		

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11/06/23 to identify any other resident with behavior symptoms that may result onto physical abuse. No other resident identified with behaviors that may result onto physical abuse to another resident.

100% audit of current resident's medical records in assisted living facility completed by director of Nursing, Unit coordinator #1, and/or unit coordinator #2 on 11/06/2023, to identify any other resident with behavior symptoms that may result onto resident-to-resident abuse. No other resident identified to have behaviors that may result onto resident-to-resident abuse.

Systemic Changes and Modification:

Effective 11/06/2023, the facility will ensure each resident retains the right to be free from abuse, neglect, misappropriation of resident property, and/or exploitation, to include freedom from resident-to-resident abuse. This systemic change will be accomplished through the implementation of the following measures:

Effective 11/06/2023 all new residents will have a behavior assessment completed on admission, re-admission, annually, and with any changes in their behavior status by the licensed nurse. The appropriate measures will be implemented to manage identified behaviors and deescalated such behaviors to prevent resident to resident abuse.

Effective 11/06/2023, all new resident's medical records will be reviewed for any behaviors that may result in resident-to-resident abuse. Any resident identified with any behavior symptoms will have appropriate interventions to reduce escalation of behaviors that may result in

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resident-to-resident abuse. This will be reviewed in the daily clinical meeting and be documented on each resident's medical records.

Effective 11/06/2023, the facility clinical team to include the Director of Nursing, assistant director of Nursing, Unit Manager #1 and/or Unit Manager #2 revised the process of reviewing new admits/readmits in a daily clinical meeting. The revised process includes the provision for behavior assessment, ensuring it is completed, documented, with an appropriate care plan in place. Any discrepancies identified will be corrected promptly. Finding of this systemic change is documented on the daily clinical meeting report form located on the daily clinical meeting binder.

100% education of all current assisted living staff to include full-time, part-time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to; the importance of completing behavior assessment on admission, annually, and with changes of behavior status, abuse prohibition policy and procedures to include resident to resident abuse, the importance of identifying, managing and deescalating resident behaviors to prevent resident to resident abuse, reporting any incident/accident to a licensed nurse, and the requirements to follow up with resident/residents post incident to ensure their physical and psychosocial wellbeing is not affected. This education will be completed by 11/24/2023. Any assisted living staff members not educated 11/24/2023, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire

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orientation for all new assisted living employees effective 11/24/2023.

Monitoring Process:
Effective 11/06/2023, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all new admissions for the last 24 hours or from last clinical meeting to ensure behavior assessment has been completed, and appropriate intervention are implemented to ensure that behaviors are not escalating to cause resident to resident abuse. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the "behavior assessment tool for new residents" located in the facility compliance binder.

Effective 11/06/2023, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor incident/accident reports to ensure resident/residents involved have been assessed to ensure their physical and/or psychosocial wellbeing are not affected. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the "incident report monitoring tool" located in the facility compliance binder.

Effective 11/06/2023 Director of Nursing and/or assisted living resident care coordinator will

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D 338	Continued From page 10 report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. Person(s) Responsible to implement Corrective Plan of Care: Effective 11/06/20232, the Executive Director, Director of Nursing, and/or Assisted living Resident care coordinator will be responsible for the implementation of this plan to immediately remove the Type B Violation in order to protect residents from further risk or additional harm.	D 338		