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 08/27/2024

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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 8/26/24 through 8/27/24. Event ID# 604X11. The following intakes were investigated NC00220931, NC002200851 and NC00220800. 1 of the 9 complaint allegations resulted in a deficiency.	F 000		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		9/11/24

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

Electronically Signed | 09/10/2024

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F 842	Continued From page 1 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 842	The facility sets forth the following plan of	

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F 842	Continued From page 2 facility failed to maintain an accurate Treatment Administration Record (TAR) for wound care treatments for 1 of 1 resident (Resident #2) reviewed for accurate medical records. The findings included: 1a. Review of Resident #2's medical record revealed a physician's order dated 7/19/24 that indicated apply alginate calcium with silver sodium (a highly absorbent antimicrobial pad that contains calcium and silver and is used to treat wounds) and Dakins solution (antiseptic solution used for wound cleaning and wound packing) daily to sacral wound. The order entered in the TAR stated as needed (PRN). Review of Resident #2's TAR revealed no documentation of Resident #2's sacral wound treatment from 8/1/24 to 8/26/24. 1b. Review of Resident #2's medical record revealed a physician's order dated 8/4/24 that indicated apply hydrogel impregnated dressing (a wound saturated with gel used to moisten and heal dry wounds) to left heel then cover with dry dressing daily. Review of Resident #2's TAR revealed no documentation of left heel wound treatment on 8/6/24, 8/7/24, 8/10/24, 8/11/24, 8/17/24, 8/18/24, 8/24/24, 8/25/24 and 8/26/24. During an interview with Nursing Assistant #2 (NA) #2 on 8/27/24 at 3:14 pm, NA #2 reported she completed wound treatments for Resident #2's left heel and sacral wound Monday- Friday daily per physician orders. She stated she had completed the treatments daily but may have	F 842	correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F842 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #2 was discharged to the hospital on 8/27/24 and has not returned. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with wounds that are documented on the treatment administration record are at risk. An audit of all residents with wounds on the treatment administration record was completed by the director of nursing, assistant director of nursing and staff development coordinator to ensure that wound care orders are correct and documented accurately. This was completed on 9/10/24. Any discrepancies were corrected immediately. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; Licensed nursing staff, including FT, PT, PRN and Agency staff, were educated by the director of nursing regarding maintaining an accurate medical record, to include ensuring the wound care orders	

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F 842	Continued From page 3 forgotten to document on some of the days for the left heel wound. NA #2 stated she did not document the sacral wound treatments for August because the order was entered incorrectly in the TAR to indicate as needed (PRN) instead of daily but she completed the treatment daily according to the wound doctor's order. NA #2 stated she was supervised by Nurse #1 who was the current wound treatment nurse, but she could not recall if she had informed Nurse #1 that the order for the sacral wound was entered as PRN into the TAR instead of daily. During an interview on 8/27/24 at 3:55 pm with Nurse # 4, he stated he completed the wound treatments for Resident #2 on the weekends because the wound treatment nurse did not work on the weekends. Nurse #4 stated Resident #2 had a sacral and left heel wound which were to be completed daily according to the wound doctor treatment order dated 7/19/24. He reported that he completed the treatments on Saturday and Sunday dayshift but had forgotten to document. He also stated he did not realize the TAR stated PRN since the order stated daily. During an interview with Nurse #1 on 8/27/24 at 3:49 pm she revealed she became the wound treatment nurse approximately 3 weeks ago. Nurse #1 stated she entered wound treatment orders given by the Wound Doctor into the facility's documentation system, completed some of the wound treatments and supervised NA #2 who completed some of the wound dressings. Nurse #1 reported she was not aware that Resident #2's sacral wound treatment was not entered into the TAR correctly and that the treatments were not documented daily. She	F 842	are accurate on the Treatment Administration Record and signed off once completed. In service began on 9/8/24 and will be completed on 9/10/24. • All new hires after 9/10/2024 will receive training during orientation. • Nurses will not be allowed to work until this education is received. Treatment administration records will be audited by the director of nursing, assistant director of nursing and/or the unit manager 5x per week for 4 weeks, then 3x per week for 4 weeks and weekly for 4 weeks to ensure that the treatments are accurate and documented on the treatment administration record. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. 5.Date of Compliance: 9/11/2024	

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F 842	Continued From page 4	F 842		

stated that the wound was improving as evidenced by the wound doctor's weekly wound evaluation documentation from 7/18/24 to 8/20/24. Nurse #2 stated that the sacral wound order was given prior to her assuming the responsibility of the wound treatment nurse but she should have ensured that it was documented correctly after she became the wound treatment nurse.

An interview was conducted on 8/27/24 at 4:34 pm with the facility Administrator and Director of Nursing (DON). The DON stated she was not aware that Resident #2's sacral wound order was entered inaccurately and that the wound treatments were not documented in Resident #2's medical records. The DON reported that the facility had changed their documentation system in July 2024, and she could not tell if some of the information had not transferred correctly. She stated she expected nursing staff to make sure treatments were entered accurately as indicated. The Administrator stated nursing staff should have documented Resident #2's wound treatments accurately.