STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with staff, responsible party, and medical director the facility failed to notify the resident's responsible party (RP) of a resident's death (Resident #1) for 1 of 3 residents reviewed for notification. Findings included: Resident #1 was admitted to the facility on [DATE] with most recent reentry [DATE]. His [DIAGNOSES REDACTED]. The resident's Profile revealed a family member was listed as emergency contact and responsible party (RP). Nursing progress notes dated [DATE] at12:51 am, revealed Nurse # 3 found Resident #1 unresponsive, began CPR, and called Emergency Medical Services (EMS). The resident was pronounced dead by EMS at 7:15pm on [DATE]. Nurse #3 documented the family was call three times with no response and EMS transported body to the local hospital morgue. A phone interview was conducted with Resident #1's RP on [DATE] at 2:42pm. RP stated he was never notified by the facility of Resident #1's death. The RP stated he was notified of the resident's death by the hospital morgue on [DATE] at 9:15am. Resident #1's RP stated when the facility had an outbreak of COVID19, all residents were assigned a liaison who would call family daily to update them on a resident's condition. Resident #1 was assigned to the facility's Human Resource (HR) representative. On [DATE] Resident #1's RP notified the HR representative he would be traveling out of the country with his job and he would be calling her for an update on Resident #1 until his return to the United States. On [DATE] around lunch time Resident #1's RP spoke with the HR representative to receive and update on Resident #1 and to confirm with her the cell phone he mailed to Resident #1 had arrived. The HR representative was not in the facility that day, it was a Sunday, but confirmed with him the cell phone had arrived and she would get it to Resident #1 on Monday morning ([DATE]). The RP also notified the HR representative he would be on an overnight flight returning to the U. S. on [DATE]. On [DATE] at 1:09pm an interview was conducted with Human Resource (HR) representative who was assigned to communicate with Resident #1's RPs during the COVID outbreak. She stated Resident #1 was on her list of residents to contact RPs daily with updates. She stated she spoke with resident's RP frequently up until [DATE] when he told her he would be traveling out of the country with his job. He told her he would be contacting the facility until his return. She stated on [DATE] around 12:56pm she received a call from the RP to confirm she had received the cell phone he mailed to Resident #1 and let her know he had a flight overnight returning home on [DATE]. She confirmed she had received the phone and would give it to Resident #1 when she returned to the facility on the morning of [DATE]. When she went into the facility on [DATE] nursing staff informed her of the resident's death. She stated she did not attempt to notify the RP on [DATE] or [DATE]. An interview was conducted [DATE] at 4:30pm with Nurse #3. Nurse #3 stated she worked night shift on [DATE] and arrived at the facility that evening around the time Resident #1 was found unresponsive. She stated she went into the room and was asked to contact the resident's RP. She further stated she called the first RP listed and left a message. She thought she attempted the second contact number but did not get an answer. She recalled trying the RP number two more times while EMS was in the building but did not get a response from the RP. The Director of Nursing (DON)was made aware of the resident's death and that the nurse was unable to contact the RP on the evening of [DATE]. Nurse #3 stated she did not speak to any of Resident #1's family after the death of the resident on [DATE]. On [DATE] at 10:19am an interview was conducted with the Director of Nursing (DON) in which she stated she was on call the night of [DATE] and was made aware of the resident's death by the night shift nurse. She stated she did not attempt to contact the RP that evening but made the ADON aware on the morning of [DATE]. At that point the Assistant Director of Nursing (ADON) was given the task of notifying the resident's family. When asked about the facility's protocol if an RP can not be contacted, she stated the facility would send a certified letter to the RP if they could not be reached by phone. The DON stated a certified letter had not been sent to Resident #1's RP. When asked for documentation of attempts to notify family on [DATE] or [DATE] of Resident #1's death, no documentation was provided. An interview was conducted with the ADON on [DATE] at 11:48am. The ADON stated she was made aware of the resident's death on [DATE]. She stated she attempted to call the RP around lunch time on [DATE] but did not get an answer. When asked if she documented her attempt to call the RP, she stated she did not. She worked late the evening of [DATE] and when she returned to work on [DATE] the RP had already been notified by the morgue of Resident #1's death. An interview was conducted with the Administrator on [DATE] at 12:33pm. He stated the facility had attempted to notify the RP on [DATE] and left him a message to call the facility. He further stated the call log on [DATE] indicated the RP was out of the country and would call the facility for updates. It was unfortunate that the morgue notified the RP before the facility could contact him. When asked about expectations on documentation of attempts to notify family of change in status or death, the Administrator stated it is his expectation that staff document attempts to notify RPs of changes in status or death.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews the facility failed to complete skin assessments weekly per facility protocol on 1 of 3 (Resident #1) reviewed for pressure sore. Findings included: Resident #1 was admitted to the facility on [DATE] with most recent reentry 5/13/2020. His [DIAGNOSES REDACTED]. The resident ' s most recent reentry minimum data set ((MDS) dated [DATE] revealed the resident had functional hearing, functional vision, and was able to understand others and was understood by others. The resident was coded as having mildly impaired cognition and no behaviors or moods. He was coded as an everyday smoker. Functionally, the resident was totally dependent upon staff for activities of daily living and personal hygiene. Resident #1 ' s comprehensive care plan dated 3/5/2020 revealed a goal of remaining free of further skin breakdown through next review. The interventions included full skin evaluations with bath/shower as per facility protocol. A record review revealed the last full skin assessment completed on Resident #1 prior to his hospitalization , on 5/5/2020, was completed on 4/11/2020. There were no full skin assessments documented on the resident between 4/11/2020 and 5/5/2020. An interview was conducted with nurse aide (NA) #1 on 6/22/2020 at 12:25pm. NA#1 stated she had been employed in the facility for a few years. She further stated the nurse aides are responsible for documenting and reporting any skin breakdown observed during bed baths to the nurse working the hall where the resident resides. NA#1 stated she had worked with the resident prior to his hospitalization for COVID19 on 5/5/2020 but she did not recall if he had any skin breakdown at that time. On 6/22/2019 and interview was conducted with the Director of Nursing. She stated the facility protocol included weekly full skin assessments for each resident and they were routinely completed by the NAs during a bed bath or shower. She further stated she did not know why skin assessments were not documented in Resident #1 ' s electronic medical record after 4/11/2020 and prior to his admission to the hospital on [DATE]. She expected full skin assessments to be completed and documented weekly on all residents.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on record reviews and interviews with staff and facility administrator, and medical director the facility failed to follow physician's order to check respiratory status and vital signs every four hours for 1 of 3 residents (Resident #1) reviewed for respiratory care. Findings included: Resident #1 was admitted to the facility on [DATE] with most recent reentry 5/13/2020. His [DIAGNOSES REDACTED]. Resident #1's most recent comprehensive care plan dated 3/5/2020 revealed a goal of remaining free of signs and symptoms of shortness of breath related to [MEDICAL CONDITION], history of pneumonia, and [MEDICAL CONDITION]. Interventions for this goal included obtaining oxygen levels as per physician's orders and as symptoms warrant. Additionally, the resident had a goal of remaining free of hypertensive episodes. The interventions for this goal included obtaining blood pressure per physician's order and as symptoms warrant. The resident's most recent reentry minimum data set ((MDS) dated [DATE] revealed the resident had functional hearing, functional vision, and was able to understand others and was understood by others. The resident was coded as having mildly impaired cognition and no behaviors or moods. He was coded as an everyday smoker. Functionally, the resident was totally dependent upon staff for activities of daily living and personal hygiene. A record review revealed Resident #1 was discharged from the facility on 5/5/2020 with signs and symptoms consistent with COVID19. The resident had been tested for COVID19 twice by the facility, on 4/17/2020 and 5/1/2020, and found to be negative. Hospital records dated 5/5/2020 through 5/13/2020 revealed the resident was positive for COVID19 and found to have pneumonia related to this respiratory virus. He was discharged back to the facility on [DATE]. Resident #1's record revealed he was a full code when he returned to the facility on [DATE]. A review of the physician's orders for Resident #1 revealed an order, dated 5/13/2020, for vital signs and respiratory assessment every four hours. This included oxygen saturation, blood pressure, pulse rate, respiratory rate, and temperature. The Medication Administration Record [REDACTED]. Between 5/13/2020, the date the order was written, and 5/31/2020, the date of the resident's death, there were only two days, 5/22/2020 and 5/28/2020, that the resident's respiratory status and vital signs were monitored every 4 hours per physician's order. Specifically, on the date of the resident's death, 5/31/2020, there were no vital signs or respiratory assessments completed between 10:38am and approximately 6:30pm when the resident was found to be in respiratory and [MEDICAL CONDITION]. The last documented vital signs on Resident #1 on 5/31/2020 were at 10:38am: oxygen saturation 95%, blood pressure 114/77, pulse rate 78 beats per minute, respiratory rate of 19 breaths per minute and a temperature of 97 degrees Fahrenheit. Nursing progress notes were reviewed for 5/31/2020. The last progress note documented on Resident #1 was documented by Nurse #3 at 6:49am. There were no progress notes documented on Resident #1 between 6:49am and approximately 6:30pm when he was found in respiratory and [MEDICAL CONDITION]. Emergency Medical Service's (EMS) record dated 5/31/2020 revealed they arrived at the facility at 6:42pm on 5/31/2020 to find resident #1 cold, absent of pulse, absent of spontaneous respirations, with pupils fixed and dilated at 4mm. Nursing facility staff were attempting to resuscitate Resident #1. The resident was placed on a cardiac monitor and determined to be in asystole (no electrical activity). Due to obvious signs of death, resuscitation efforts were not performed by EMS and Resident #1 was pronounced dead. EMS record indicated the resident's nurse stated she knew he was going to die that day. On 6/22/2020 at 2:08pm an interview was conducted with Nurse # 1 in which she stated she cared for Resident #1 on 5/31/2020 during the 7:00am- 7:00pm shift. She stated the resident was up out of bed and in his wheelchair for breakfast and lunch but had a poor appetite. She stated he just seemed weak and tired. She further stated she check the resident last around 5:00pm and he seemed fine, she did not have any cause to be concerned. When asked if she checked the resident's vital signs and respiratory status at 5:00pm or prior to that time, she could not recall but thought she had. Nurse #1 attempted to find documentation of 5:00pm vital signs and respiratory assessment for Resident #1 but was not successful. The last documentation by Nurse #1 was between 4:30pm and 5:00pm when she documented a blood sugar level of 114. Nurse #1 stated she was still in the facility around 6:30pm when Resident #1 was found in respiratory and [MEDICAL CONDITION] and she was in the room when Emergency Medical Services (EMS) arrived. When asked if she made a comment regarding the resident's death in front of EMS, she stated she thought the resident was going to pass. When asked what assessment this was based on, Nurse #1 stated the resident did not have an abnormal presentation that would have warranted her calling the physician, it was just a feeling she had. An interview was conducted with Nurse # 2 on 6/22/2020 at 3:32pm in which she revealed she also worked with Resident #1 on the date of his death, 5/31/2020. She recalled seeing the resident at breakfast and at lunch time that day and he had a poor appetite. She recalled he removed his oxygen frequently and needed to be reminded to keep the oxygen on. She stated he didn't voice any pain or appear to be in any distress, but he appeared a little gray. Nurse #2 described Resident #1 as having been weak and tired but conversive during her shift on 5/31/2020. When asked if his presentation warranted calling the physician, she stated the resident did not appear to be in distress or in danger of deteriorating. Nurse #2 stated she did not obtain vitals on Resident #1 during the time she worked him on 5/31/2020. An interview with the facility's medical director was conducted on 6/23/2020 at 9:57am. He stated he had been providing services via telehealth since the COVID19 outbreak. He stated he was familiar with Resident #1 and recently placed the resident on intravenous antibiotics after chest x-ray had confirmed pneumonia. He stated the resident was diagnosed with [REDACTED]. He further stated that if he wrote an order for [REDACTED].