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	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

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43798 Based on record review and staff interviews the 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 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. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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 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.