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	05/23/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observations and staff interviews, the facility failed to place a resident's adaptive flat call light device within reach to allow for the resident to request assistance if needed for 1 of 4 residents reviewed for accommodation of needs (Resident #81). Findings included: Resident #81 was admitted to the facility on [DATE] with diagnoses including legal blindness. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #81 was moderately cognitively impaired, had no impairments with range of motion to both upper body extremities and was dependent on staff assistance for all mobility in and out of the bed. Resident #81's revised care plan dated 4/27/2025 indicated Resident #81 was legally blind. There was no intervention for keeping the call bell in the reach of Resident #81. On 5/19/2025 at 11:01 am, Resident #81 was observed lying in the bed with her head of the bed elevated and an adaptive flat call bell was observed attached to the upper right corner of the mattress cover with the call bell hanging toward the back side of the mattress. When Resident #81 was asked where the call ball was located, Resident #81 was observed moving her hands against the bed on each side of her body to search for the adaptive flat call bell. Resident #81 explained she was blind and stated she did not know where the call bell was located at that moment. When Resident #81 was informed where the adaptive call bell was located (hanging on the right corner of the mattress), Resident #81 stated she was unable to reach the adaptive flat call bell. Resident #81 needed assistance with incontinence care, and Nurse #2 was informed of the Resident #81 needs. On 5/20/2025 at 4:51 pm, Resident #81 was observed lying in the bed and the adaptive flat call bell was observed lying in a chair positioned four feet from the right side of the bed. Resident #81 was observed attempting to locate the call bell on the bed and stated she was unable to locate the adaptive flat call bell. Resident #81 stated they (nursing staff) put the call bell where they want to. (continued on next page)

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

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	05/23/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/2025 at 4:56 pm in an observation and interview with Nurse Aide (NA) #2 who was assigned Resident #81, she stated Resident #81 communicated her needs to staff when they were making rounds. NA #2 stated Resident #81 was checked every hour and when she was last in Resident #81's room thirty minutes ago, Resident #81's call bell was on the bed. NA #2 stated she had no idea Resident #81's call bell was in the chair and the call bell should be clipped to the bed in Resident #81's reach. NA #2 was observed moving the adaptive flat call bell to Resident #81's right side of the bed and informing Resident #81 where the adaptive flat call bell was located. NA #2 stated Resident #81 was unable to get out of bed independently to move the call bell into the chair beside the bed. On 5/21/2025 at 3:50 pm, Resident #81 was observed resting in the bed with a push button call bell positioned on the right side of the bed beside Resident #81. On 5/22/2025 at 8:38 am in an interview with Nurse #2, she stated Resident #81 was able to use the adaptive flat call bell to call for assistance as needed and had always known Resident #81 to use the adaptive flat call bell. She stated Resident #81's call bell was to be within reach for use and when the call bell was observed hanging from the right corner of the mattress (5/19/2025) and in the chair (5/20/2025), the call bell was not in the reach of Resident #81. On 5/22/2025 at 8:40 am in an interview with the Director of Nursing, she stated Resident #81 could use the adaptive flat call bell to call for assistance and Resident #81's adaptive flat call bell should be in the reach of Resident #8. The DON stated Resident #81's adaptive flat call bell should not have been changed to a push button call bell due to Resident #81's blindness and the possibility of Resident #81 missing the button to call for help. On 5/21/2025 at 8:49 am in an interview with Nurse #8, she stated Resident #81 required an adaptive flat call bell and the reason Resident #81 was observed with a push button call bell (5/22/2025) was because the adaptive flat call bell for Resident #81 and the push button call bell for Resident #81's roommate had been switched. On 5/23/2025 at 11:30 am in an interview with the Administrator, she stated Resident #81 adaptive flat call bell should be positioned within the reach of the resident

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	05/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 Based on record review, and Physician and staff interviews, the facility failed to protect a resident's right to be free from abuse when a cognitively intact resident (Resident #326) hit a moderately cognitively impaired resident (Resident #325) on his arms with an ashtray holder. Resident #325 sustained 3 small skin tears on his left forearm, left elbow, left posterior arm, and right ring finger. This deficient practice affected 1 of 3 residents reviewed for abuse (Resident #325). The findings included: Resident #326 was admitted to the facility on [DATE] and was discharged on [DATE]. His diagnoses included osteomyelitis, anxiety disorder, depression, and hallucinations. Resident #326's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. He was independent with upper body dressing, rolling left and right, sitting to lying, lying to sitting on side of bed, picking up an object, wheeling 50 feet with 2 turns, and wheeling 150 feet. He required partial/moderate assistance with toileting hygiene, showering/bathing himself, lower body dressing, putting on/taking off footwear, and personal hygiene. He needed supervision/touch assistance to sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. Resident #326's revised care plan dated 10/7/24 revealed he exhibited behaviors that included throwing items at staff, cursing at staff, cursing at other residents, destroying others personal property, manipulative behaviors/ fabrication of stories, hitting staff and other residents. Interventions included 1:1 supervision, administering medications as ordered, diverting Resident #326 by giving him an alternative object or activity, listening and calming him. Resident #325 was admitted to the facility on [DATE] and was discharged on [DATE]. His diagnoses included epidural hemorrhage with loss of consciousness, dementia, muscle weakness, abnormalities of gait and mobility, major depressive disorder, seizures, schizophrenia, and chronic pain syndrome. Resident #325's Minimum Data Set (MDS) dated [DATE] revealed he was moderately cognitively impaired. He was independent in the areas of eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, personal hygiene, rolling left and right, sitting to lying, lying to sitting on side of bed, toilet transfer, wheeling 50 feet with 2 turns, and wheeling 150 feet. He required set up/clean up assistance for tub/shower transfer. He needed supervision/touch assistance with shower/bathing himself, sitting to standing, chair/bed to chair transfer, walking 10 feet, and walking 50 feet with 2 turns. He required partial/moderate assistance to walk 150 feet. Resident #325's revised care plan dated 9/4/24 included the focus area of behaviors such as spitting on the floor and throwing briefs on the floor. Review of Resident #326's nursing progress note dated 9/30/24 at 10:40 AM entered by the Director of Nursing (DON) revealed Resident #326 was agitated and challenging with redirection. Resident #326 was medicated for pain and monitored closely for aggression. An emergency mental health tele-visit for Resident #326 was requested. (continued on next page)

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	05/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Physician medical progress note dated 9/30/24 at 11:37 AM indicated during this visit Resident #326 was upset about his pain medication, used profanity and attempted to hit and throw things at the Physician. The Physician's progress note stated Resident #326 was asking for more anxiety medications. The Physician indicated psychiatry was seeing him and reportedly did not change his anxiety medications. The physician further indicated Resident #326 was upset his Physician would not increase his pain medication and started hitting, throwing things, and cursing at the Physician. An interview was conducted with Physician #1 on 5/22/25 at 11:31 AM. He stated Resident #326 always requested to have his pain medication increased. Physician #1 stated as he exited the room Resident #326 told him not to shut the door and then came after him in the hallway. Physician #1 stated Resident #326 attempted to hit him but instead punched his laptop twice. Physician #1 stated Resident #326 continued to follow him, and Physician #1 went into another resident room. Resident #326 came into the room and took one of the drawers out of a dresser and tried to hit Physician #1 with it. Physician #1 stated a physical therapist was near the room and attempted to intervene. Physician #1 indicated he was told later Resident #326 had an altercation in the courtyard. Regarding emergency mental health tele-visits, Physician #1 stated if a resident was experiencing a serious mental health emergency, that resident would be sent directly to the emergency room (ER). Otherwise, he stated, it was his expectation that a practitioner would see a resident within 24 hours. An interview with the Rehabilitation Director was conducted on 5/22/25 at 1:51 PM. He stated he and his Physical Therapy Assistant (PTA) saw Resident #326 yelling and belligerent. The Rehabilitation Director stated Resident #326 had cornered the provider in a resident room and was verbally abusive. He stated he removed Resident #326 from the room by pulling on the handles of his wheelchair. On 5/22/25 at 2:00 PM an interview was conducted with the Physical Therapy Assistant (PTA). He stated he heard a commotion, saw a provider (Physician #1) backing out of a room, and Resident #326 followed him and was verbally abusive and pushing the provider. The PTA stated he and the Rehabilitation Director walked to meet them. The provider backed into another resident's room and Resident #326 followed him and attempted to hit the provider. The PTA stated there was a resident in that room near the window. He stated the provider was positioned in the middle of the room in front of the resident in the bed by the window. He further stated it appeared that Resident #326 pulled on dresser drawers, while he was being backed out of the room. The PTA stated the Rehabilitation Director grabbed the back of Resident #326's wheelchair and backed him out of the room. The PTA stated it all happened very fast, in less than a minute. He added the provider was able to get out of the room and go down the hall. The PTA recalled that the Rehabilitation Director released the wheelchair and Resident #326 began pursuing the provider again. The PTA tried to talk to Resident #326 and distract him, however Resident #326 punched the PTA in the stomach and chest to continue to pursue the provider. The PTA talked to Resident #326 to calm him down. Both Resident #326 and the PTA went out to the courtyard and talked while Resident #326 smoked. The PTA stated the Social Worker came out to talk to Resident #326 and the police showed up. A review of the facility's Initial Allegation Report dated 9/30/24 revealed on 9/30/24 at 12:00 PM there was a resident-to-resident altercation. Resident #326 hit Resident #325 with a small table stand during an argument in the courtyard. The residents were separated immediately, and Resident #326 was placed on one-to-one supervision. Law enforcement was notified. (continued on next page)

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	05/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the witness statement from Medication Aide #1 dated 9/30/24 indicated she was outside with Resident #326 while he was smoking. Resident #326 and Resident #325 started to argue. Resident #326 picked up the ashtray stand and started hitting Resident #325. Medication Aide #1 attempted to grab the ashtray stand but a male housekeeper grabbed it. Medication Aide #1 brought Resident #326 inside and informed the nurse that Resident # 325 needed help. An interview was conducted on 5/22/25 at 9:15 AM with Medication Aide #1 who completed one to one observation of Resident #326 on 9/30/24. She stated she did not recall the incident between Resident #326 and Resident #325. A follow up interview was conducted with Medication Aide #1 on 5/23/25 at 10:34 AM. She stated she performed 15-minute checks on Resident #326 the morning of 9/30/24 after he had requested medications. She stated she was unsure what time he was placed on one-to-one observation. An interview with Housekeeping Staff #1 who witnessed the incident 9/30/24 was conducted on 5/21/25 at 7:03 PM. Housekeeping Staff #1 stated he was on the 500-hall taking out the garbage and was looking out the window toward the courtyard and saw a resident hit another resident with an ashtray holder. Housekeeping staff #1 stated he ran out and grabbed the ashtray holder out of the resident's hand, separated the residents, and went inside to report it to a staff member immediately. He was unsure which staff member he reported it to and did not recall seeing anyone else outside. An interview was conducted on 5/23/25 at 12:05 PM with Nurse #9 who was assigned to both Resident #326 and Resident #325 on 9/30/24. Nurse #9 stated she recalled there was an altercation because a housekeeper had reported the incident to her on 9/30/24. Nurse #9 was unsure if Resident #326 was on one-on-one observation prior to the incident, but stated he was supervised after the incident. Nurse #9 indicated when she was informed of the incident she assessed both residents for injuries. Resident #325 had skin tears on one arm. An interview was conducted with the Director of Nursing (DON) on 5/22/25 at 6:45 AM. She stated on 9/30/24 Resident #326 was checked on continuously and was kept at the nurse's station after he became agitated that morning. The DON indicated she was unsure how he could have left the nurse's station. Additional interventions included administering pain and antianxiety medications and 15-minute checks. The DON stated Resident #326's mental health practitioner saw him in person the next day on 10/1/24. She further stated that monitoring a resident closely entailed the resident was monitored every 15 minutes, and those logs were kept in a binder. She stated a safety attendant for one-to-one observations for Resident #326 were in effect until 11/7/24 for the duration of his stay. A review of Resident #326's one-to-one 15-minute monitoring logs 9/30/24 through 11/7/24. Resident #326's monitoring logs revealed he had 15-minute checks signed by staff. An interview was conducted with the Social Worker (SW) on 5/22/25 at 2:10 PM. He stated he saw Resident #326 after the incident with the provider (Physician #1) as well as after the incident with another resident. He stated they discussed his aggressive behavior in both instances. He stated he recalled Resident #326 was on one-to-one observation, however, was unsure of how long. The SW stated he could not recall anything further about the incidents that occurred on 9/30/24. (continued on next page)

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	05/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a psychiatry progress note dated 10/4/24 revealed Resident #326 was able to express insight into the altercation with Resident #325 and demonstrated emotional awareness and control. There were no changes made to Resident #326's medications. Recommendations included continued practice of calming techniques, redirection techniques, support, and redirection as needed. A review of the facility's investigation report dated 10/4/24 revealed in summary, Resident #325 sustained small skin tears on his left forearm, left elbow, left posterior arm, and right ring finger. Resident #325 declined to press charges. Resident #325 denied any lasting trauma because of the incident, stated he felt safe at the facility, and was not afraid of Resident #326. Resident #326 also denied a traumatic response to the incident, was placed on one-to-one observation, and received a mental health evaluation. This was completed by the Administrator. An interview was conducted with the Administrator on 5/22/25 at 3:47 PM. She stated interventions were put in place (15-minute observations and placing Resident #326 at the nurse's station) and was unsure why they did not prevent the incident.

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	05/23/2025

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48007 Based on record review and staff interviews, the facility failed to notify the resident representative in writing of the reason for the transfer/discharge to the hospital and had not mailed a copy of the bed hold policy for 2 of 2 residents (Resident #73 and #45) reviewed for hospitalization . 1) Resident #73 was admitted into the facility on [DATE]. A review of Resident #73's quarterly Minimum Data Set, dated dated dated [DATE] indicated that she was moderately cognitively impaired. A review of Resident #73's nursing progress notes revealed that she was discharged to the hospital on 3/12/25 and returned on 3/29/25. A review of Resident #73's medical record indicated that on 3/12/25 at both 2:03 PM and 5:20 PM Nurse #1 attempted to contact Resident #73's responsible party by telephone to inform them Resident #73 was transferred to the hospital but were unable to reach them. There was no documentation that a written notice of transfer or discharge was provided or notice of the bed-hold policy. An interview with the Admissions Staff #1 on 5/20/25 at 2:42 PM revealed that they called or attempted to call the families/resident representative on the day of transfer or the next business day if a resident was transferred after hours or on the weekend. They had not mailed any notices regarding the bed hold policy or written notification of transfer or discharge including the reason for the transfer to the families/resident representative. She stated that she was unaware that it was a requirement for these to be mailed. An interview with the Administrator on 05/20/25 02:55 PM indicated that the bed hold information and written notice of transfer or discharge including the reason for transfer should be mailed to the family/resident representative and given to the resident when sent to the emergency room or hospital. 2) Resident #45 was admitted into the facility on [DATE]. A review of Resident #45's significant change Minimum Data Set, dated dated dated [DATE] indicated that she was severely cognitively impaired. A review of Resident #45's nursing progress notes revealed that she was discharged to the hospital on 5/17/25 and returned to the facility on [DATE]. A review of Resident #45's medical record indicated Nurse #2 notified the resident representative was by telephone of the transfer to the hospital. There was no documentation that a written notice of transfer or discharge was provided or notice of the bed-hold policy. (continued on next page)

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	05/23/2025

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview with the Admissions Staff #1 on 5/20/25 at 2:42 PM revealed that they called or attempted to call the families/resident representative on the day of transfer or the next business day if a resident was transferred after hours or on the weekend. They had not mailed any notices regarding the bed hold policy or written notification of transfer or discharge including the reason for the transfer to the families/resident representative. She stated that she was unaware that it was a requirement for these to be mailed. An interview with the Administrator on 05/20/25 02:55 PM indicated that the bed hold information and written notice of transfer or discharge including the reason for transfer should be mailed to the family/resident representative and given to the resident when sent to the emergency room or hospital.

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	05/23/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observations, and staff interviews and Nurse Practitioner interview, the facility failed to change a chronic wound dressing as ordered by the provider for 1 of 1 resident reviewed for venous wound care (Resident # 40). Findings included: Resident #40 was admitted to the facility on [DATE] with diagnoses including chronic idiopathic (arising spontaneously with unknown cause) venous hypertension with ulcer to the left lower extremity and pyoderma gangrenosum (a rare condition that causes large painful sores on the skin). Resident's #40's revised care plan dated 1/7/2025 included a focus for a chronic left lower leg vascular wound. Interventions included treatments per the Treatment Administration Record (TAR). The care plan also included a focus for behaviors due to Resident #40 refusing care that included wound care. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #40 was moderately cognitively impaired. The MDS was coded for one venous/arterial ulcer and treatments included application of ointments, medications and nonsurgical dressings. A review of physician orders indicated on 3/20/2025 Resident #40 was ordered daily wound care that included to cleanse the left lower extremity wound with wound cleanser, pat dry, apply collagen soaked gauze followed by calcium alginate with silver to the open area, cover with ABD pads (highly absorbent pads for large wounds) and apply Kerlix (crinkle-weave bandage used for wound care). Physician orders dated 5/9/2025 included a change in the wound care order to cleanse the left lower extremity wound with Vashe (a pure hypochlorous acid solution used to fight bacteria and infection), pat dry, apply collagen particles (provides support for cell organization and faster tissue formation, helps maintain a moist environment and stimulated new tissue growth), cover with Xeroform (sterile, non-adherent wound dressing that prevent air for reaching the wound) and infections), apply ABD pads and wrap the wound with Kerlix every day shift. The Nurse Practitioner's wound documentation dated 5/14/2025 reported the left lower ulcer wound was improving without complications and measurements were recorded as 14.5 centimeters (cm) by 25 cm by 0. 30cm with moderate odorless serosanguineous drainage. The frequency of dressing changes was recorded for daily dressing changes. A review of Resident #40's May 2025 TAR recorded the following order for wound care: Cleanse left lower extremity wound with Vashe, pat day, apply collagen particles, cover with Xeroform, apply ABD pads then wrap with kerlix every day shift for wound care and the order date was recorded as 5/9/2025 at 10:20 am. There was no wound care recorded provided to Resident #40's left lower leg wound for the following dates on Resident #40's May 2025 TAR: 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025. There was no documentation in the electronic medical record (EMR) that wound care was provided to Resident #40 or Resident #40 refused wound care on 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025. (continued on next page)

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	05/23/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/2025 at 8:54 am in a phone interview with Nurse #3, she explained she served as the nurse supervisor for nursing station #2 that included Resident #40's room. Nurse #3 explained on weekends there were medication aides assigned to Resident #40 to administer medications and as nurse supervisor she was responsible for Resident #40's wound care. Nurse #3 stated on 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025 she did not provide or offer to provide wound care to Resident #40 because she thought Resident #40 received wound care on Monday, Wednesday and Friday. Nurse #3 stated she was not aware of the new order for left lower extremity wound care written on 5/9/2025 and explained the resident would communicate when there were new orders for wound care and nurses reviewed Resident #40's EMR for new wound care orders. Nurse #3 stated she had not checked Resident #40's EMR for wound care orders. On 5/23/2025 at 9:20 am in an interview with Nurse #2, she stated she had been the unit manager for nurse's station #2 that included Resident #40's room since the end of March 2025. Nurse #2 stated Resident #40's left lower extremity wound care had been ordered daily since March 2025 and could not recall a change in the frequency of Resident #40's wound care. On 5/19/2025 at 12:52pm, Resident #40's left lower extremity wound dressing was observed with moderate amount of dried light brown drainage to the outer wound dressing and moderate amount of dried yellowish brown stains to the under pad on the bed underneath the left lower extremity. There was no date or initials on the dressing indicating when the dressing was last changed. On 5/19/2025 at 12:52 pm, Resident #40's Representative stated the dressing to the left lower extremity was not changed on the weekend. Resident #40 confirmed that the left lower wound dressing was not changed on the weekend (5/17/2025 and 5/18/2025). On 5/20/2025 at 11:26 am, Nurse #6 and Nurse #7 were observed educating Resident #40 on the importance of daily wound care before Resident #40 consenting to treatment. Nurse #7 was observed assisting Resident #40 in participating in the wound care and wound care was conducted as ordered by the provider. The large open wound area to the left lower leg was observed with dark burgundy-red color tissue covered with a thin clear to white slough in areas. There was no odor noted. On 5/20/2025 at 12:02 pm in a interview with Nurse #7, she stated when she changed Resident #40's left lower extremity wound dressing on 5/19/2025, there was no date or initials on the old dressing and the wound dressing appeared to not have been changed on the weekend. On 5/22/2025 at 9:03 am in a phone interview with the Wound Nurse Practitioner, she stated Resident #40's refused wound care at times and had refused debridement of the left lower extremity wound to remove the slough. She explained Resident #40 was scheduled wound care three times a week (Monday, Wednesday and Friday) at one time and because Resident #40 would refuse wound care, she had changed the frequency of Resident #40's left lower extremity wound dressing from three times a week (Monday. Wednesday and Friday) to daily. She explained when Resident #40 was receiving wound care three times a week and refused wound care, the dressing to the left lower extremity wound would go three to four days without treatment. Therefore, to ensure Resident #40 was receiving lower extremity wound care more consistently, the wound nurse practitioner increased the wound care to daily to capture the performance of wound care more routinely. She explained the resident had been more cooperative and there was less time in between wound care dressing changes even when Resident #40 refused wound care with daily wound care. The Nurse Practitioner stated Nurse #3 should have attempted to perform wound care as ordered for Resident #40 on 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025. (continued on next page)

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	05/23/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/2025 at 9:03 am in an interview with the Director of Nursing, she stated the nurse assigned to nursing station #2 was responsible for performing wound care to the assigned area on weekends. She stated Nurse #3 should have verified Resident #40 wound care orders and offered Resident #40 wound care as ordered on 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025.

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	05/23/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35930 Based on observations, record review, and staff interviews, the facility failed to ensure a severely impaired resident with a diagnosis of dysphagia (difficulty swallowing) and a physician order for a pureed diet (foods that are smooth and pudding-like texture) did not have access to mechanically chopped food. A nursing assistant realized the resident had received mechanically chopped breakfast sausage on a meal tray and left it with the resident who was able to feed himself independently. This deficient practice occurred for 1 of 3 residents reviewed for accidents. The findings included: Resident #84 was admitted to the facility on [DATE] with diagnoses which included Progressive Supranuclear Palsy (a neurodegenerative disease involving the gradual deterioration of the brain), secondary Parkinsonism, and dysphagia (difficulty swallowing). Record review indicated Resident #84 had a Physician's Order, dated 1/16/25, for a Regular Diet, pureed texture, thin liquids consistency, and double protein for all meals. A review of Resident #84's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident to have the ability to understand others and to make himself understood. The MDS indicated he was severely cognitively impaired. He had no impairment in his upper extremities and required set up or clean-up assistance when eating. The MDS indicated Resident #84 had a swallowing disorder and was on a mechanically altered diet. A review of Resident #84's Care Plan, last revised on 4/16/25, indicated the following focuses: 1) at risk for injury related to his medical diagnoses and stated he pockets food at times (holding food in the mouth without swallowing it); 2) refuses to allow staff to assist with meals and eating; and 3) requires assistance with his Activities of Daily Living. Interventions included, in part, a therapeutic diet as ordered, staff assistance with meal setup, encouragement by staff to allow with assistance with his meals, cues and reminders to improve his meal intake, assurance that he is safe and if he became distressed to listen to him and try to calm him. An observation of Resident #84 was conducted on 5/23/25 at 8:36 AM. He was sitting up in his bed and was observed eating. A small bowl that contained grits, scrambled eggs and sausage had been placed on his overbed table which was positioned across his lap. The eggs and sausage appeared to have a mechanically chopped texture (foods that are ground into very small pieces making it easier for people who have difficulty chewing or swallowing eat) instead of pureed texture (foods that are smooth and pudding-like texture). He was observed using an adaptive spoon (a utensil with an easy-grip handle) to eat the grits. There was no tray or meal ticket on the table or in his room. Resident #84's nursing assistant (NA), NA #1, entered the room, introduced herself as the NA assigned to his care that day, and asked him if he was done eating and the resident indicated he was. (continued on next page)

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	05/23/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with NA #1 on 5/23/25 at 12:05 PM. NA #1 stated Resident #84 had orders for a pureed diet with double portions. When asked about his breakfast, NA #1 claimed she knew the resident's likes and dislikes very well and because she had fed him most of his breakfast, she had asked if he would like to eat some more, by himself and said he indicated he would like to do that. Instead of leaving everything, she had taken some of the remaining eggs and sausage from his plate and put them into his bowl of grits, placed the bowl on his overbed table and gave him his spoon. She then removed the tray and left him to eat on his own. When asked about the texture of the foods in the bowl, NA #1 explained that grits and eggs always had that consistency, but the sausage appeared to have been a mechanically chopped texture. NA #1 further explained she realized the sausage had not been pureed when she sat down to feed him and removed the dome from his plate. She stated she had planned on going to the kitchen to get him the pureed version of sausage, but said the resident told her that he did not want any sausage that morning, so she did not go to the kitchen. NA #1 could not explain why she put the sausage into the bowl of grits that she had left with the resident except for saying that because he had said he did not want to eat any sausage that morning she knew he would not eat it. When asked if she had reported Resident #84 received a mechanically chopped diet that morning, she initially said she had reported it to the Resource Nurse on the hall and then admitted she had not. An interview was conducted with the Resource Nurse, Nurse #4, on 5/23/25 at 11:15 AM. Nurse #4 explained Resident #84 had orders for a pureed diet and could feed himself, but it took a long time for him to eat. Nurse #4 stated he was unaware Resident #84 had received a mechanically chopped breakfast meal that morning and stated he would talk with the dietary department about the error. She stated she was unaware Resident #84 had received a mechanically chopped breakfast that morning. [NAME] #1 said she had placed the pureed sausage right beside the mechanically chopped sausage in the steam table and that they definitely looked different. An interview was conducted with the Director of Nursing (DON) on 5/23/25 at 11:50 AM. The DON stated it was her expectation that residents receive the food that had been ordered for them. An interview was conducted with the Administrator on 5/23/25 at 11:51 AM. The Administrator stated it was her expectation that residents receive the correct food consistency as ordered. The Administrator also stated a resident's safety should always be a priority for staff.

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	05/23/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 43798 Based on observations, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5% as evidenced by 4 errors out of 33 opportunities observed. The medication error rate was 12.12%. Findings included: 1. Resident #101 had a doctor's order dated 4/18/25 for omeprazole oral suspension 10 milliliter via Gastrotomy (G) -tube two times a day for gastroesophageal reflux disease (GERD) and scheduled to be administered at 9:00 AM and 9:00 PM. On 5/20/25 at 9:33 AM, Resident #101 was observed during the medication administration. Nurse #4 was observed preparing and administering Resident #101's scheduled 9:00 AM medications. During this medication administration, Nurse #4 did not administer omeprazole oral suspension which was scheduled for 9:00 AM. On 5/20/25 at 10:01 AM, Nurse #4 was interviewed. He stated that he had not realized that Resident #101's omeprazole was out and needed to be refilled/reordered and he was going to call the provider about it after this interview. According to the manufacturers' instructions insulin lispro should be injected under the skin within 15 minutes before or right after a meal and a meal should be consumed within 10-20 minutes after insulin aspart is administered. 2a. Resident #59 had a doctor's order dated 2/28/25 for Humalog Kwik Pen subcutaneous solution pen injector 100 unit/milliliter (Insulin Lispro) inject as per sliding scale: 201 - 250 = 5 units; 251 - 300 = 8 units; 301 - 350 = 12 Units; 351 - 400 = 16 Units subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with diabetic neuropathy. On 5/21/25 at 11:20 AM, Nurse #5 was observed checking Resident #59's blood sugar which was noted to be 244. Nurse #5 administered 5 units of insulin lispro to Resident # 59 at 11:24 AM. Resident #59 was observed receiving his lunch tray at 12:54 PM which was 1 hour 30 minutes after insulin was administered. Resident #59 sat up in bed and ate his lunch when he received his tray. 2b. Resident #21 had a doctor's order dated 2/25/25 for Insulin Lispro Injection Solution (Insulin Lispro) inject as per sliding scale: 150 - 169 = 1 unit; 170 - 189 = 2 units; 190 - 209 = 3 units; 210 - 229 = 4 units; 230 - 249 = 5 units; 250 - 269 = 6 units; 270 - 289 = 7 units; 290 - 300 = 8 units; 301+ = 9 units & notify provider, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with other specified complication. On 5/21/25 at 11:30 AM, Nurse #5 was observed checking Resident #21's blood sugar which was noted to be 180. Nurse #5 administered 2 units of insulin lispro to Resident #21 at 11:35 AM. Resident #21 was observed receiving her lunch tray at 1:03 PM which was 1 hour 28 minutes after insulin was administered. Resident #21 sat up in bed and ate her lunch when she received her tray. (continued on next page)

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	05/23/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2c. Resident #76 had a doctor's order dated 12/12/24 for Novolog Injection Solution 100 unit/milliliter (Insulin aspart) Inject as per sliding scale: 201 - 250 = 5 units; 251 - 300 = 8 units; 301 - 350 = 12 units; 351 - 400 = 16 units subcutaneously before meals and at bedtime for diabetes mellitus. On 5/21/25 at 11:42 AM, Nurse #5 was observed checking Resident #76's blood sugar which was noted to be 335. Nurse #5 administered 12 units of insulin aspart to Resident #76 at 11:48 AM. Resident #76 was observed receiving her lunch tray at 1:11 PM which was 1 hour 23 minutes after the insulin was administered. Resident #76 sat up in bed and ate her lunch when she received her tray. During an interview on 5/21/25 at 1:22 PM, Nurse #5 stated that since the blood sugar checks were scheduled for 11:00 AM she went ahead and checked the blood sugars and administered insulin at that time thinking the trays would be out shortly, but she was not sure of the exact time when the trays would be delivered to the residents. Nurse #5 indicated that now that she had thought about it, she should not have administered the insulin more than 30 minutes before the meal was served to the residents. During an interview on 5/21/25 at 1:32 PM with the facility Director of Nursing (DON), she indicated Nurse #5 should not have administered Resident #21, Resident #59 and Resident #76 insulins before she saw trays in the hallway because it was indicated to be administered before meals. The DON stated she expected fast acting insulin to be administered 15 - 30 minutes before the meal and that Nurse #5 needed to be reeducated regarding insulin timeframes. The DON verbalized Nurse #4 should have ensured Resident #101 had all her 9:00 AM scheduled medications and if there was an issue with reordering the medication the expectation was for nurses to reach out to the physician. During an interview on 5/22/25 at 2:13 PM with the facility Administrator, she indicated Nurse #5 should not have administered Resident #21, Resident #59 and Resident #76 insulins until the meal trays were within vicinity. The Administrator indicated she expected nurses to request medication refills from pharmacy ahead of time so that the residents did not run out of medications. She also indicated that if there was an issue obtaining the medication from the pharmacy, nurses should reach out to the physician for guidance ahead of time.

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	05/23/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 43798 Based on observations, record review, and staff and Medical Director interviews, the facility failed to assure the facility was free of significant medication errors when fast acting insulin (insulin lispro and insulin aspart) that starts to work approximately 15 minutes after injection to lower blood sugar levels was administered to 3 residents more than 1 hour before their meal tray was delivered. The significant medication errors could have resulted in adverse side effects for 3 of 8 residents observed for medication administration (Resident #59, Resident #21 and Resident #76). Findings included: According to the manufacturers' instructions insulin lispro should be injected under the skin within 15 minutes before or right after a meal and a meal should be consumed within 10-20 minutes after insulin aspart is administered. 1a. Resident #59 had a doctor's order dated 2/28/25 for Humalog Kwik Pen subcutaneous solution pen injector 100 unit/milliliter (Insulin Lispro) inject as per sliding scale: 201 - 250 = 5 units; 251 - 300 = 8 units; 301 - 350 = 12 Units; 351 - 400 = 16 Units subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with diabetic neuropathy. On 5/21/25 at 11:20 AM, Nurse #5 was observed checking Resident #59's blood sugar which was noted to be 244. Nurse #5 administered 5 units of insulin lispro to Resident # 59 at 11:24 AM. Resident #59 was observed receiving his lunch tray at 12:54 PM which was 1 hour 30 minutes after insulin was administered. Resident #59 sat up in bed and ate his lunch when he received his tray. 1b. Resident #21 had a doctor's order dated 2/25/25 for Insulin Lispro Injection Solution (Insulin Lispro) inject as per sliding scale: 150 - 169 = 1 unit; 170 - 189 = 2 units; 190 - 209 = 3 units; 210 - 229 = 4 units; 230 - 249 = 5 units; 250 - 269 = 6 units; 270 - 289 = 7 units; 290 - 300 = 8 units; 301+ = 9 units & notify provider, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with other specified complication. On 5/21/25 at 11:30 AM, Nurse #5 was observed checking Resident #21's blood sugar which was noted to be 180. Nurse #5 administered 2 units of insulin lispro to Resident #21 at 11:35 AM. Resident #21 was observed receiving her lunch tray at 1:03 PM which was 1 hour 28 minutes after insulin was administered. Resident #21 sat up in bed and ate her lunch when she received her tray. 1c. Resident #76 had a doctor's order dated 12/12/24 for Novolog Injection Solution 100 unit/milliliter (Insulin aspart) Inject as per sliding scale: 201 - 250 = 5 units; 251 - 300 = 8 units; 301 - 350 = 12 units; 351 - 400 = 16 units subcutaneously before meals and at bedtime for diabetes mellitus. On 5/21/25 at 11:42 AM, Nurse #5 was observed checking Resident #76's blood sugar which was noted to be 335. Nurse #5 administered 12 units of insulin aspart to Resident #76 at 11:48 AM. Resident #76 was observed receiving her lunch tray at 1:11 PM which was 1 hour 23 minutes after the insulin was administered. Resident #76 sat up in bed and ate her lunch when she received her tray. (continued on next page)

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	05/23/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/25 at 1:22 PM, Nurse #5 stated that since the blood sugar checks were scheduled for 11:00 AM she went ahead and checked the blood sugars and administered insulin at that time thinking the trays would be out shortly, but she was not sure of the exact time when the trays would be delivered to the residents. Nurse #5 indicated that now that she had thought about it, she should not have administered the insulin more than 30 minutes before the meal was served to the residents. During an interview on 5/21/25 at 1:32 PM with the facility Director of Nursing (DON), she indicated Nurse #5 should not have administered Resident #21, Resident #59 and Resident #76 insulins before she saw trays in the hallway because it was indicated to be administered before meals. The DON stated she expected fast acting insulin to be administered 15 - 30 minutes before the meal and that Nurse #5 needed to be reeducated regarding insulin timeframes. An interview was conducted on 5/22/25 at 8:46 AM with the facility Medical Director. The Medical Director stated that nurses should not be administering insulin before residents' meals are ready. He indicated that the window for administering fast acting insulin should be 15-30 minutes before meals. The Medical Director explained that if the residents' blood sugar was well controlled and insulin was administered before the resident is ready to eat there was potential for the blood sugar to get really low, the resident to develop hypoglycemia, become unconscious and develop associated complications. During an interview on 5/22/25 at 2:13 PM with the facility Administrator, she indicated Nurse #5 should not have administered Resident #21, Resident #59 and Resident #76 insulins until the meal trays were within vicinity.

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	05/23/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35930 Based on observations, record review, and resident, family and staff interviews, the facility failed to serve food in a form that met the resident's needs for 1 of 1 resident (Resident #84) reviewed. Resident #84 had been ordered food that was pureed texture and was observed eating a mechanically chopped breakfast meal. The findings included: Resident #84 was admitted to the facility on [DATE] with diagnoses which included Progressive Supranuclear Palsy (a neurodegenerative disease involving the gradual deterioration of the brain), secondary Parkinsonism, and dysphagia (difficulty swallowing). Record review indicated Resident #84 had a Physician's Order, dated 1/16/25, for a Regular Diet, pureed texture, thin liquids consistency, double protein for all meals. A review of Resident #84's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident to have the ability to understand others and to make himself understood. The MDS indicated he was severely cognitively impaired. He had no impairment in his upper extremities and required setup or clean-up assistance when eating. The MDS indicated Resident #84 had a swallowing disorder and was on a mechanically altered diet. A review of Resident #84's Care Plan, last revised on 4/16/25, indicated the following focuses: 1) at risk for injury related to his medical diagnoses and stated he pockets food at times (holding food in the mouth without swallowing it); 2) refuses to allow staff to assist with meals and eating; and 3) requires assistance with his Activities of Daily Living. Interventions included, in part, a therapeutic diet as ordered, staff assistance with meal setup, encouragement by staff to allow with assistance with his meals, cues and reminders to improve his meal intake, assurance that he is safe and if he became distressed to listen to him and try to calm him. An interview was conducted with Resident #84's Responsible Party (RP) on 5/19/25 at 1:34 PM. The RP stated he and another family member visit the resident at the facility almost daily and while there, assist him with his lunch and supper meals. He explained the resident ate a pureed diet and took a long time to eat. The RP expressed concern that the resident had been brought solid food for a couple of his meals in January 2025. An observation of and interview with Resident #84 was conducted on 5/20/25 at 11:38 AM. He was observed sitting up in his wheelchair, in his room beside his bed. He was awake, alert and able to respond to yes and no questions by giving a thumbs-up for a yes answer and a thumbs-down for a no answer. When he was asked if he had ever been served food that was not in pureed form, he gave a thumbs up. When asked if that had happened often, he gave a thumbs down. When asked if the staff who had brought that regular consistency food to him in the past had realized the error and replaced it with the pureed version of that food, he gave a thumbs up. (continued on next page)

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	05/23/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of Resident #84 was conducted on 5/23/25 at 8:36 AM. He was sitting up in his bed and was observed eating. A small bowl that contained grits, scrambled eggs and sausage had been placed on his overbed table which was positioned across his lap. The eggs and sausage appeared to have a mechanically chopped texture (foods that are ground into very small pieces making it easier for people who have difficulty chewing or swallowing eat) instead of a pureed texture (foods that are smooth and pudding-like texture). He was observed using an adaptive spoon (a utensil with an easy-grip handle) to eat the grits. There was no tray or meal ticket on the table or in his room. Resident #84's nursing assistant (NA), NA #1, entered the room, introduced herself as the NA assigned to his care that day, and asked him if he was done eating and the resident indicated he was. An interview was conducted with NA #1 on 5/23/25 at 12:05 PM. NA #1 stated Resident #84 had orders for a pureed diet with double portions. When asked about his breakfast, NA #1 claimed she knew the resident's likes and dislikes very well and because she had fed him most of his breakfast, she had asked if he would like to eat some more, by himself, and said he indicated he would like to do that. Instead of leaving everything, she had taken some of the remaining eggs and sausage from his plate and put them into his bowl of grits, placed the bowl on his overbed table and gave him his spoon. She then removed the tray and left him to eat on his own. When asked about the texture of the foods in the bowl, NA #1 explained that grits and eggs always had that consistency, but the sausage appeared to have been a mechanically chopped texture. NA #1 further explained she realized the sausage had not been pureed when she sat down to feed him and removed the dome from his plate. She stated she had planned on going to the kitchen to get him the pureed version of sausage, but said the resident told her that he did not want any sausage that morning, so she did not go to the kitchen. NA #1 could not explain why she put the sausage into the bowl of grits that she had left with the resident except for saying that because he had said he did not want to eat any sausage that morning she knew he would not eat it. When asked if she had reported Resident #84 received a mechanically chopped diet that morning, she initially said she had reported it to the Resource Nurse on the hall and then admitted she had not. An interview was conducted with the Resource Nurse, Nurse #4, on 5/23/25 at 11:15 AM. Nurse #4 explained Resident #84 had orders for a pureed diet and could feed himself, but it took a long time for him to eat. He explained that nursing staff would assist him, if he allowed it, and said the resident would sometimes push away staff who are trying to feed him. Nurse #4 stated when the resident wants to feed himself, staff will make frequent checks on his progress and offer him verbal cues and encouragement to eat. Nurse #4 stated he was unaware Resident #84 had received a mechanically chopped breakfast meal that morning and stated he would talk with the dietary department about the error. An interview was conducted with the Dietary Manager (DM) on 5/23/25 at 11:27 AM. The DM explained the difference between a mechanically chopped food item and a pureed one. He stated that for mechanically chopped food, they have a machine that grinds the food into very small pieces. For pureed food, the food is blended to the consistency of applesauce and is smooth. The DM stated a resident's diet order is entered into their computer system and tray tickets that contain the order are printed out for each meal. He explained at mealtimes, one staff member calls out the diet order from the ticket and another staff member puts the correct consistency foods on the trays. The DM stated he had prepared all the breakfast trays that morning and could not offer an explanation as to how Resident #84 received a mechanically chopped diet that morning. The DM stated he had thought the pureed food appeared grainy instead of smooth that morning but did not question [NAME] #1 who had prepared the food that morning. (continued on next page)

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	05/23/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with [NAME] #1 on 5/23/25 at 11:34 AM. [NAME] #1 stated that you could see the difference between the different types of textures of the foods she prepared, explaining that mechanically chopped food was ground up food that had a bumpy texture while pureed food looked smooth, like baby food. She stated she was unaware Resident #84 had received a mechanically chopped breakfast that morning. [NAME] #1 said she had placed the pureed sausage right beside the mechanically chopped sausage in the steam table and that they definitely looked different. An interview was conducted with the Director of Nursing (DON) on 5/23/25 at 11:50 AM. The DON stated it was her expectation that residents receive the food that had been ordered for them. An interview was conducted with the Administrator on 5/23/25 at 11:51 AM. The Administrator stated it was her expectation that residents receive the correct food consistency as ordered.

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	05/23/2025

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 51581 Based on record review, observations, and resident interviews and staff interviews, the facility failed to provide the breakfast meal on 5/22/2025 at times comparable to normal, scheduled mealtimes at the facility. This affected all residents that received food by mouth on 7 of 7 halls (Halls, 100,200, 300, 400, 500, 600 and 700). The facility had a census of 141. The findings included: Based on review of the meal serving times for the facility, breakfast was scheduled as follows: -the 700-hall breakfast time was 07:20 AM -the 200-hall breakfast time was 07:40 AM -the 300-hall breakfast time was 07:50 AM - the 400-hall breakfast time was 08:00 AM - the 100-hall breakfast time was 07:35 AM -the 500-hall breakfast time was 07:00 AM On 05/22/2025 at 09:00 AM an observation was made that 100 hall breakfast trays had not arrived at the 100 hall. Further observation revealed that the only trays that had arrived on any halls were 500 hall trays. Nursing staff were observed offering cereal and milk to residents due to the delay in receiving breakfast meal trays and there were no issues identified with diabetic residents receiving breakfast meal trays later than regularly scheduled The following carts arrived on the halls as follows: -700 hall breakfast cart arrived on the hall at 09:10 AM on 5/22/2025 -200 hall breakfast cart arrived on the hall at 09:19 AM on 5/22/2025 -the second breakfast cart for the 200-hall arrived at 0923 AM on 5/22/2025 -the 300/400 hall breakfast cart arrived at 09:27 AM on 5/22/2025 -the 400-hall breakfast cart arrived at 09:33 AM on 5/22/2025 -the 100-hall breakfast cart arrived at 09:40 AM on 5/22/2025 (continued on next page)

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	05/23/2025

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/22/2025 at 09:13 AM a brief interview with the Dietary Manager revealed that two cooks had called out from work to the Dietary Manager. 05/22/25 at 09:06 AM an interview with Nurse Aide (NA) staff NA #1 revealed that breakfast trays normally were delivered to the hall between 08:00 AM and 08:15 AM. On 5/22/2025 at 11:52 AM an interview with the Dietary Manager revealed the reason the breakfast meal was late today was because two scheduled cooks called out and there was not enough time to schedule another staff. The Dietary Manager stated he was made aware at 7:00 AM. The Dietary Manager revealed that another team from a sister facility arrived and they were able to get started at 800 AM. On 5/23/2025 10:31 AM an interview with the Director of Nursing (DON) revealed that every staff understood when the trays were supposed to be on the hall. If trays are not seen and are late, staff would use the group chat on their phones to text management to communicate if trays were late as well as ask if snacks were available, for instance cereal and milk for breakfast. On 5/22/2025 02:09 AM An interview with the Administrator revealed that food trays are expected to be delivered on time. If the food trays are late, a snack should be offered to the residents.

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	05/23/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51581 Based on observations and staff interviews, the facility failed to remove leftover food stored past the use by date in 1 of 2 refrigerators observed (reach-in refrigerator). This practice had the potential to affect food served to residents. The findings included: On 5/19/25 at 09:50 AM during the observation of the kitchen area with the Dietary Manager (DM) revealed leftover prepared food in the reach in refrigerator. The Dietary Manager reported leftover food was good for 48 hours after being prepared. The following leftover items observed were: - chicken soup in a stainless-steel container covered with plastic wrap dated 5/10/25 - diced ham in a stainless-steel container covered with plastic wrap dated 5/13/25 - spinach in a stainless-steel container covered with plastic wrap dated 5/13/25 - cauliflower puree in a stainless-steel container covered with plastic wrap dated 5/15/25 - sliced turkey in a stainless-steel container covered with plastic wrap dated 5/15/25 On 05/20/25 08:53 AM an interview with the Dietary Manager (DM) revealed that if there were leftovers, the leftovers were cooled down, wrapped and dated for the day the leftovers were prepared. The DM reported the leftovers were dated using a date dot label, that included the item name, date of prep, date of holding time (how long it was to be kept) and name of the staff who dated the item. The leftovers were kept no more than 48 hours per the DM. The DM indicated the cooks were responsible for checking the refrigerators daily and disposing of the leftover food after 48 hours. On 05/22/25 02:09 PM Interview with the Administrator revealed food storage should be done according to the facility's policy and food safety guidelines were followed.