STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 07/02/2019

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UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

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F 000	INITIAL COMMENTS An onsite revisit was conducted 7/1/19 to 7/2/19. Tags F550, F567, F584, F636, F637, F641, F655, F656, F657, F680, F732, F761, F773, F808, F842, F849, and F921 were corrected as of 7/2/19. Repeat tags (F585, F812, and F865) were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585		7/15/19

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

Electronically Signed | 07/18/2019

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F 585	Continued From page 1	F 585		

provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,

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F 585	Continued From page 2 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document a summary of the resident's grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued for three of three grievance forms reviewed (Grievance Record #1, #2, and #3) and failed to document the steps taken to	F 585	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth by the survey team, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for all of our residents. The Grievance/Concern Form dated	

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F 585	Continued From page 3 investigate a grievance for one of three grievance forms reviewed (Grievance Record #1). Findings include: A review was completed of the Grievances policy with an effective date of October 2017. The review revealed the Grievance Official was defined as an individual who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. In addition, it stated, the facility will ensure prompt resolution to all grievances, keeping the resident and resident representative informed throughout the investigation and resolution process. The facility grievance process will be overseen by a designated grievance official who will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations, maintaining the confidentiality of all information associated with grievances, communicate with residents through the process to resolution and coordinate with other staff (including the Administrator, if he or she is not the designated Grievance Official) and with state or federal agencies as may indicate by specific allegations. 1. Review of Grievance #1, a grievance dated 5/31/19, revealed the grievance was filed regarding several missing clothing articles. The	F 585	6/24/19 (Grievance #1) regarding missing clothing was completed as of 7/15/19 by the Housekeeping Director and the Administrator, to include the following sections: Summary of the grievance, steps taken to investigate, summary of findings, if the grievance was confirmed, correction actions and the signature of the grievance official. The resident was informed of the findings of the investigation and verbalized that the grievance was resolved,the resident did not wish to have a written copy. This grievance was verified to be resolved per the Resident by the Housekeeper Manager as of 7/15/19. The Grievance/Concern form dated 6/18/19 (Grievance #2) regarding a missing phone was completed to include the following sections: What other action was taken to resolve concern section. Results of action taken, grievance resolved, steps taken to investigate, summary of findings, name, date, grievance received, summary of grievance, confirmation of grievance, corrective actions, grievance official and signature. The resident did not wish to have a written decision. This grievance was verified to have been resolved per the resident. The Grievance/Concern form dated 6/24/19 (Grievance #3) regarding a missing clear cup with a black top was completed to include the following sections: Individual designated to take action on the grievance,what other action	

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F 585	Continued From page 4 individual designated to take action on the grievance was the Housekeeping Director (HD) and it was assigned on 6/3/19. The HD documented under the, What other action was taken to resolve concern section, all clothing items except one was located and returned to the resident. The HD documented the remaining article of clothing was still being looked for. The HD signed as the staff member and signed as the form having been completed by her. Review of the back of the form revealed no information documented on the back of the form. The sections on the back of the form included: Name, date grievance received, summary of grievance, steps taken to investigate, summary of findings, grievance was confirmed or not confirmed, corrective actions, date written decision issued, grievance official, signature, and contact information. An interview was conducted with the Administrator on 7/2/19 at 2:38 PM. The Administrator stated she was currently and has been the Grievance Official for the facility. The Administrator stated the process was she would receive the grievance, then assign the grievance, and give the assigned staff member the grievance. Upon completion of the grievance, the grievance would be returned to her. The Administrator reviewed Grievance #1 and stated the grievance had been assigned to the HD and the HD had returned the items. The Administrator stated she was sure the HD had discussed the missing items with the resident when the items were returned. The Administrator stated the HD would have asked the resident if they wanted a written copy or if a verbal discussion would have been OK. The Administrator stated the following had not been	F 585	was taken to resolve concern section. Results of action taken, grievance resolved, steps taken to investigate, summary of findings, name, date, grievance received, summary of grievance, confirmation of grievance, corrective actions, grievance official as well as contact information and signature. The resident's Responsible Party did not wish to have a written decision. This grievance was verified with the Resident's Responsible Party to have been resolved by the Social Service Director as of 7/15/19. An audit of Grievance/Concern forms for thirty days was completed by the Administrator as of 7/5/19 to determine if they were completed in their entirety and the resolution was presented to the named Resident or the Resident's responsible party and a copy given to the resident per his/her wishes. There were 14 other Grievance/Concern forms with missing information found during this audit. Of those found to not be fully completed, 100% are completed as of 7/15/19 and the resolution communicated to the complainant. The Administrator was re-educated by the Regional Nurse Consultant regarding f585 as of 7/15/19. This education included: The Grievance/Concern policy and the importance of completing the Grievance/Concern forms correctly,	

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F 585	Continued From page 5 documented on the form: Summary of the grievance, Steps taken to investigate, Summary of findings, if the grievance was confirmed, Corrective actions, date the written decision was issued, or the signature of the grievance official. The Administrator stated it was her expectation for the resolution to be communicated to the resident or the interested party and the resolution to be documented on the grievance form and if the resident or family member desired a written copy, a copy would be provided. 2. Review of Grievance #2, a grievance dated 6/18/19, revealed the grievance was filed regarding a missing phone. There was no individual designated to take action on the grievance. There was no information recorded under the, What other action was taken to resolve concern section. There was no information recorded under results of action taken, grievance resolved, or completion of the form. On the top right-hand corner of the form the word "Resolved" was hand written. Review of the back of the form revealed the only information documented on the back of the form was under the section labeled, steps taken to investigate, summary of findings. The information listed was: 1) Housekeeping to search laundry area. 2) Maintenance has a phone that may be a match to missing phone. There was no information recorded in the other sections on the back of the grievance form including: Name, date grievance received, summary of grievance, , grievance was confirmed or not confirmed, corrective actions, date written decision issued, grievance official, signature, and contact information. An interview was conducted with the Administrator on 7/2/19 at 2:38 PM. The	F 585	resolving the concern, communicating to the resident and/or complainant and giving them a written resolution per his/her wishes. Newly hired Administrators will be educated at the time of hire regarding f585 and the Grievance/Concern policy. 100% of Department Managers were re-educated as of 7/15/19 regarding the Grievance/Concern policy and the importance of completing the Grievance/Concern forms correctly, resolving the concern, communicating to the resident and/or complainant and giving them a written resolution per his/her wishes. Department Managers not available for the re-education will not be allowed to work until the re-education is received. All newly hired Department Managers will be educated at the time of hire. 100% of staff were re-educated regarding f585 and the importance of reporting, documenting and resolving grievances as of 7/15/19. Staff not available for re-education will not be allowed to work until the re-education is completed. Newly hired staff will be educated regarding the Grievance policy at the time of hire. The Social Services Director will ensure that all Grievances/Concerns will be logged, the resolution is accomplished and the resolution is communicated to the resident/complainant. The Administrator as the Grievance Official will review all	

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F 585	Continued From page 6 Administrator stated she was currently and has been the Grievance Official for the facility. The Administrator stated the process was she would receive the grievance, then assign the grievance, and give the assigned staff member the grievance. Upon completion of the grievance, the grievance would be returned to her. The Administrator reviewed Grievance #2 and stated the phone which the Maintenance Department had was the resident's phone and it was returned to the resident, but it was not documented. The Administrator stated the grievance was resolved, but there was no follow-up documented. The Administrator stated the grievances were being investigated and they were being resolved. The Administrator stated the evidence of the resolution of the grievances was that the items were being found and returned to the residents. The Administrator stated the following had not been documented on the form: Summary of the grievance, Summary of findings, if the grievance was confirmed, Corrective actions, date the written decision was issued, or the signature of the grievance official. The Administrator stated it was her expectation for the resolution to be communicated to the resident or the interested party and the resolution to be documented on the grievance form and if the resident or family member desired a written copy, a copy would be provided. 3. Review of Grievance #3, a grievance dated 6/24/19, revealed the grievance was filed regarding a missing clear cup, with a black top, and a metal straw. There was no individual designated to take action on the grievance. There was no information recorded under the, What other action was taken to resolve concern section. There was no information recorded	F 585	Grievances/Concerns and validate that the form is completed in its entirety and the results have been communicated to the complainant. Upon validating the completion and resolution, the Administrator will sign the form. The Administator will audit Grievance and Concern forms daily, Monday through Friday on-going to ensure that the form is completed in its entirety and the results have been communicated to the complainant in the method of their preference. The Administrator will compile a report on the findings of these audits monthly and report to the Quality Assurance and Performance Improvement committee monthly The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary. The facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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F 585	Continued From page 7	F 585		

under results of action taken, grievance resolved, or completion of the form. Review of the back of the form revealed the only information documented on the back of the form was under the section labeled, steps taken to investigate, summary of findings. The information listed was: 1) Nurse Supervisor called to be on lookout for item described. 2) Dietary now involved. There was no information recorded in the other sections on the back of the grievance form including: Name, date grievance received, summary of grievance, , grievance was confirmed or not confirmed, corrective actions, date written decision issued, grievance official, signature, and contact information.

An interview was conducted with the Administrator on 7/2/19 at 2:38 PM. The Administrator stated she was currently and has been the Grievance Official for the facility. The Administrator stated the process was she would receive the grievance, then assign the grievance, and give the assigned staff member the grievance. Upon completion of the grievance, the grievance would be returned to her. The Administrator reviewed Grievance #3 and stated the Nurse Supervisor and the dietary staff were looking for the cup, and the cup may have been found, or the cup may have been replaced. The Administrator stated the following had not been documented on the form: Summary of the grievance, Summary of findings, if the grievance was confirmed, Corrective actions, date the written decision was issued, or the signature of the grievance official. The Administrator stated it was her expectation for the resolution to be communicated to the resident or the interested party and the resolution to be documented on the grievance form and if the resident or family

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F 585	Continued From page 8 member desired a written copy, a copy would be provided.	F 585		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to air dry plastic plate lids, bowls and cups and failed to clean a thermometer prior to using it to check food temperatures. This had the potential to affect 87 of 87 residents. Findings included: 1. The dishwashing room was observed on 7/1/2019 at 11:45 AM. Dishwasher (DW) #1 was observed removing plate lids that had just been washed and sanitized from the dishwasher and wiping them off with a towel.	F 812	The domes, cups, glasses and plates were allowed to air dry following washing prior to the dinner meal on 7/1/19. 100% of thermometers were cleaned and sanitized prior to the next use by the Certified Dietary Manager or the Assistant Dietary Manager as of 7/1/19 An audit of dishes was completed by the Certified Dietary Manager as of 7/15/19 to ensure that all dishes showed no	7/15/19

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F 812	Continued From page 9 The dishwashing room was observed again on 7/1/2019 at 12:00 PM and DW #1 was observed using a towel to wipe water off plastic bowls and cups that were just washed and sanitized in the dishwasher. DW #1 was interviewed on 7/1/2019 at 11:45 AM and she reported she used a towel to wipe off plastic plate lids, plastic bowls and cups prior to air-drying. DW #1 reported the plastic dishes had a lot of water from the dishwasher and were very wet. The Dietary Manager (DM) was interviewed on 7/1/2019 at 2:10 PM and she reported the staff had been in-serviced on air drying dishware and DW #1 should not have used a towel to remove the excess water from the dishwasher on the plastic plate lids, bowls or cups. The DM reported it was her expectation all dishes would be air-dried prior to storage or use. The Administrator was interviewed on 7/2/219 at 4:10 PM and she reported it was her expectation the dishes were air-dried prior to use or storage. 2. The facility food service tray line was observed on 7/1/2019 at 12:26 PM. The Assistant Dietary Manager (ADM) was observed removing a thermometer from her pocket of her shirt from under her apron and she handed the thermometer to Cook #1 and told her to use that thermometer to obtain temperatures of the foods being served from the tray line. Cook #1 was observed to insert the thermometer provided by the ADM into foods on the tray line. Cook #1 did not clean or sanitize the thermometer prior to	F 812	evidence cloth drying and that air drying was occurring. 100% of food thermometers were audited by the Certified Dietary Manager as of 7/5/19 to ensure that they are clean. The Certified Dietary Manager was re-educated by the Administrator on the importance of allowing dishes to air dry and that they are not to be towel dried as well as the importance of cleaning thermometers prior to use. 100% of Dietary staff members were re-educated by the Dietary Manager as of 7/15/19 on the importance of allowing all dishes to air dry prior to use. 100% of Dietary staff including the Assistant Dietary Manager were re-educated by the Certified Dietary Manager as of 7/15/19 regarding the importance of cleaning and sanitizing thermometers prior to use. Dietary staff members unavailable for re-training will not be allowed to work until they receive the education. Newly hired Dietary staff will be educated at the time of hire on the importance of allowing dishes to air dry as well as the importance of cleaning and sanitizing thermometers prior to use. Effective 7/15/19 The Certified Dietary Manager or Assistant Dietary Manager will audit dishes to ensure air drying prior to use daily, Monday through Friday x two	

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F 812	Continued From page 10 inserting it into the food items. The ADM was interviewed on 7/1/2019 at 2:10 PM and she reported she thought she had cleaned off the thermometer before she handed it to Cook #1 for use. The Dietary Manager (DM) was interviewed on 7/1/2019 at 2:10 PM and reported it was her expectation the thermometers were cleaned prior to being used to check food temperatures. Cook #1 was interviewed on 7/2/2019 at 10:45 AM and she reported she had been nervous during the observation and thought ADM had cleaned the thermometer prior to handing it to her and Cook #1 had not thought to clean it prior to use. The Administrator was interviewed on 7/2/219 at 4:10 PM and she reported it was her expectation thermometers were cleaned prior to checking food temperatures.	F 812	weeks. These audits will continue weekly x two weeks, then monthly x 11 months. The Certified Dietary Manager will complete a random audit of thermometer use for one meal daily x one week, Monday through Friday to ensure that thermometers are cleaned and sanitized prior to use. These audits will then continue weekly x three weeks and then monthly x 11 months. The Certified Dietary Manager will compile a report on the findings of these audits for the Quality Assurance and Performance Improvement committee monthly x one year. The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary. The facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	