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 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted on 9/20/21. 22 of the 22 complaint allegations were not substantiated. A new tag was cited as a result of the complaint investigation survey that was conducted. The facility is still out of compliance. Event ID#QBPN12 and Event ID#Y2G711.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, family, and staff interviews, the facility failed to plug in an air mattress for one of one sampled resident (Resident #3) who had a history of pressure ulcers. and therefor was at high risk of recurrent pressure ulcers. Findings included: Resident #3 was admitted to the facility on 3/3/21.	F 686	This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate	10/7/21

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

Electronically Signed | 10/07/2021

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 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 1 The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 7/13/21 indicated Resident #3 had severe cognitive loss. The resident was coded as requiring extensive assistance of two people for Activities of Daily Living (ADLs) of one to two people for bed mobility, transfer (such as moving from the bed to a wheelchair), dressing, and toilet use. The resident did not have any pressure ulcers at the time of the assessment. Resident #3 was seen by the Nurse Practitioner on 9/8/21 and the resident was documented as having had warm and dry intact skin. Review of Resident #3 ' s electronic medical record (EMR) revealed a skin assessment dated 9/13/21, completed by Nurse #1, which documented the resident ' s skin was intact. An observation of Resident #3 ' s room was conducted on 9/14/21 at 9:24 AM. The observation revealed the resident ' s bed had an air mattress on the bed frame, with a pump hung on the footboard. The pump mechanism was observed to not have any indication of being on as evidenced by lights or making noise and the plug for the pump was discovered on the floor under the bed, not plugged into the outlet. The air mattress was felt to be soft and when pressed on pushed down indicating there was some type of foam supporting the mattress from completely deflating down to the bed frame. During an interview conducted on 9/14/21 at 9:49 AM with Resident #3 ' s nurse, Nurse #1, he stated the resident did not have any pressure ulcers.	F 686	the good faith attempts by the provider to improve the quality of life of each resident. F686 1. The unit coordinator immediately plugged in the mattress for resident #3 on 9/16/21 and assessed for proper function. 2. An observation round was conducted on 9/16/2021 on all air mattresses in the facility by the unit coordinators and all other air-mattresses were plugged in and functioning properly. 3. All nursing staff were re-educated by the Assistant Director of Nursing 10/6/2021 on recognizing proper function of an air mattress which includes ensuring the air mattresses are plugged in. 4. Unit Coordinators will assess for proper function and ensuring air mattresses are plugged in, this will be audited 5x weekly for 4 weeks, then 4x weekly for 4 weeks, and then 3x weekly for 4 weeks for a total of 3 months. 5. Data obtained during the observation rounds will be reviewed weekly by the Director of Nursing weekly until it is determined our plan of correction has been affective and the deficient practice corrected. The director of nursing or administrative nurse will complete a summary of these audit results. All results will be reported to Quality Assurance and Performance Improvement monthly x3 months to check for effectiveness.	

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 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 2 An interview was conducted with the private sitter for Resident #3 on 9/14/21 at 11:13 AM and she stated the resident ' s air mattress was not plugged in today and she could not remember when it was last plugged in. During an interview conducted on 9/14/21 at 9:49 AM with Resident #3 ' s Nursing Assistant (NA), NA# 1, she stated she did not believe the resident had any pressure ulcers. An interview with NA #1 was conducted in conjunction of an observation of Resident #3 ' s room on 9/15/21 at 8:22 AM. The observation revealed the air mattress remained unplugged with the plug under the bed, not plugged into the outlet. The NA stated the air mattress was not plugged in and should have been plugged into the outlet behind the resident ' s nightstand. The NA proceeded to plug the air mattress in, the pump lights turned on, and the mattress was observed to inflate. The NA stated she had not observed the pump to not have been plugged in because the mattress was soft, and it appeared to have been inflated. She stated she was unaware the mattress was not plugged in and was not inflated when she had assisted the resident out of bed that morning and removed the sheets. An interview was conducted on 9/15/21 at 9:17 AM with the wound nurse. The nurse stated Resident #3 did not have a pressure ulcer but had been admitted to the facility with a stage IV pressure ulcer to her coccyx, but it had resolved. She explained because the resident had a history of a pressure ulcer, the resident was at high risk for developing future pressure ulcers, and that was the reason the resident remained on an air mattress. She further stated for the mattress to	F 686	6. Person Responsible: Director of Nursing. Date of compliance: 10/11/2021	

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 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 3 work properly, the air mattress needed to be plugged in. An interview was conducted with the Director of Nursing (DON) in the presence of the Administrator on 9/15/21 at 12:00 PM. The DON stated if a resident had an air mattress then it should be plugged in at all times. She further stated she would review the importance of and making sure air mattresses are plugged in with the nursing staff during the next meeting with them.	F 686		