DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> </u>
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	COM	E SURVEY PLETED
		345183	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	04	/07/2018
				43	80 BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & REI	ТАВ		C	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FO	000			
		encies cited as a result of gation survey of 4/7/18.					
F 561	4/27/18. The 2567 w error was discovered Self-Determination	as amended because an at tag F697	F 5	61			5/1/18
SS=D	CFR(s): 483.10(f)(1)-	(3)(8)					5/1/10
	promote and facilitate through support of rea	right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f)					
	activities, schedules (waking times), health						
		ident has a right to make s of his or her life in the cant to the resident.					
	with members of the	ident has a right to interact community and participate in both inside and outside the					
	religious, and commu	ident has a right to ttivities, including social, inity activities that do not ts of other residents in the					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
Electroni	cally Signed						04/27/2018

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/24/2018 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	COMF	SURVEY PLETED
		345183	B. WING				C /07/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE & REI			4	30 BROOKWOOD AVENUE NE		
UNIVERSA				c	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	by: Based on observatio and staff interview, th	is not met as evidenced n, record review, resident facility failed to consider	F	561	The plan of correction constitutes a written allegation of compliance.		
	device for 1 of 23 res	for side rails or an alternative idents, Resident #33, who or repositioning in bed and om the bed.			Preparation and submission of this pla correction does not constitute an admission or agreement by the provic the truth of the facts alleged or the correction conclusion set forth on the statement of deficiencies. This plan of	ler of	
	Record Review for Rewas admitted to the fa	nuscles, major depressive			correction is prepared and submitted solely because of requirement under federal law, and to demonstrate the g faith attempts by the provider to contin to improve the quality of life of each resident.	ood	
	Annual Assessment of required limited assis extensive assistance bed and chair, eating assessment also reve limitation of range of extremities, and she is wheelchair for locomod	ealed Resident #33 had no motion on her upper or lower used a walker and otion. #33's most recent Quarterly			Root Cause Analysis Based on the root cause analysis by t administrative team and the facility Executive Director, it was determined the facility did not follow policy and procedure for providing an alternative the side rails for repositioning in bed a transfers. Immediate Action Resident #31 was screened by therap an appropriate repositioning in bed ar	that to and by for	
	1/24/18 revealed she with bed mobility, trar and chair, eating, and MDS Assessment als had no functional limi on her upper or lower walker and wheelcha A Side Rail Use and	MDS) Assessment dated required limited assistance asfers to and from the bed d toileting. The Quarterly so revealed Resident #33 tations of range of motion r extremities, and she used a ir for locomotion. Alternative Review Form ed Resident #33 desired to			transfer device on 4/20/18. A side rai and alternative review form was completed on 4/20/18 by the ADHS. Resident declined alternative. Identification of Others On 4/25/18 interviews were conducted with all alert and oriented residents to determine who may want an assistive devise to assist with transfers and repositioning in bed by members of th administrative team. If a need or reco	d	

Facility ID: 923114

STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			B NO. 0938-039 DATE SURVEY COMPLETED
			A. BUILDING	3		С
		345183	B. WING			04/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	θE	
UNIVERS	AL HEALTH CARE & RE	НАВ		430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 561	Continued From page	e 2	F 56	51		
	have her side rails ra assessment stated th indicated at this time, listed. The Side Rail Form also revealed F for positioning and th form lying down to sit position. On 4/3/18 at 3:11 pm Resident #33 she sta side rails and did not alternative when she back on her bed. Re the side rails for repo transferring to and fro wheelchair. During th demonstrated how sh assist her with transfe during the transfer ar keep her balance. On 4/4/18 at 2:26 pm Aide #4 revealed she rails were removed a anymore. She stated upset because they w they did not give ther On 4/4/18 at 2:29 pm revealed she was infor removed per corpora stated there were a co the smaller bars on th	ised while in bed. The ne side rails were not , but no alternative was Use and Alternative Review Resident #33 used side rails e side rails helped her to rise ting and/or standing during an interview with ted the facility removed her replace them or give her an requested they be placed sident #33 stated she used sitioning in bed and om her bed and electric ne interview Resident #33 ne would use the side rails to ers. She was unsteady and grasped the mattress to an interview with Nurse e didn't know why all the side nd they don't use them d several residents were vanted their side rails but		 was present a therapy screer conducted. No other resident identified. Systemic Changes Effective 4/27/18, 100% of st educated by the Assistant Din Nursing and/or the Executive Resident s Rights and Resid Choice. Any resident identifia an assistive device for reposit transfers will be addressed w alternative. A therapy screer conducted on all residents repositioning devices for reposit transfers. Any staff not educate be allowed to work until educeducation will be added to the process. Monitoring The Director of Nursing/Assis of Nursing/Unit Manager will during clinical meeting 5 days (Monday-Friday) that all new who request a side rail or posidevice or residents with chan will be assessed for the need repositioning and transfer demonitoring will be conducted 4weeks, then weekly x 4 wee monthly thereafter. Findings reported to monthly to the Qu Assurance Performance Impl (QAPI) committee for recommor or modification until a pattern compliance is achieved. 	ts were aff were rector of Director on dent⊡s ed requiring tioning and ith an o will be quiring tioning or ited will not ated. This e new hire stant Director monitor s per week admissions sitioning ge in mobility of vices. This daily for vices. This daily for vices and then will be iality rovement nendations	
	On 4/6/18 at 3:50 pm	an interview with the Nursing revealed it was a				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345183	B. WING				C 107/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & REF	IAB			30 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
	corporate decision to She stated the reside such as smaller mobil instead of regular side #33 parked her electr bed and used it to aid On 4/7/18 at 3:20 pm Administrator reveale facility would allow Re side rails if they wante safest solution. On 4/7/18 at 3:25 pm Director of Nursing re would be the resident the most appropriate to assist Resident #33 transfers. The Director facility would allow all the safest alternative Medicaid/Medicare Co CFR(s): 483.10(g)(17) \$483.10(g)(17) The fac (i) Inform each Medica writing, at the time of facility and when the to Medicaid of- (A) The items and ser nursing facility service for which the resident (B) Those other items facility offers and for v charged, and the and services; and (ii) Inform each Medica	remove all the side rails. Ints were given alternatives lity aids and trapeze bars e rails. She stated Resident ic wheelchair against the e in transferring. an interview with the d her expectation was the esident #33 an alternative to ed side rails and provide the an interview with the vealed her expectation s would be kept safe and intervention would be used b with bed mobility and or of Nursing stated the ernatives to side rails and should be used. overage/Liability Notice)(18)(i)-(v) acility must aid-eligible resident, in admission to the nursing resident becomes eligible for vices that are included in es under the State plan and		561			5/1/18

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345183	B. WING				C 07/2018
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
UNIVERSA	AL HEALTH CARE & REH	148			430 BROOKWOOD AVENUE NE		
					CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 582	specified in §483.10(g) section. §483.10(g)(18) The faresident before, or at periodically during the available in the facility services, including an covered under Medica facility's per diem rate (i) Where changes in and services covered Medicaid State plan, fanotice to residents of reasonably possible. (ii) Where changes are items and services the facility must inform the 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or est deposit or charges all per diem rate, for the resided or reserved o facility, regardless of discharge notice requi- (iv) The facility must r resident representative the resident within 30 date of discharge from (v) The terms of an ac behalf of an individua	g)(17)(i)(A) and (B) of this acility must inform each the time of admission, and e resident's stay, of services y and of charges for those y charges for services not are/ Medicaid or by the e. coverage are made to items by Medicare and/or by the the facility must provide the change as soon as is re made to charges for other at the facility offers, the e resident in writing at least mentation of the change. or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any ready paid, less the facility's days the resident actually r retained a bed in the any minimum stay or irements. efund to the resident or re any and all refunds due days from the resident's	F	582			
	by:	is not met as evidenced ew and staff interviews, the			F 582		

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		MEDICAID SERVICES				<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>'</i>		. ,	E SURVEY PLETED
			A. BUILDING	3		С
		345183	B. WING			/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				430 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & REI	HAB		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 500		-				
F 582			F 58			
		le facility residents with		Root Cause Analysis		
	CMS-10055 Skilled N			Based on the root cause		
		NFABN) prior to discharge		administrative staff and f	•	
		es for two of three residents		Director it was determine		
	-	e documentation (Resident		a lack of clear understan	-	
	#81 and #198).			regulatory requirement to		
	F irstlin and in all other de			Nursing Facility Advance	-	
	Findings included:			Notice (SNF ABN) prior t		
	1 Decident #01 we			Medicare part A services		
		as admitted to the facility on		who planned to remain in	the facility for	
	3/2/2018.	al record for Decident #01		long term care.		
		cal record for Resident #81		Immediate Action		
		23 NOMNC (Notice of		Advanced Beneficiary No for resident #81 and resident		
		ge) letter had been signed 3/19/2018. Therapy services		issued on 4/27/2018.	uenii #190 were	
		nd on 3/21/2018 for Resident		Identification of Others		
	#81.			On 4/24/18 a 100% audi	t of the last 30	
	#01.			days of discharges was of		
	A review of the chart	revealed a CMS-10055		Social Service Director to	•	
		en provided to Resident #81.		others who may have be		
				the alleged deficient Prac	-	
	The Administrator wa	is interviewed on 4/7/2018 at		Systemic Changes		
		ed the social worker was		On 4/24/18 education wa	as provided the	
		g the forms signed by the		Executive Director to the		
		ledicare services were going		Director regarding the re		
		worker had left for the day		requirements for issuing	• •	
		e for interview until 4/9/2018.		education included that r		
		ported it was her expectation		remain in the facility after		
		e used for residents when		services ended require a		
	their Medicare service	es ended.		Beginning 4/24/2018 the	•	
				Director will maintain a lo	og of resident who	
	The Social Worker (S	SW) was interviewed on		are discharged from Med	-	
		via phone call. The SW		services and plan to rem	ain in the facility	
		ponsible for submitting the		for long term care. On th	-	
		letter to residents when they		resident⊡s name, date N		
		n skilled services. She		discharge and the date the		
		was not aware a CMS-10055		provided. The log will be	-	
		ubmitted to the resident and		along with a copy of the		
	signed if the resident	was staying in the facility.		been provided to long ter	m care residents	1

Facility ID: 923114

If continuation sheet Page 6 of 45

(EACH DEFICIENC REGULATORY OR I Continued From page She concluded by rep	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	, ,	STREET ADDRESS, CITY, STATE, ZIP COL 3 STREET ADDRESS, CITY, STATE, ZIP COL 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE		E SURVEY IPLETED C 4/07/2018
SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	HAB ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	B. WING	STREET ADDRESS, CITY, STATE, ZIP COU 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO	DE ORRECTION IN SHOULD BE	4/07/2018 (X5)
SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	HAB ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP COL 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO	DE ORRECTION IN SHOULD BE	(X5)
SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	430 BROOKWOOD AVENUE NE CONCORD, NC 28025 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO	ORRECTION IN SHOULD BE	
SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page She concluded by rep	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	CONCORD, NC 28025 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO	N SHOULD BE	
(EACH DEFICIENC REGULATORY OR I Continued From page She concluded by rep	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTIO	N SHOULD BE	
She concluded by rep			DEFICIENCY)		DATE
	e 6	F 58	32		
SNFABN in the future rom skilled services. 2. Resident #198 w 1/4/2017. A review of the medic evealed a CMS 1012 signed by Resident # services were schedu Resident #198. A review of the chart SNFABN had not bee #198. The Administrator wa 1:43 PM. She reporte esponsible for getting esident when their M o end, but the social and was not available The Administrator rep he correct forms wer heir Medicare service the SW was interview ia phone call. The S esponsible for submit NOMNC letter to resid lischarged from skille eported she was not SNFABN was to be s	borting that she would submit NOMNC and CMS-10055 a for residents discharged vas admitted to the facility on cal record for Resident #198 23 NOMNC letter had been 198 on 1/9/2018. Therapy uled to end on 1/12/2018 for revealed a CMS-10055 en provided to the Resident s interviewed on 4/7/2018 at ed the social worker was g the forms signed by the ledicare services were going worker had left for the day e for interview until 4/9/2018. borted it was her expectation re used for residents when es ended. wed on 4/9/2018 at 9:20 AM SW reported she was itting the CMS 10123 dents when they were ed services. She further aware a CMS-10055 ubmitted to the resident and		Monitoring Beginning 4/24/18 the Execut (ED) of the facility will review Part A discharge binder week validate that the ABN has be to those long term residents Medicare Part A services ha The ED will sign the Medicar discharge log weekly for 4 we then monthly for 3 months. F be reported to the Quality As Performance Improvement ((committee for recommendati	v the Medicare kly and en provided who⊟s we ended. re Part A eeks and Findings will ssurance QAPI) ions or	
	. Resident #198 w 1/4/2017. review of the medic evealed a CMS 1012 igned by Resident # ervices were schedu tesident #198. review of the chart NFABN had not bee 198. he Administrator wa :43 PM. She reporte esponsible for gettin esident when their M o end, but the social nd was not available he Administrator rep ne correct forms wer neir Medicare service the SW was interview ia phone call. The S esponsible for subm IOMNC letter to resi ischarged from skille eported she was not NFABN was to be s igned if the resident the concluded by rep oth the CMS-10123 NFABN in the future	. Resident #198 was admitted to the facility on 1/4/2017. Treview of the medical record for Resident #198 evealed a CMS 10123 NOMNC letter had been igned by Resident #198 on 1/9/2018. Therapy ervices were scheduled to end on 1/12/2018 for tesident #198.	 Resident #198 was admitted to the facility on 1/4/2017. review of the medical record for Resident #198 evealed a CMS 10123 NOMNC letter had been igned by Resident #198 on 1/9/2018. Therapy ervices were scheduled to end on 1/12/2018 for tesident #198. review of the chart revealed a CMS-10055 iNFABN had not been provided to the Resident 198. the Administrator was interviewed on 4/7/2018 at 4:43 PM. She reported the social worker was esponsible for getting the forms signed by the esident when their Medicare services were going to end, but the social worker had left for the day nd was not available for interview until 4/9/2018. The Administrator reported it was her expectation he correct forms were used for residents when heir Medicare services. She further seponsible for submitting the CMS 10123 IOMNC letter to residents when they were ischarged from skilled services. She further seported she was not aware a CMS-10055 INFABN was to be submitted to the resident and igned if the resident was staying in the facility. the concluded by reporting that she would submit oth the CMS-10123 NOMNC and CMS-10055 INFABN in the future for residents discharged 	 Resident #198 was admitted to the facility on 1/4/2017. review of the medical record for Resident #198 evealed a CMS 10123 NOMNC letter had been growed by Resident #198 on 1/9/2018. Therapy ervices were scheduled to end on 1/12/2018 for tesident #198. review of the chart revealed a CMS-10055 NFABN had not been provided to the Resident 198. he Administrator was interviewed on 4/7/2018 at 2:43 PM. She reported the social worker was seponsible for getting the forms signed by the sident when their Medicare services were going o end, but the social worker had left for the day and was not available for interview until 4/9/2018. the Administrator reported it was her expectation he correct forms were used for residents when meir Medicare services. She further aported she was asponsible for submitting the CMS 10123 IOMNC letter to residents when they were ischarged from skilled services. She further aported she was not aware a CMS-10055 NFABN was to be submitted to the resident and igned if the resident was staying in the facility. he concluded by reporting that she would submit oth the CMS-10123 NOMNC and CMS-10055 NFABN in the future for residents discharged 	 Resident #198 was admitted to the facility on 1/4/2017. Resident #198 was admitted to the facility on 1/4/2017. Review of the medical record for Resident #198 evealed a CMS 10123 NOMNC letter had been gined by Resident #198 on 1/9/2018. Therapy ervices were scheduled to end on 1/12/2018 for tesident #198. Review of the chart revealed a CMS-10055 NFABN had not been provided to the Resident 198. he Administrator was interviewed on 4/7/2018 at 4:3 PM. She reported the social worker was asponsible for getting the forms signed by the social worker had left for the day and was not available for interview until 4/9/2018. The Administrator reported it was her expectation the Administrator reported it was her expectation the correct forms were used for residents when heir Medicare services ended. he SW was interviewed on 4/9/2018 at 9:20 AM ia phone call. The SW reported is was asponsible for submitting the CMS 10123 IOMNC Here residents when heir Medicare services show and are a CMS-10055 NFABN was to be submitted to the resident and igned if the resident was staying in the facility. The concluded by reporting that she would submit of the CMS-10123 NOMNC and CMS-10055 NFABN in the future for residents discharged for the facility. The concluded by reporting that she would submit to the resident and igned if the resident discharged for the discharged fo

Facility ID: 923114

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345183	B. WING				07/2018
	ROVIDER OR SUPPLIER	IAB	1	4	STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 585 SS=D	CFR(s): 483.10(j)(1)-4 §483.10(j) Grievance: §483.10(j)(1) The res grievances to the faci that hears grievances reprisal and without fe reprisal. Such grievar respect to care and tr furnished as well as th furnished, the behavior residents, and other of facility stay. §483.10(j)(2) The res facility must make pro- resolve grievances th accordance with this §483.10(j)(3) The faci on how to file a grieva to the resident. §483.10(j)(4) The faci grievance policy to er of all grievances rega contained in this para provider must give a to to the resident. The g include: (i) Notifying resident i postings in prominent facility of the right to f (meaning spoken) or grievances anonymou of the grievance offici can be filed, that is, h address (mailing and	s. ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination or heres include those with eatment which has been hat which has not been for of staff and of other concerns regarding their LTC ident has the right to and the ompt efforts by the facility to e resident may have, in paragraph. lity must make information ance or complaint available lity must establish a hsure the prompt resolution rding the residents' rights graph. Upon request, the copy of the grievance policy rievance policy must ndividually or through locations throughout the	F	585			5/1/18

Facility ID: 923114

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/24/2018 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345183	B. WING				C 07/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
	AL HEALTH CARE & REF	IAB		430 BROOKWOOD AVEN	UE NE		
				CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	to obtain a written dec grievance; and the co independent entities w be filed, that is, the pe Quality Improvement Agency and State Lor program or protection (ii) Identifying a Griew responsible for overse receiving and tracking conclusions; leading a by the facility; maintai information associate example, the identity grievances submitted written grievance dec coordinating with state necessary in light of s (iii) As necessary, tak prevent further potent right while the alleged investigated; (iv) Consistent with §4 reporting all alleged v abuse, including injur	of the grievance; the right cision regarding his or her ntact information of with whom grievances may ertinent State agency, Organization, State Survey ng-Term Care Ombudsman and advocacy system; ance Official who is eeing the grievance process, g grievances through to their any necessary investigations ning the confidentiality of all d with grievances, for of the resident for those anonymously, issuing isions to the resident; and e and federal agencies as specific allegations; ing immediate action to ial violations of any resident I violation is being 483.12(c)(1), immediately iolations involving neglect, ies of unknown source, on of resident property, by	F 58				
	provider, to the admin as required by State I (v) Ensuring that all w include the date the g summary statement o the steps taken to inv summary of the pertin regarding the resident as to whether the grie	istrator of the provider; and					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345183	B. WING			04/	_ 07/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
UNIVERS	AL HEALTH CARE & REF	IAB			30 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE					(X5) COMPLETION DATE
F 585	taken by the facility as and the date the writte (vi) Taking appropriate accordance with State of the residents' rights or if an outside entity the State Survey Age Organization, or local confirms a violation for rights within its area of (vii) Maintaining evide result of all grievance 3 years from the issue decision. This REQUIREMENT by: Based on record revis staff interviews the fa- grievance and failed to grievance summary for for grievances (Resid Findings include: Resident #48 was mod 6/1/17 and was origin with admission diagno Diabetes, Chronic Ob Disease (COPD), kidn generalized weakness Review of Resident # Data Set (MDS) reveat with an Assessment F 2/2/18. The resident v cognitively intact. The	s a result of the grievance, en decision was issued; e corrective action in e law if the alleged violation is is confirmed by the facility having jurisdiction, such as ncy, Quality Improvement law enforcement agency or any of these residents' of responsibility; and ence demonstrating the s for a period of no less than ance of the grievance " is not met as evidenced ew, resident interview, and cility failed to record a o provide a written or 1 of 4 residents reviewed ent #48). est recently readmitted on ally admitted on 11/18/16 oses which included: structive Pulmonary ney failure, heart failure, and s. 48's most recent Minimum aled a quarterly assessment Reference Date (ARD) of vas coded as having been e resident was coded as nations or delusions and did	F	585	F585 Grievances Root Cause Analysis Based on the root cause analysis by th facility administrative staff and the facil Executive Director, it was determined t the facility did not follow policy and procedure for executing a grievance. Immediate Action On 4/7/18 a grievance was filled out for resident #48. Identification of others On 4/9/18 Residents were educated or what a grievance is, how to file a grievance and what the process is duri Resident Council meeting. Systemic Changes Effective 4/27/18, 100% of staff was in-serviced on the grievance process. education was provided by Executive Director/ Assistant Director of Nursing. Grievances will be addressed in daily stand up meeting Monday through Frid to ensure department heads are aware	ity hat r ng Γhis	

Facility ID: 923114

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345183	B. WING _				C 4/07/2018
NAME OF P	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE	1 0	4/07/2010
	AL HEALTH CARE & RE	НАВ		43	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 585	An interview was cor	nducted with Resident #48 on	F 5	85	grievances filed. Any staff not educate will not be allowed to work until educa		
 4/3/18 at 3:33 PM. Resident #48 stated last month she had a carton of cigarettes come up as missing. The resident further stated she told a facility staff person and she had not received a response. An interview was conducted with Nurse #4 on 4/5/18 at 11:30 AM. The nurse stated Resident #48 had informed her of the allegation the resident was missing cigarettes. The nurse further stated she had informed the Social Worker and the Supervisor about the allegation. The nurse stated she may have completed a 				This education will also be added to t new hire process. Monitoring Effective 4/27/18, the Executive Direct will discuss grievances in daily stand	tor up		
		The nurse stated Resident r of the allegation the g cigarettes. The nurse d informed the Social ervisor about the allegation.			meeting Monday through Friday. The grievance log will be signed every we by the administrative team that is responsible for investigating and follo through with grievances. Grievances be monitored by the Executive Director This monitoring will be conducted dail	ek wing will or.	
	grievance form, but s An interview conduct (SW) on 4/5/18 at 11 been out sick for the	ted with the Social Worker :51 AM revealed she had month of March. The SW			weeks, then weeklyx4, then monthly thereafter. Findings will be reported i monthly Quality Assurance Performar Improvement (QAPI) committee for recommendations and modifications of	n the nce	
	prior to her being out The SW stated the A the grievances once month of March and to be in charge of the she did not recall a g regarding an allegatio	in charge of the grievances t sick for the month of March. dministrator had taken over she went out sick for the the Administrator continued e grievances. The SW stated irievance from Resident #48 on of missing cigarettes.			a pattern of compliance is achieved.		
	grievance log to verif not been logged for F missing cigarettes du had taken charge of	-					
	During an interview of Administrator on 4/5/ had not been reporte alleged she had miss received a grievance alleging she had miss						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345183	B. WING				C 107/2018	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSA	AL HEALTH CARE & REF	IAB			430 BROOKWOOD AVENUE NE CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 585	Continued From page	2 11	F	585	5			
	revealed no recorded	grievances since 10/1/17 grievances in regards to she was missing any items. onducted with the						
	was her expectation w informed about an all items, a grievance for it would be forwarded Administrator further	18 at 4:18 PM she stated it when a staff member was egation of a missing item or m would be completed and to the administrator. The stated in addition to the						
	of a missing item, a re the Health Care Regis Services (APS) would would be reported to ombudsman would be	l be notified, the allegation the police, and the e notified.						
F 660 SS=D			F	660			5/1/18	
	effective discharge pla on the resident's discl of residents to be acti transition them to pos reduction of factors le readmissions. The fac process must be cons rights set forth at 483 (i) Ensure that the dis resident are identified development of a disc resident. (ii) Include regular re- identify changes that	Plop and implement an anning process that focuses harge goals, the preparation ve partners and effectively t-discharge care, and the ading to preventable cility's discharge planning sistent with the discharge .15(b) as applicable and- charge needs of each and result in the						

Event ID: KOJ711

Facility ID: 923114

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
						(C
		345183	B. WING			04/	07/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & REH	IAB			30 BROOKWOOD AVENUE NE		
	1			C	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
TAG F 660	Continued From page updated, as needed, (iii) Involve the interdi by §483.21(b)(2)(ii), in developing the discha (iv) Consider caregive and the resident's or of person(s) capacity an required care, as part discharge needs. (v) Involve the resider representative in the discharge plan and in resident representative (vi) Address the resider treatment preferences (vii) Document that a about their interest in regarding returning to (A) If the resident indit to the community, the referrals to local conta appropriate entities m (B) Facilities must up comprehensive care p appropriate, in respor from referrals to local appropriate entities. (C) If discharge to the to not be feasible, the made the determinati (viii) For residents wh SNF or who are disch LTCH, assist resident representatives in sel provider by using data limited to SNF, HHA, patient assessment d	e 12 to reflect these changes. sciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support d capability to perform of the identification of it and resident development of the form the resident and re of the final plan. ent's goals of care and s. resident has been asked receiving information the community. cates an interest in returning facility must document any act agencies or other hade for this purpose. date a resident's of an and discharge plan, as has to information received contact agencies or other e community is determined facility must document who on and why. o are transferred to another harged to a HHA, IRF, or s and their resident ecting a post-acute care a that includes, but is not IRF, or LTCH standardized		660			

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DICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA 1DENTIFICATION NUMBER:			OMB NO. 0938-0	1 XU1
IDENTIFICATION NONDER.		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	001
345183	B. WING		-	
		STREET ADDRESS, CITY, STATE, ZIP CODE		
		430 BROOKWOOD AVENUE NE		
3		CONCORD, NC 28025		
MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETI	
3 e facility must ensure that dardized patient on quality measures, and relevant and applicable to are and treatment e on a timely basis based and include in the clinical i the resident's discharge an. The results of the ussed with the resident or e. All relevant resident orporated into the te its implementation and elays in the resident's a not met as evidenced or and staff interviews, the nt an effective discharge reviewed for discharge and #98). edmitted to the facility on es to include malignant obe, chronic obstructive tia. The admission S) assessment assessed act. (CAA) from the /4/2017 did not trigger for nity. ion MDS dated 8/4/2017 ion Q0400 "discharge or Question Q0600 "Has	F	F 660 Discharge Planning Process Root Cause Analysis Based on the root cause analysis by facility administrative staff and the fac Executive Director the facility did not follow policy and procedures for prov and updating discharge plans of care conjunction with the MDS section Q. Immediate Actions On 4/25/18, the MDS section Q was modified for residents #41 and #98. discharge plan of care was modified resident #41. Identification of Others Effective 4/27/18 an audit of the last days of section Q of the MDS and discharge care plans was conducted the Social Services Director to deterr others who may have been affected	cility ding in 'he for 30 by nine by	
vor 3 econna e ar an ar other of a conta a (//n icid	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) a facility must ensure that dardized patient in quality measures, and elevant and applicable to re and treatment on a timely basis based and include in the clinical the resident's discharge in. The results of the ssed with the resident or . All relevant resident rporated into the te its implementation and lays in the resident's not met as evidenced and staff interviews, the it an effective discharge reviewed for discharge and #98). dmitted to the facility on is to include malignant be, chronic obstructive tia. The admission assessment assessed ct. (CAA) from the 4/2017 did not trigger for nity. on MDS dated 8/4/2017	B. WING MENT OF DEFICIENCIES ID IST BE PRECEDED BY FULL PREFID DENTIFYING INFORMATION) TAG Active and the active and the active and the active and the active and applicable to re and treatment Feb on a timely basis based and include in the clinical the resident's discharge n. The results of the ssed with the resident or . All relevant resident reported into the e its implementation and lays in the resident's not met as evidenced and staff interviews, the the an effective discharge eviewed for discharge eviewed for discharge and #98). dmitted to the facility on is to include malignant be, chronic obstructive tia. The admission (CAA) from the 4/2017 did not trigger for hity. on MDS dated 8/4/2017 on Q0400 "discharge	345183 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 AENT OF DEFICIENCIES INT OF DEFICIENCY INT OF DEFICIENCY <tr< td=""><td>345183 B. WING C 345183 STREET ADDRESS, CITY, STATE, ZIP CODE 39 BROOKWOOD AVENUE NE CONCORD, NC 28025 MENT OF DEFICIENCIES IST BE PRECEIPED BY FULL DENTIFYING INFORMATION) DD PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT DEFICIENCY If a cality must ensure that Jardized patient in quality measures, and elevant and applicable to re and treatment F 660 F 660 If a cality must ensure that Jardized patient in quality measures, and elevant and applicable to re and treatment F 660 F 660 If a cality measures, and elevant and applicable to re and treatment F 660 State Revision DEFICIENCY Comment DEFICIENCY If a cality must ensure that Jardized patient in quality measures, and elevant and applicable to re and treatment F 660 State Revision DEFICIENCY Comment DEFICIENCY If a cality administration and lays in the resident's in the resident's is o include malignant be, chronic obstructive ita. The admission) assessment assessed ct. F 660 Discharge Planning Process Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director the facility di not follow policy and procedures for providing and updating discharge plans of care in conjunction with the MDS section Q. Immediate Actions On 4/25/18, the MDS section Q. Immediate Actions On 4/25/18, the MDS section Q. Immediate Actions of Others Effective 4/27/18 an audit of the last 30 discharge care plans was conducted by the Social Services Director to determine others Who may have been affected</td></tr<>	345183 B. WING C 345183 STREET ADDRESS, CITY, STATE, ZIP CODE 39 BROOKWOOD AVENUE NE CONCORD, NC 28025 MENT OF DEFICIENCIES IST BE PRECEIPED BY FULL DENTIFYING INFORMATION) DD PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT DEFICIENCY If a cality must ensure that Jardized patient in quality measures, and elevant and applicable to re and treatment F 660 F 660 If a cality must ensure that Jardized patient in quality measures, and elevant and applicable to re and treatment F 660 F 660 If a cality measures, and elevant and applicable to re and treatment F 660 State Revision DEFICIENCY Comment DEFICIENCY If a cality must ensure that Jardized patient in quality measures, and elevant and applicable to re and treatment F 660 State Revision DEFICIENCY Comment DEFICIENCY If a cality administration and lays in the resident's in the resident's is o include malignant be, chronic obstructive ita. The admission) assessment assessed ct. F 660 Discharge Planning Process Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director the facility di not follow policy and procedures for providing and updating discharge plans of care in conjunction with the MDS section Q. Immediate Actions On 4/25/18, the MDS section Q. Immediate Actions On 4/25/18, the MDS section Q. Immediate Actions of Others Effective 4/27/18 an audit of the last 30 discharge care plans was conducted by the Social Services Director to determine others Who may have been affected

Facility ID: 923114

-		ID HUMAN SERVICES			FOR	D: 05/24/2018 MAPPROVED O. 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED C
		345183	B. WING		04	
NAME OF PROVIDER OR SU	JPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSAL HEALTH C	ARE & RE	IAB		30 BROOKWOOD AVENUE NE CONCORD, NC 28025		
PREFIX (EACI	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
agency?" wA care planthe problem"(Residentpossibly bewith intervermeeting toneeds; asscommunityThe resider8/23/2017 vservices" whandwrittermember). OA nursing mand the notmember ' shim.A handwrittWorker (SVhealthcareindicated thCabarrus OThe care p11/23/2017(long-termThe resider12/16/2017services" d	een made vas answe dated 8/1 n statemer #41) want moved cli- entions to i discuss (R ist (Reside resources nt care pla was review as rev	to the local contact red 0-no. 1/2017 was reviewed and at was documented as is to return to the community, oser to (family member)" include "schedule a family resident #41 ' s) discharge ont #41) with obtaining for discharge." nning conference dated yed. The section "social ed and revealed a ssible move to (family with care plan." 8/29/2017 was reviewed inted Resident #41 ' s family move Resident #41 closer to ated 10/5/2017 by the Social ented communication with a om Ohio and the SW ' would need to call the partment of Social Services. handwritten note dated tt #41) will be LTC	F 660	were identified. Systemic Changes On 4/24/18 education was prov Executive Director to the Social Director regarding the regulator requirements for Section Q of th and discharge care planning. T Services Director was educated initiating a discharge plan of ca as continued updates to said pl needed. Monitoring Beginning 4/24/18 the Executiv will review audit of new admissi discharge care plans and Section the MDS accuracy weekly x 4 v monthly for 3 months. Findings reported to the Quality Assuran Performance Improvement (QA committee for recommendation modifications until pattern of co is achieved.	I Service y he MDS The Social d on re as well an as e Director ions for on Q on veeks, then s will be ce .PI) s and	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345183	B. WING				07/2018
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE & REF	IAB			430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 660	was reviewed and quiplan" was answered a referral been made agency?" was answered a referral been made agency?" was answered the most recent quart dated 1/25/2018 assesses everely cognitively in required extensive on bed mobility, transferst total assistance with p bathing. Resident #41 without staff assistance with p bathing. Resident #41 without staff assistance with p bathing. Resident #41 's famil move closer to him, b on a regular basis with had spoken to him, bu conversations and was specifics of the conversations and was specifics of the conversations and was specifics of the conversation and was specific as a no longer employ. The Administrator was no longer employ nurse who documented and was specific as a no longer employ nurse who documented as the handwritten note was no longer employ. The Administrate conversation that care was no longer employ nurse who documented as the handwritten note was no longer employ. The Administrate conversation that care was no longer employ nurse who documented as the handwritten note was no longer employ. The Administrate conversation t	terly MDS dated 12/22/2017 estion Q0400 "discharge 1-yes. Question Q0600 "Has to the local contact red 0-no. terly MDS assessment essed the resident to be mpaired. The resident re-person assistance with s, dressing, toileting and bersonal hygiene and 1 was unable to balance ce. ducted with the SW on The SW reported that y member wanted him to ut had not communicated h SW. The SW reported she ut had not documented the as unable to recall the ersations. wed on 4/7/2018 at 11:56 t she was not certain why was not transcribed into the tion system. s interviewed on 4/7/2018 at d the nurse who plan in November 2017 yed with the facility, and the ed the nursing note in longer employed with the ator reported it was her	F	660			

Facility ID: 923114

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345183	B. WING				C 07/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
UNIVERS	AL HEALTH CARE & REH	IAB			430 BROOKWOOD AVENUE NE		
	· · · · · · · · · · · · · · · · · · ·			(CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 660	Continued From page	9 16	F	660			
		s admitted to the facility on s for Resident #98 included walking and muscle					
	identified the care are the goal to "achieve of interventions to interv	n care plan dated 10/3/2017 ea "discharge planning" with lischarge as planned" and iew resident, make post nts and referrals as needed.					
	10/10/2017 assessed cognitively intact and one-person assistanc locomotion, dressing,	she required extensive					
		sment from the admission I7 did not trigger discharge					
		lans for Resident #98 in place for discharge					
	"discharge plan" was	wed and question Q0400 answered 1-yes. Question I been made to the local					
	social services dated documented a friend was unable to care fo discharged home. Th	al record revealed a note by 11/28/2017 that of Resident #98 stated she r Resident #98 if she was e note further documented a occupational therapist (OT)					

Facility ID: 923114

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY LETED
		345183	B. WING				07/2018
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE & REF	IAB			I30 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 660	living care for Resider walking and toileting. intent to have further #98 regarding dischard A social service note of reviewed and reveale conversation with Res resident stated she w The SW documented of Resident #98 that of not be able to care for discharged home. The Protection Services (A intention of Resident and medical advice (AMA communicate if Resident the note documented from the facility AMA. An interview was com- 4/7/2018 at 2:09 PM. not started a care plat #98 because she had initiating the discharg reported Resident #96 finances and did not w The Administrator was 2:42 PM. The Administ expectation that care updated and reviewed	sident #98. The SW had recommended assisted int #98 due to difficulties with The note documented SW discussions with Resident rge from the facility. dated 12/29/2017 was d the SW had a sident #98 in which the as going to return home. a conversation with a friend disclosed the friend would r Resident #98 if she was he SW contacted Adult APS) and communicated the #98 to return home against) and APS instructed SW to ent #98 left the facility. 1/2/2018 was reviewed and Resident #98 's discharge ducted with the SW on The SW reported she had in for discharge for Resident in ot been in the habit of e care plan. SW further 8 had concerns regarding want to apply for Medicaid. s interviewed on 4/7/2018 at strator reported it was her	F	660			
F 677	for the residents. ADL Care Provided for	or Dependent Residents	F	677			5/1/18

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		0.15400			С
		345183			04/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE & RE	НАВ		430 BROOKWOOD AVENUE NE CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET
F 677	Continued From page	e 18	F 677	7	
SS=D					
	out activities of daily services to maintain g personal and oral hyg This REQUIREMENT by: Based on observation facility failed to provide residents reviewed for (ADLs) (Resident #16 The findings included Resident #16 was ad 12/6/12 with diagnose Alzheimer's disease, dysphagia (difficulty se Review of Resident # Data Set (MDS) reve with an Assessment I 1/8/18 revealed the re severely impaired. T extensive or total stat of daily living.	 is not met as evidenced is not met as evidenced ins and staff interviews the de nail care to 1 of 3 or Activities of Daily Living or Activities of Daily Living b). i: mitted to the facility on es which included: generalized weakness, and swallowing). it fo's most recent Minimum aled a quarterly assessment Reference Date (ARD) of esident's cognition was he resident required ff assistance for all activities 		F 677 ADL Care Root Cause Analysis Based on the root cause analysis b facility administrative staff and the f Executive Director the facility did no follow policy and procedure for prov ADL care for a dependent resident Immediate Actions On 4/7/2018 resident #16 finger na were cleaned and trimmed. Identification of others All residents are at risk for the defice practice therefore an on 4/25/18 a audit was conducted on the condition the resident finger nails. Any residen identified with needing nails cleaned trimmed. Systemic Changes Effective 4/27/2018 the Director of	acility ot viding ils cient 100% on of ents d or nd
	most recently review resident was care pla extensive assistance resident would not in own related to demen resident were for the participate in part of A	t16's care plan which was ed on 1/11/18 revealed the inned as having required for all ADLs due to the itiate or follow through on her ntia. The goals listed for the resident to be able to ADLs as able and the her personal care needs met the next review. The		Nursing / Assistant Director of Nurs review 5 resident s finger nails to ve condition of finger nails in daily clin meeting 5 days per week (Monday Friday) Findings will be documente the daily clinical rounds report form filed in a binder in the Director of N office. If any finger nails identified in needing care, the administrative nu will follow up with the assigned staf	erify ical d on and ursing n irses

Facility ID: 923114

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	CONSTRUCTION		O. 0938-03 E SURVEY
ND PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COM	IPLETED
							С
		345183	B. WING			04	/07/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & RE	НАВ			30 BROOKWOOD AVENUE NE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 677	Continued From page	e 19	F 6	77			
		resident with bathing and one			Effective 4/27/2018 100% of nursing s		
	_ · ·	tensive assistance with			was in-serviced on providing nail care	for	
	bathing, dressing, an	iu grooming.			a depended resident during showers, bathing ADL care and as needed. The	2	
	An observation cond	ucted on 4/3/18 at 12:19 PM			education was provided by the Directo		
	revealed Resident #1	16's fingernails extended			nursing/ Assistant Director of Nursing,		
		s on all five fingers on each			staff not educated will not be allowed t		
		nails on each hand were			work until education is completed. This		
	each nail.	lebris under the free edge of			education will be added to the new him	е	
					process for new nursing staff. Monitoring		
	An observation cond	ucted on 4/5/18 at 11:13 AM			Effective 4/27/2018 the Director of Hea	alth	
	revealed Resident #1			Services/Assistant Director of Health			
		s on all five fingers on each			Services, and or Unit Manager will rev		
	-	nails on each hand were			clinical report sheet daily during clinica		
	observed with dark d each nail.	lebris under the free edge of			meeting (Monday Friday) to identify residents needing nail care. This	any	
					monitoring process will be continued b	W	
	An interview was cor	npleted with Nursing			the charges on Saturday and Sunday.	•	
	Assistant (NA) #6 wh				This monitoring will be conducted daily		
		ent #16 was conducted on			weeks, then weekly x4weeks, then		
		Resident #16's fingernails			monthly thereafter. Findings will be		
		beyond her fingertips on all			reported in the monthly Quality Assura Performance Improvement (QAPI)	ince	
		ark debris remained under nail on each of the resident's			committee for recommendations or		
		NA stated Resident #16 was			modifications until a pattern of complia	ince	
		nd she had provided morning			is achieved.		
		which had included washing					
		pper body, and administering					
		e NA also stated she had					
		with breakfast. The NA					
		urday, it was Thursday so the					
		y had been scheduled for the					
	day before.						
	An observation cond	ucted on 4/6/18 at 11:31 AM					
		16's fingernails extended					
	beyond her fingertips	s on all five fingers on each					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/24/2018 1 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345183	B. WING		_	(04/0	; 07/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
UNIVERSA	L HEALTH CARE & REH	IAB		430 BROOKWOOD AVENU	IE NE		
				CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page		F 677	7			
		ails on each hand were bris under the free edge of					
	4/6/18 at 11:43 AM. F remained extended by ten fingers and the da the free edge of the n ten fingernails. The N	le conducting an ent #16 was conducted on Resident #16's fingernails eyond her fingertips on all irk debris remained under ail on each of the resident's IA stated Resident #16 was					
	fingernails did appear	The NA stated the resident's to have dark matter under ingers and the resident's eaned and trimmed.					
	revealed Resident #1 beyond her fingertips hand. All five fingerna	acted on 4/7/18 at 11:48 AM 6's fingernails extended on all five fingers on each ails on each hand were abris under the free edge of					
	while conducting an of was conducted on 4/7 #16's fingernails were extended beyond her and the dark debris re of the nail on each of fingernails. The DON expectation for the re- kept shorter and clear	stated it was her sidents' fingernails to be n.					
F 692 SS=D	Nutrition/Hydration St CFR(s): 483.25(g)(1)-		F 692	2			5/1/18
	§483.25(g) Assisted r	nutrition and hydration.					

Facility ID: 923114

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345183	B. WING			04/	C 07/2018
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0112010
				4	30 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & REH	IAB		c	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 692	(Includes naso-gastric both percutaneous err percutaneous endosc enteral fluids). Based comprehensive asses ensure that a residen §483.25(g)(1) Maintai of nutritional status, s desirable body weigh balance, unless the re demonstrates that this preferences indicate of §483.25(g)(2) Is offer maintain proper hydra §483.25(g)(3) Is offer there is a nutritional p provider orders a ther This REQUIREMENT by: Based on observatio interviews the facility interventions for a res- identified as having h 1 of 4 residents review #16). The findings included Resident #16 was add 12/6/12 with diagnose Alzheimer's disease, dysphagia (difficulty s Review of Resident # Data Set (MDS) revea	c and gastrostomy tubes, adoscopic gastrostomy and copic jejunostomy, and d on a resident's ssment, the facility must t- ins acceptable parameters uch as usual body weight or t range and electrolyte esident's clinical condition is is not possible or resident otherwise; ed sufficient fluid intake to ation and health; ed a therapeutic diet when problem and the health care rapeutic diet. is not met as evidenced ins, record review, and staff failed to put into place sident as having been ad significant weight loss for wed for nutrition (Resident : mitted to the facility on es which included: generalized weakness, and wallowing). 16's most recent Minimum aled a quarterly assessment	F	692	F 692 Nutrition/Hydration Status Root Cause Analysis Based on the root cause analysis by th facility Administrative staff and the facil executive director the facility did not fo policy and procedure by failing to put interventions in place for a resident ha been identified with significant weight I Immediate Action On April 11, 2018 the Dietitian was not and the resident was placed on Med P 2.0, 120ml by mouth four times per day Identification of Others All residents are at risk for the deficient practice therefore a 100 percent audity completed by the Dietary manager on	ity llow ving oss. ified ass /. t was	
	12/6/12 with diagnose Alzheimer's disease, dysphagia (difficulty s Review of Resident # Data Set (MDS) revea	es which included: generalized weakness, and wallowing). 16's most recent Minimum			On April 11, 2018 the Dietitian was not and the resident was placed on Med P 2.0, 120ml by mouth four times per day Identification of Others All residents are at risk for the deficient practice therefore a 100 percent audit	ass /. t was	

Event ID: KOJ711

Facility ID: 923114

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED
						С
		345183	B. WING			04/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				430 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & RE	HAB		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 692	Continued From page	- <u>22</u>	F 69	2		
1 092			F 09		aignificant	
	severely impaired. T	esident's cognition was		to identify any residents with weight loss. If any resident w	•	
		ff assistance for all activities		with significant weight loss a		
		ng extensive assistance of		was put in place and placed		
		. The resident was coded		the dietitian to see on her ne		
	as having been 65 in	ches tall and weighed 119		Systemic Changes		
	-	t was coded as having been		Effective April 27, 2018 The	•	
	on a therapeutic diet.			Manager will review weekly a	•	
	Deview of Desident #	40 cla sere plan which was		weights to identify any reside		
		416's care plan which was ed on 1/11/18 revealed the		significant weight loss. The c manager will place those res	-	
		inned as having had a risk		identified on the weekly stan		
		status due to the resident		list to be reviewed by the ID		
		c diet. The care plan also		weekly standards of care me		
		dent received small portions		discuss interventions to put i	-	
		ell as not wanting to gain		residents will be placed on th	ne Dietitian⊡s	
	U U	e need section documented		list to review during her next		
		erous food preferences and		management will notified the		
		preakfast at times. The goal		Nurse Practitioner to inform		
		nt would tolerate diet as		and approve interventions su		
		i-100% most meals and eight changes through the		Effective 4/27/2018 the Dieta was in-serviced by the exect		
		The approaches listed		to report any residents identi		
		Dietitian to follow up with the		significant loss to the Dietitia		
		encourage resident to		director, and Nurse manager		
	consume 75-100% of	f most meals, provide small		weekly/monthly to ensure int	erventions	
		dent request, and provide a		are put in place to prevent fu	-	
	heartier 10 AM snack	ς.		loss or to maintain weight. E		
				identified must be placed on	•	
		16's recorded weights in her		standards of care meeting lis	st and the	
	following weights: 5/2	ecord (EMR) revealed the		Dietitian list for review. Effective April 27, 2018 100%	6 of nursing	
		, 7/16/17-132.0 pounds,		staff was in-serviced to repo		
		s, 8/15/17-123.2 pounds,		residents intake or the abili		
	-	s, 9/14/17-118.0 pounds,		or any weight changes to nu	•	
		s, 10/8/17-120.8 pounds,		administration as soon as ide	-	
	10/20/17-118.9 pound	ds, 11/9/17-118.9 pounds,		Licensed staff to place on 24		
		s, 12/27/17-118.9 pounds,		sheet. Nursing administration		
	1/2/18-118 6 nounds	2/1/18-118.2 pounds,		24 hour report sheet daily du	iring clinical	

Facility ID: 923114

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		ND HUMAN SERVICES				RM APPROVE NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345183	B. WING			C 04/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
	AL HEALTH CARE & RE			430 BROOKWOOD AVENUE NE		
				CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 692	3/15/18-108.0 pound 8.6% in one month), 3/30/18-106.0 pound Review of Resident # revealed an order da milliliters (ml) of nutrit three times for weigh a regular consistency and the resident was portions at meal per to request. Review of Resident # (RD) notes revealed dated 12/27/17. The resident was seen du continue the resident salt, small portions, a three times a day.	s (a significant weight loss of 3/21/18-107.0 pounds, s, and 4/2/18 106.0 pounds. 416's physicians' orders ted 8/18/17 to give 120 tional supplement orally t loss. The resident was on v diet, with no added salt, ordered to receive small	F 6	 92 rounds. This education was p the Director of Nursing/ Assis of Nursing, any staff not educ be allowed to work until educa education will also be added thire process. Monitoring Effective April 28, 2018 the Di Nursing/ Assistant Director of Unit Manager will review the 2 report to identify any residents intake, decrease in the ability and weight changes during da meeting 5 days per week (Mo Friday). This Monitoring will the by the Charge nurses on Satu Sundays. The Dietary manager will more /monthly weights to identify re- significant weight loss and ve- intervention is put in place. The monitoring will be conducted weeks, then weekly x4 weeks 	tant Director ated will not ated. This to the new rector of Nursing / 24 hour s with poor to feed self aily clinical inday be continued urdays and hitor weekly esidents with rify an his daily x4	
	documented, the residuring the weekly we resident's weight was The note documented recommendations an Review of Resident # revealed the following nurse attempted to ca (RP) of Resident #16 resident's 11 pound v The nurse left a mess nurse.	ident's weight was discussed hight meeting and the s found to have been stable. d to continue with dietary d monthly weights. 416's Departmental Notes g: 3/23/18 at 2:58 PM, the all the Responsible Party		monthly thereafter. Findings v reported monthly to the Qualit Performance Improvement (C committee for recommendatio modifications until a pattern o is achieved.	vill be ty Assurance API) ons or	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345183	B. WING				C 07/2018
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
UNIVERS	AL HEALTH CARE & REH	IAB			430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	RP returned call and #16's weight loss. Th having voiced no con An interview was con at 11:15 AM. The NA resident #16 with brea at about 50% of her b she was aware the re- supplement. An observation or Re- conducted on 4/5/18 was being assisted w resident was observe her lunch. An interview was con at 1:19 PM. The NA been eating well. The inform the nurse the r 25% of her meal. An interview was con at 11:49 AM. The NA ability to feed herself stated she used to be months ago and in the condition staff member with feeding. A phone interview was Registered Dietitian (The RD stated she was #16 and was not awa experienced a 10.2 pr from February 1, 2015 had continued to have	made aware of Resident he RP was documented as cerns. ducted with NA #6 on 4/5/18 a stated she had assisted akfast and the resident had oreakfast. The NA stated isident received a nutritional sident #16 eating lunch was at 1:04 PM. The resident ith lunch by NA #6. The d to eat less than 25% of ducted with NA #6 on 4/5/18 stated Resident #16 had not e NA stated she would resident had at less than ducted with NA#7 on 4/6/18 a stated Resident #16's had declined. The NA e able to feed herself about 3 e resident's current ers had to assist the resident s conducted with the RD) on 4/7/18 at 2:33 PM. as not familiar with Resident	F	692	2		

Facility ID: 923114

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345183	B. WING				C 07/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & REH	IAB			30 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	stated she was unabl as to why the residen to not having familiar stated she was going 4/11/18 and she woul eating, place the resid review her meal intak her nutritional supplet stated after she had r intake, and weight loss intervention to put inter resident's weight loss the facility on 4/3/18 a resident's weight loss review the resident for An interview was con Nursing (DON) on 4/7 stated she was aware loss. The DON stated switched to weekly we was identified. The re discussed in the Inter meeting. The DON s small portion size req staff members had for regarding their request DON stated the small on the resident's diet dietary was responsib the RD to review whe The DON stated she not see the resident w on 4/3/18. An interview was con 4/7/18 at 3:54 PM. The expectation when a response	e to comment on the reason t was on small portions due with Resident #16. The RD to be at the facility on d observe the resident dent on weekly weights, e percentages, and review ment percentages. The RD eviewed the resident, her as she would determine what o place to address the . The RD stated she was at and had not reviewed the nor had she been asked to r weight loss. ducted with the Director Of 7/18 2:58 PM. The DON e of Resident #16's weight d Resident #16 was eights when the weight loss esident's weight loss was Departmental Team (IDT) tated the IDT discussed the uest by the family but no llowed up with the family st for small portion size. The portion size had remained orders. The DON stated ole for the list of residents for n she comes to the facility. did not know why the RD did when she was at the facility ducted with the DON on he DON stated it was her	F	692			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE SUF COMPLET C	
		345183	B. WING				。 07/2018
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE & REI	HAB		4	30 BROOKWOOD AVENUE NE		
				C	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 692	put into place. An interview was con Administrator on 4/7/ Administrator stated i RD to see a resident	rage weight gain would be ducted with the 18 at 4:31 PM. The t was her expectation for the	F	692			
F 697 SS=D		cant weight loss to increase	F	697			5/1/18
	provided to residents consistent with profes the comprehensive p and the residents' goa	ure that pain management is who require such services, ssional standards of practice, erson-centered care plan,					
	Based on record revi interview the facility fa pain in addition to the Instrument in 2 of 3 re #89, reviewed for pain Findings included:				F697 Pain Management Root Cause Analysis Based on root cause analysis by the facility administrative staff and the executive director the facility did not fol policy and procedure to asses each resident for pain each shift. Immediate Action		
	#15 was admitted to t diagnoses of Neuropa frequent falls. He had Fentanyl Patch 24 mi one patch and Fentar patch every three day	al record revealed Resident the facility on 8/18/16 with athic Pain, weakness, and d a physician's orders for crograms per hour (mcg/hr) nyl Patch 12 mcg/hr one /s for pain. He also had a Tramadol 50 milligrams (mg) n.			On April 9, 2018 pain assessment was placed on the MAR for resident # 15 ar resident # 89. Identification of Others All residents are at risk for the deficient practice therefore on April 9, 2018 a 10 audit was conducted to verify that each resident had pain assessment every sh on the medication administration record	nd t 00% n nift	

Event ID: KOJ711

Facility ID: 923114

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/24/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345183	B. WING		C 04/07/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE
UNIVERS	AL HEALTH CARE & RE	НАВ		430 BROOKWOOD AVENUE NE CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED	
F 697	Continued From page	e 27	F 69	-	tified the pain
	Set (MDS) Assessme 8/25/17 revealed he was independent with toileting. The assess pain at 6 on a scale of occasionally in pain. Review of the most re Data Set (MDS) Asse dated 1/8/18 revealed and was independent and toileting. The as his pain at 4 on scale occasionally in pain. Review of Resident # 1/12/18 revealed care presence of pain in ri to recent fractures" a to 4 or less." Review of the Nurse' 4/1/18 revealed one in addressed pain for R Nurses Note stated, ' at times and schedule effectiveness."	ecent Quarterly Minimum essment for Resident #15 d he was cognitively intact t with bed mobility, transfers, sessment stated he rated of 1-10 and he was e14's Care Plan dated e plan of "Experiencing the ght lower extremity related nd "a goal of decreased pain s Notes from 2/7/18 to note on 4/1/18 that esident #15. The 4/1/18 'resident complains of pain ed meds given with some		For reach resident idem assessment each shift of medication administration Systemic Changes Effective 4/27/2018 the Nursing/ Assistant Direct Unit Manager will review and 5 residents to verify assessment every shift Medication administration documentation is comp clinical meetings 5 days (Monday □ Friday). Find documented on the clin and filed in a clinical meet Effective 4/27/2018 100 nursing staff was in-ser pain assessment Q shift medication administration new admissions and to shift on new and curren education was provided Nursing/ Assistant Direct Any staff not educated to work until educated. be added to the new hir new licensed nurses. Monitoring The Director of Nursing Director of Nursing/Unit monitor daily during clin days per week (Monday new admissions and cu have pain assessment of medication administration documentation is comp	was placed on the on record. Director of ctor of Nursing/ w new admissions y that pain is placed on the on record and that lete during daily s per week dings will be ical rounds forms betting binder 0% of licensed viced on placing t on the on record on all document every t residents. This l by the Director of ctor of Nursing. will not be allowed This education will re process for all / Assistant : Manager will hical meeting 5 y- Friday) that all rrent residents every shift on the on record and that
		8 at 4:30 pm with the Nursing revealed pain ot done on the residents, but		monitoring process will Charge Nurses on Satu This monitoring will be o	irday and Sunday.

Facility ID: 923114

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/24/2018 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345183	B. WING				C 07/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & REH	IAB					
				С	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	28	F	697			
	the nurses chart in the resident's pain. An interview on 4/7/18 revealed that the nurs rate pain unless the re- needed pain medicati documents in her Nur had a bad pain day. On 4/7/18 at 2:00 pm Director of Nursing re- document in the nurse signs of distress or co- scale is used for prn p pain medication) whe medication or has nor stated they do not rou	e notes regarding the 8 at 1:44 pm with Nurse #1 ses do not have anywhere to esident receives a PRN (as on). She stated she rses Note when the resident			weeks, then weekly x4 weeks and ther monthly thereafter. Findings will be reported monthly to the Quality Assura Performance Improvement (QAPI) committee for recommendations or modification until a pattern of compliant is achieved.	nce	
	diagnoses of history of Diabetes, right above Depressive Disorder, Disease, and difficulty physician's orders rew physician's orders for mouth each night at b 3/25/18) and Acetami every 6 hours as need 3/25/18). A review of the most n Minimum Data Set (N dated 2/20/18 revealed cognitively intact; he n with moving about in	y swallowing. Review of the yealed Resident #89 had Gabapentin 300 mg by bedtime for pain (ordered nophen 325 mg 2 tablets ded for pain (ordered recent comprehensive IDS) Admission Assessment					

Facility ID: 923114

If continuation sheet Page 29 of 45

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345183	B. WING				C /07/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE & REH			4	430 BROOKWOOD AVENUE NE		
ONTERO				C	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	5 days prior to the as: Review of Resident # revealed he was care pain due to recent rig was resident would he of 3 or less throughou Review of the physici Resident #89 had phy Gabapentin 300 millig night at bedtime for p Acetaminophen 325 r every 6 hours as need 3/25/18). Review of Nurse's Nor revealed Resident #8 or discomfort" docum days reviewed. There pain assessment on 4 Review of Resident # Administration Record there was no docume or as needed pain me Interview on 4/5/18 at revealed his hips hurt spoke with the nurse do anything about it. On 4/5/18 at 4:39 pm Aide #5 revealed Resi ask for pain medicatio tell when he is in pain	orst on scale of 1-10 over the sessment date. 89's Care Plan for 2/23/18 planned for, "Complaints of ht hip fracture" and "the goal ave a decreased pain goal at his daily activities." an's orders revealed ysician's orders for grams (mg) by mouth each ain (ordered 3/25/18) and milligrams (mg) 2 tablets ded for pain (ordered bets from 3/25/18 to 4/5/18 9 had "no complaints of pain ented in 9 days of the 12 e was no documentation of 4/3/18, 3/29/18, or 3/28/18. 89's Medication d for April 2018 revealed entation of pain being rated edications given. t 4:34 pm with Resident #89 thim all the time and he about his pain but they don't an interview with Nurse sident #89 usually doesn't on but she states she can h.	F	697			
	On 4/5/18 at 4:39 pm Aide #5 revealed Res ask for pain medication tell when he is in pain	ident #89 usually doesn't on but she states she can					

If continuation sheet Page 30 of 45

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345183	B. WING				C 07/2018
NAME OF PF	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE & REF	IAB			0 BROOKWOOD AVENUE NE DNCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	she could document to shift. She stated there electronic documental scale. She stated she tell us that he was hun On 4/7/18 at 2:00 pm Director of Nursing re document in the nurse signs of distress or dia having pain. She also used for as needed por resident asks for pain pain. She stated the ask the residents to ra ask for pain medication On 4/7/18 at 3:18 pm Administrator reveale	how if there was a place that hat she assessed pain each e was no place on their tion that asks for a pain e hoped Resident #89 would rting but he is very quiet. an interview with the vealed the nurses should e's notes when they see any scomfort that the resident is o stated the pain scale is ain medications when the or has nonverbal signs of facility does not routinely ate their pain unless they on. an interview with the d her expectation was that uld be assessed every shift ed pain medication.	F 6	97			
F 710 SS=D	Director of Nursing re the residents' pain sh shift, with any indicati with any as needed p the assessment shou needed pain medicati Resident's Care Supe CFR(s): 483.30(a)(1)(vealed her expectation was ould be assessed every on a resident is in pain, and ain medications. She stated ld not be limited to as ons. ervised by a Physician (2)	F 7	10			5/1/18
	recommendation that	sonally approve in writing a an individual be admitted to ent must remain under the					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345183	B. WING				C 07/2018
NAME OF PI	ROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				4	30 BROOKWOOD AVENUE NE		
UNIVERSI	AL HEALTH CARE & REH	1AD		c	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 710	assistant, nurse pract specialist must provid immediate care and r §483.30(a) Physician The facility must ensu §483.30(a)(1) The me is supervised by a ph §483.30(a)(2) Anothe medical care of reside physician is unavailat This REQUIREMENT by: Based on record revi facility failed to have a resident as having be significant weight loss reviewed for nutrition The findings included Resident #16 was add 12/6/12 with diagnose Alzheimer's disease, dysphagia (difficulty s Review of Resident # Data Set (MDS) revea with an Assessment F 1/8/18 revealed the re severely impaired. Th extensive or total staf of daily living, includir one person for eating as having been 65 inc	 itioner, or clinical nurse le orders for the resident's needs. Supervision. ure that- edical care of each resident ysician; er physician supervises the ents when their attending ble. is not met as evidenced iew and staff interviews the a physician evaluate a sen identified as having had as for 1 of 4 residents (Resident #16). : mitted to the facility on es which included: generalized weakness, and swallowing). et 6's most recent Minimum aled a quarterly assessment Reference Date (ARD) of esident's cognition was 	F	710	F710 Resident s Care Supervised by Physician Root Cause Analysis Based on root cause analysis by the facility administrative staff and the Executive Director it was determined th facility failed to follow policy and procedure for notification of physician resident having significant weight loss. Immediate Action On 4/7/18 Telephone order was obtain for Fortified shake at all meals on 4/11 a telephone order was obtained for Me Pass 2.0 120mls four times per day. C 4/20/18 Physician assessed resident # for significant weight loss. Identification of Others All residents are at risk for deficient practice therefore 100% audit was completed by the Dietary Manager on resident monthly and weekly weights to identify any residents with significant weight loss. If any residents were	ne of a ed /18 ed Dn :16	
PRÉFIX TAG	(EACH DEFICIENC REGULATORY OR I REGULATORY OR I Continued From page assistant, nurse pract specialist must provid immediate care and r §483.30(a) Physician The facility must ensu §483.30(a)(1) The me is supervised by a ph §483.30(a)(2) Anothe medical care of reside physician is unavailat This REQUIREMENT by: Based on record revi facility failed to have a resident as having be significant weight loss reviewed for nutrition The findings included Resident #16 was add 12/6/12 with diagnose Alzheimer's disease, dysphagia (difficulty s Review of Resident # Data Set (MDS) revea with an Assessment F 1/8/18 revealed the re severely impaired. Th extensive or total staf of daily living, includir one person for eating as having been 65 inc	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) a 31 ditioner, or clinical nurse le orders for the resident's needs. Supervision. ure that- edical care of each resident ysician; or physician supervises the ents when their attending ole. is not met as evidenced few and staff interviews the a physician evaluate a ten identified as having had s for 1 of 4 residents (Resident #16). : mitted to the facility on es which included: generalized weakness, and swallowing). 16's most recent Minimum aled a quarterly assessment Reference Date (ARD) of esident's cognition was he resident required f assistance for all activities ng extensive assistance of . The resident was coded ches tall and weighed 119 t was coded as having been	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) F710 Resident □ s Care Supervised by Physician Root Cause Analysis Based on root cause analysis by the facility administrative staff and the Executive Director it was determined th facility failed to follow policy and procedure for notification of physician resident having significant weight loss. Immediate Action On 4/7/18 Telephone order was obtain for Fortified shake at all meals on 4/11 a telephone order was obtained for Me Pass 2.0 120mls four times per day. O 4/20/18 Physician assessed resident # for significant weight loss. Identification of Others All residents are at risk for deficient practice therefore 100% audit was completed by the Dietary Manager on resident monthly and weekly weights t identify any residents with significant	r a ne of a ed /18 ed Dn f16	COM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIE		ONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	MPLETED
				<u> </u>			С
		345183	B. WING			04/07/2018	
NAME OF PF	ROVIDER OR SUPPLIER		-	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 *	
				430	BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & REI	НАВ		CO	NCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 710	Continued From page	e 32	F 71	10			
					requisition for the Physician /NP to se	e	
	Review of Resident #	16's care plan which was			them on their next visit would be initial		
		ed on 1/11/18 revealed the		•	The nurse would also document the		
	•	inned as having had a risk			request for the Physician/NP to see th	е	
		status due to the resident			residents identified.		
	•	c diet. The care plan also			Systemic Changes		
		dent received small portions			Effective April 27, 2018 The Dietary	i	
		ell as not wanting to gain e need section documented			Manager was educated by the Execut Director to review weekly and monthly		
	-	erous food preferences and			weights to identify any residents with		
		preakfast at times. The goal			significant weight loss. The dietary		
		nt would tolerate diet as			manager will place those residents		
	ordered, consume 75	-100% most meals and		i	identified on the weekly standards of o	are	
	-	eight changes through the			list to be reviewed by the IDT during the	ne	
	next review period. T				weekly standards of care meeting to		
	•	Dietitian to follow up with the			discuss interventions to put in place an	nd	
	resident as needed, e	f most meals, provide small			the nurse management will notify the Physician/ Nurse Practitioner to inform	of	
		dent request, and provide a			significant weight loss.	101	
	heartier 10 AM snack				Effective April 27, 2018 100% of nursi	na	
					staff was in-serviced to report a declin	-	
	Review of Resident #	16's recorded weights in her			resident⊡s intake or the ability to feed		
		ecord (EMR) revealed the		(or any weight changes to nursing		
	following weights: 5/2				administration as soon as identified.		
	•	, 7/16/17-132.0 pounds,			Licensed staff is to place on 24 hour		
		s, 8/15/17-123.2 pounds,			report sheet. Nursing administration is	s to	
	-	s, 9/14/17-118.0 pounds, s, 10/8/17-120.8 pounds,			review the 24 hour report sheet daily, Monday through Friday, during daily		
	•	ds, 11/9/17-118.9 pounds,			clinical rounds. This education was		
		s, 12/27/17-118.9 pounds,			provided by the Director of Nursing/		
	•	2/1/18-118.2 pounds,			Assistant Director of Nursing. Any stat	ff	
		s (a significant weight loss of			not educated will not be allowed to wo		
		3/21/18-107.0 pounds,			until education is completed. This		
	3/30/18-106.0 pounds	s, and 4/2/18 106.0 pounds.			education will also be added to the ne	W	
	_				hire process.		
		16's physicians' orders			Monitoring		
		ted 8/18/17 to give 120 tional supplement orally			Effective April 28, 2018 the Director of Nursing/ Assistant Director of Nursing		
	munimers (mi) of nufrit	nonal supplement orally	1	1	NUTSION ASSISTANT LIFACTOR OF NUTSION	1	1

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE S	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPL	
					C	;
		345183	B. WING	B. WING		7/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
UNIVERS	AL HEALTH CARE & REH	IAB		430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 710	Continued From page	• 33	F 71	0		
	a regular consistency and the resident was portions at meal per t request. Review of Resident # (RD) notes revealed t dated 12/27/17. The resident was seen du continue the resident" salt, small portions, a three times a day. Review of Resident # the most recent note documented, the resid during the weekly wei resident's weight was The note documented recommendations and Review of Resident # notes revealed the ph visit was 3/9/18. The resident's nutritional s progress note. Review of Resident # revealed the following nurse attempted to ca (RP) of Resident #16 resident's 11 pound w The nurse left a mess nurse. Review of Resident #	diet, with no added salt, ordered to receive small he resident's family's 16's Registered Dietitian he most recent note was note documented the e to supplement use and to s current diet of no added nd nutritional supplement 16's dietary notes revealed was dated 1/4/18 which dent's weight was discussed ght meeting and the found to have been stable. I to continue with dietary d monthly weights. 16's physician progress sysician's last documented re was no mention of the status or weight loss in the 16's Departmental Notes g: 3/23/18 at 2:58 PM, the all the Responsible Party to inform her of the reight loss in three months. sage for the RP to call the 16's Departmental Notes g: 3/23/18 at 3:38 PM, the		report to identify any reside intake, decrease in the abi and weight changes during meeting 5 days per week (Friday). Findings will be do the daily clinical rounds for binder in the Director of Nu This monitoring will continu Sunday by the Charge Nu manager will monitor week weights to identify resident significant weight loss and Physician/NP are notified a documentation completed. monitoring will be conducted weeks, then weekly x4 we monthly thereafter. Finding reported monthly to the Qu Performance Improvement committee for recommend modifications until a patter is achieved.	lity to feed self g daily clinical Monday □ boumented on m and filed in a ursing office. ue Saturday and rse. The Dietary dy /monthly ts with verify the and This ed daily x4 eks, then gs will be uality Assurance t (QAPI) ations or	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345183	B. WING				07/2018
NAME OF PF	ROVIDER OR SUPPLIER	I		:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
UNIVERSA	AL HEALTH CARE & REP	IAB			430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 710	at 11:15 AM. The NA resident #16 with brea at about 50% of her b she was aware the re- supplement. An observation or Re- conducted on 4/5/18 was being assisted w resident was observe her lunch. An interview was con at 1:19 PM. The NA been eating well. The inform the nurse the r 25% of her meal. An interview was con at 11:49 AM. The NA ability to feed herself stated she used to be months ago and in the condition staff member with feeding. A phone interview wa Registered Dietitian (The RD stated she was #16 and was not awa experienced a 10.2 p from February 1, 2013 had continued to have through 3/30/18 of an	cerns. ducted with NA #6 on 4/5/18 a stated she had assisted akfast and the resident had breakfast. The NA stated asident received a nutritional sident #16 eating lunch was at 1:04 PM. The resident ith lunch by NA #6. The d to eat less than 25% of ducted with NA #6 on 4/5/18 stated Resident #16 had not e NA stated she would resident had at less than ducted with NA#7 on 4/6/18 a stated Resident #16's had declined. The NA e able to feed herself about 3 e resident's current ers had to assist the resident s conducted with the RD) on 4/7/18 at 2:33 PM. as not familiar with Resident re the resident had ound or 8.6% weight loss 8 to March 15, 2018 and e weight loss from 3/15/18 iother 2 pounds. The RD	F	710			
	stated she was unabl	e to comment on the reason t was on small portions due					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345183	B. WING				C 07/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & REF	IAB			430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE
F 710	to not having familiar stated she was going 4/11/18 and she would eating, place the resid review her meal intake her nutritional suppler stated after she had m intake, and weight loss intervention to put into resident's weight loss the facility on 4/3/18 a resident's weight loss review the resident for An interview was com Nursing (DON) on 4/7 stated she was aware loss. The DON stated switched to weekly we was identified. The re discussed in the Inter meeting. The DON st small portion size req staff members had fol regarding their reques DON stated the small on the resident's diet dietary was responsib the RD to review whe The DON stated she w not see the resident w on 4/3/18. An interview was com 4/7/18 at 3:54 PM. Th #16 was last seen by The DON stated the r	with Resident #16. The RD to be at the facility on d observe the resident dent on weekly weights, e percentages, and review ment percentages. The RD eviewed the resident, her as she would determine what o place to address the . The RD stated she was at and had not reviewed the nor had she been asked to r weight loss. ducted with the Director Of 7/18 2:58 PM. The DON e of Resident #16's weight d Resident #16's weight d Resident #16's was Departmental Team (IDT) tated the IDT discussed the uest by the family but no llowed up with the family st for small portion size. The portion size had remained orders. The DON stated ble for the list of residents for n she comes to the facility. did not know why the RD did when she was at the facility ducted with the DON on he DON stated Resident her physician on 3/9/18. esident had not been seen her significant weight loss	F	710			

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>			E SURVEY PLETED
		345183	B. WING			C / 07/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE & REF	IAB		430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 710 F 759 SS=D	resident's significant y on 3/15/18. The DON been in the facility sin had been discovered. was her expectation y a significant weight lo would actively encour put into place. An interview was com Administrator on 4/7/7 Administrator stated in resident's physician to further interventions y identified as having ha- increase or maintain the Free of Medication En- CFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ensu §483.45(f)(1) Medication The facility must ensu §483.45(f) Medication facility must ensu §483.45(f) Medication facility must ensu §483.45(f) Medicati	weight loss was discovered A stated the physician had ce the resident's weight loss The DON further stated it when a resident experienced ss an intervention which age weight gain would be ducted with the 18 at 4:31 PM. The t was her expectation for the to see a resident and explore when a resident has been ad significant weight loss to the resident's weight. ror Rts 5 Prcnt or More a Errors. Irre that its- tion error rates are not 5 T is not met as evidenced In, record review and staff failed to maintain a of less than 5% as cation error rate of 7.14% (2 tunities) (Resident #88). physician orders were prescribed Vitamin D3 5000 lated 2/5/2018. The	F 7		by the red the rration. ained s from	5/1/18

Event ID: KOJ711

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/24/2018 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		TE SURVEY MPLETED
		345183	B. WING			o	C 4/07/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & REI	HAB			30 BROOKWOOD AVENUE NE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759	 (eMAR) was reviewed was documented as a A medication adminis 4/6/2018 at 8:43 AM (MT) #1. The Vitamin Resident #88. MT #1 was interviewed She searched the store only Vitamin D3 in the stree only Vitamin D3 1000 the medication card ft D3, but was unable to reported that she though the vitamin, but she medications that medications that medications that medications that medications were administrator wa 2:42 PM. She reported medications were administrator was 2:42 PM. She reported and he was micrograms 2 sprays 4/5/2018. A medication administrator of Russing A medication administrator was a sprays 4/5/2018. A medication administrator was a sprays 4/6/2018 at 8:43 AM administered to Resident was a sprays 4/6/2018 at 8:43 AM administered to Resident the resident of the resident the resident of the resident the resident to Resident to	d and Vitamin D3 5000 units administered on 4/6/2018. tration was observed on with Medication Technician D3 was not administered to ed on 4/6/2018 at 9:32 AM. cked medications for ength 5000 units, but found 0 u. She then searched for or the resident with Vitamin o locate the medication. She ught she had administered must have been mistaken. ng (DON) was interviewed M. She reported it was her dications were administered nd professional standards. s interviewed on 4/7/2018 at ed it was her expectation that ministered correctly. physician orders were prescribed Flonase 50 each nostril daily dated tration was observed on with MT #1. Flonase was dent #88, 1 spray each	F	759	until medication is received from pharmacy for resident #75. On April 6 2018 the medication aide was re-educated on administrating medications as ordered. Identification of Others All residents are at risk for the deficie practice therefore on April 23, 2018 th Medication Aides and licensed nurses were re-educated on administering medications as ordered. Systemic Changes Effective April 27, 2018 100% of licen nurses and medication aides were in-serviced on the five rights of medic administration, make sure medication are available and do not document medications as given when medication order to hold the medication until ava from Pharmacy. All medications must administered as ordered. This educate was provided by the Assistant Directo Nursing. Any staff not educated will n allowed to work until educated. Any s not educated will not be allowed to we until educated. This education will als added to the new hire process. Monitoring Effective April 27, 2018 medication administration will be observed by the Director of Nursing/ Assistant Directo Nursing. Unit Manager and / Pharmac	nt he s sed cation is on is cian if han ilable be tion or of ot be taff ork o be r of cy.	
	A medication administration was observed on 4/6/2018 at 8:43 AM with MT #1. Flonase was administered to Resident #88, 1 spray each				medications as ordered. Systemic Changes Effective April 27, 2018 100% of licen nurses and medication aides were in-serviced on the five rights of medica administration, make sure medication are available and do not document medications as given when medication not available. Nurse is to notify physic a medication is not available to obtain order to hold the medication until ava from Pharmacy. All medications must administered as ordered. This educated was provided by the Assistant Director Nursing. Any staff not educated will n allowed to work until educated. Any s not educated will not be allowed to we until educated. This education will als added to the new hire process. Monitoring Effective April 27, 2018 medication administration will be observed by the Director of Nursing/ Assistant Director Nursing/ Unit Manager and / Pharmac Observation will consist of ensuring medications are being administered a	eation is on is cian if an ilable be ion or of ot be taff ork o be r of cy.	

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/24/2018 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	D.		CONSTRUCTION	(X3) DATE COMF	TE SURVEY MPLETED	
		345183	B. WING				C /07/2018	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
	AL HEALTH CARE & RE			43	30 BROOKWOOD AVENUE NE			
UNIVERS				С	ONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 759	Continued From page	- 38	Í F	759				
	nostril.			100	weekly x4 weeks, then monthly therea	ofter		
					Findings will be reported to the Quality			
	The DON was intervi	ewed on 4/6/2018 at 9:39			Assurance Performance Improvement	t		
		vas her expectations that			(QAPI) committee for recommendation	าร		
		ministered according to			and modifications until a pattern of			
	orders and profession				compliance is achieved.			
	2:42 PM. She reporte	is interviewed on 4/7/2018 at ad it was her expectation that						
F 000	medications were add	•	-				5/4/40	
F 880 SS=D	Infection Prevention & CFR(s): 483.80(a)(1)			880			5/1/18	
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable						
	§483.80(a) Infection	prevention and control						
	program.							
		blish an infection prevention						
	and control program a minimum, the follow	(IPCP) that must include, at						
		ving elements.						
	§483.80(a)(1) A syste	em for preventing, identifying,						
	reporting, investigatir	ng, and controlling infections						
		iseases for all residents,						
		ors, and other individuals						
	providing services un	ider a contractual ipon the facility assessment						
		to §483.70(e) and following						
	accepted national sta							
		n standards, policies, and ogram, which must include,						
		ogram, which must moluue,						
L								

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	05/24/2018 APPROVED	
STATEMENT OF DEFICIENCIES (X1) P		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345183	B. WING			_		C 07/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
	AL HEALTH CARE & REF	IAR		43	30 BROOKWOOD AVENU	ENE			
				С	ONCORD, NC 28025				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	possible communicabi infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and durat depending upon the in involved, and (B) A requirement that least restrictive possibilit circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste- identified under the fat corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will conduct	lance designed to identify le diseases or can spread to other in possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to: tion of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable in lesions from direct or their food, if direct ne disease; and procedures to be followed ect resident contact. m for recording incidents cility's IPCP and the en by the facility. e, store, process, and to prevent the spread of	F	880					

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/24/2018 FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345183	B. WING		C 04/07/2018	
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & RE	НАВ		30 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 880	by: Based on record rev interviews, the facility signage for enteric pr residents reviewed fo (Resident #197) and administering nasal s hand hygiene after and 1 of 1 residents obse administration (Resid Findings included: 1. The facility 's Int Control Program poli- reviewed. The policy categories of transmi and airborne; transm be utilized in addition when the route of tra- interrupted by using s The Center for Disea specifies that the Clo infection is caused by hand sanitizer and ha water is required. A sign for contact pre-	F is not met as evidenced iew, observations and staff railed to display correct recautions for 1 of 1 or contact precautions failed to use gloves when apray medication or perform dministering nasal spray for rved for medication lent #88).	F 880	F 880 Infection Control Root Cause Analysis Based on root cause analysis by the facility administrative staff and the faci executive director it was determined th the facility failed to follow policy and procedure for infection control. Immediate On April 6, 2018 the correct signage for enteric precautions was placed on the door for resident # 197. The Med aide administering medications to resident a was in-serviced on wearing gloves whi performing invasive procedures during medication pass and proper hand washing with observation doing medication pass . The education was provided by the Assistant Director of Health Services/Infection Control Nurs Identification of Others All residents are at risk for the potentia risk so therefore no other residents we identified with a diagnosis of c-diff requiring enteric precautions. All nursin staff will be re-educated on placing the correct signage for transmission precautions and proper handwashing technique. Systemic Changes	at vr # 88 le a e. l re ng	
	AM. The sign did not precautions to be use Instructions on the co "perform hand hygier and after exiting". The Infection Preven			Effective April 27, 2018 the Director of Nursing/ Assistant Director of Nursing/ Manager will review 24 hour report to s if any resident was admitted with or ha new diagnosis of c-diff requiring enteri precautions or any other diagnosis requiring transmission precaution and verify the correct signage is posted on	Unit see s a c	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/24/20 FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFICIENCIES (2 AND PLAN OF CORRECTION				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345183	B. WING		C 04/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
UNIVERS	AL HEALTH CARE & RE	НАВ		430 BROOKWOOD AVENUE NE CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 880	F 880Continued From page 41signage for review. Noted on the sign was instructions stated to "perform hand hygiene before entering room and wash hands with soap and water before leaving room".Resident #197 was admitted to the facility on 3/30/2018 with diagnoses to include chronic obstructive pulmonary disease, enterocolitis due to Clostridium difficile (c. dif) and muscle weakness.The physician orders were reviewed and an order for contact isolation for c. dif was dated 3/30/2018.A baseline care plan dated 3/30/2018 noted isolation for c. dif.A nursing note dated 3/31/2018 documented the c. dif infection and contact precautions in place.Nurse #4 was interviewed on 4/3/2018 at 9:22 AM. She reported the resident was under contact		F 88	 resident s door. This more completed 5 days per wee meeting (Monday Friday this meeting will be docum clinical meeting form and f meeting binder. The Assistant Director of FUnit Manager will observe members per week during administration and while per a resident for proper handwer technique and wearing glo invasive procedures during administration. Effective April 27, 2018 10 staff was in-serviced on er proper signage is posted for precautions, proper handwer soap and water after proving resident with a diagnosis of wear gloves during an invasion administration. 	k during Clinical /). Findings of iented on the iled in a clinical Health Services / 10 nursing staff medication roviding care for washing ves during g medication 0% nursing nsuring the or transmission vashing with ding care to a of c-diff, must asive procedure tration and and after
	state hand washing w required when a resid An interview was cor 4/5/2018 at 2:14 PM. when a resident was reviewed and if admi contact precautions, gather the equipmen sign on the door to th unable to list the diffe and was unable to st	cautions and was unable to with soap and water was dent had a diagnosis of c. dif. nducted with Nurse #1 on . The nurse reported admitted, the orders were ssion orders specified the admitting nurse would t and place a precautions he resident ' s room. She was erent types of precautions ate hand washing with soap red when a resident had a		 provided by the Director of Assistant Director of Nursii members not educated wil to work until education is of education will also be adde hire process for all nursing Monitoring Effective April 27, 2018 the Nursing/ Assistant Director Unit manager will review of sheet daily during clinical r per Week (Monday Grida residents requiring transmit precautions and ensure the signage is posted. The Dir 	ng. Any staff I not be allowed completed. This ed to the new I staff. e Director of r of Nursing/ linical report meeting 5 days ay) to identify ission e correct

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/24/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345183	B. WING				C 07/2018
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				43	30 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & REH	IAB		с	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
TAG F 880	Continued From page Nurse #2 was intervie PM. She was unable precautions and was washing with soap and a resident had a diage Nurse #3 was intervie She was unable to lis precautions and was washing with soap and a resident had a diage An interview was con- assistant (NA) #2 on 4 #2 reported she did in between contact prec- sign and followed the NA #3 was interviewe reported she read the the resident. Nurse #5 was intervie PM. She could state of and the difference be and enteric precaution must be washed with exiting the resident 's The infection control in 4/6/2018 at 3:08 PM. antibiotic steward for responsible for trackin She reported she was had a contact precaution	e 42 wed on 4/5/2018 at 2:25 to list the different types of unable to state hand d water was required when hosis of c. dif. wed on 4/5/2018 4:06 PM. t the different types of unable to state hand d water was required when hosis of c. dif. ducted with nursing 4/7/2018 at 10:32 AM. NA ot know the difference autions, but she read the directions on the sign. d at the same time, and she sign to know what to do for wed on 4/7/2018 at 12:33 different types of precautions tween contact precautions tween contact precautions tween contact precautions tween contact precautions to a not a interviewed on She reported she was the the facility and was ng infections in the facility. a not aware Resident #197 ion sign in place and not a		880		Unit r a ring ing vy cted	DATE

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345183	B. WING				C 107/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERSAL HEALTH CARE & REHAB					430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	on 4/7/2018 at 12:49 expectation that the c signs were displayed good understanding c precautions. The Administrator war 2:42 PM. She reporter the correct signage w type of contact precau 2. A review of staff I dated 1/18/2018 and technician (MT) #1 inc completed hand wash A handwashing valida signed by MT #1 indic with handwashing and alcohol-based hand s Resident #88 was add 2/5/2018 with diagnos (low oxygen), cerebra The admission Minim 2/12/2018 assessed t cognitively impaired. Resident #88 ' s phys and he was prescribe sprays each nostril da A medication adminis 4/6/2018 at 8:43 AM. administer to Resident #	PM. She reported it was her correct contact precaution and that all staff have a of the different types of s interviewed on 4/7/2018 at d it was her expectation that as used for each different utions. handwashing check off signed by Medication dicated MT #1 had hing to meet requirements. ation dated 1/24/2018 and cated she was competent d hand hygiene with anitizer. mitted to the facility on ses to include hypoxemia al palsy and difficulty walking. um Data Set (MDS) dated the resident to be severely ician orders were reviewed d Flonase 50 micrograms 2	F	880			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345183	B. WING				C /07/2018
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 •	
UNIVERSAL HEALTH CARE & REHAB					430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 880	unlocked the mechan nasal spray tip into Re MT then attempted to but found the medical spray. She removed Resident #88 's nose spray, then reinserted administered the medical spray in each nostril. medication administration cart. She did not perfor proceeded to use her medication administration drawer to the medical hand hygiene. MT#1 was interviewer She reported she usu the medication cart, b morning. She reported she did not wear glov administration or why hygiene. The DON was intervie PM. She reported it w used gloves during ad that required gloves a performed before and administration. The Administrator was	he removed the spray and ism, then reinserted the esident #88 ' s nose. The administer the nasal spray, tion needed to be primed to the nasal spray tip from a and primed the nasal d the nasal spray and lication to Resident #88, one MT #1 completed her ation and returned to the form hand hygiene. MT #1 computer to start the next ation. MT #1 opened the tions without performing d on 4/6/2018 at 9:12 AM. hally kept hand sanitizer on but had forgotten it this ed she was not certain why es for the medication she did not perform hand ewed on 4/7/2018 at 12:49 vas her expectation the staff dministration of medications ind that hand hygiene was a fafter all medication s interviewed on 4/7/2018 at d it was her expectation	F	880			

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