	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245402					С
		345183	B. WING			06	5/11/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & R	ЕНАВ			30 BROOKWOOD AVENUE NE CONCORD, NC 28025		
	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 677 SS=D		ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)		677			6/18/18
	out activities of daily services to maintain personal and oral h This REQUIREMEN by: Based on observation interviews and reco provide Activity of D providing showers f reviewed who requi (Resident #6 and R resident for reviewer bed (Resident #8). Findings included: 1. Resident #6 was facility on 2/14/18. to a hospital on 5/28/ diagnoses included Obstructive Pulmon (infection) of the rig Review of the Minima assessments for Re assessment with an (ARD) of 4/20/18. F revealed the resider cognitively intact. T having had rejection assessment period. having required exti- members for bed m a bed to a chair), dr	AT is not met as evidenced ions, resident interviews, staff rd reviews the facility failed to paily Living (ADL) care by not or 2 out of 5 residents red assistance with showers esident #8) and assist 1 of 1 ed for transfers into and out of a originally admitted to the The resident was discharged D/18 and was most recently 18. The resident's admission : Pneumonia, Chronic iary Disease, and cellulitis			This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provide the truth of the facts alleged or the correction conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under federal law, and to demonstrate the go faith attempts by the provider to continue to improve the quality of life of each resident. Root Cause Analysis: Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined the staff did not follow the facility policy with regards to providing showers per reside preferences. Immediate Action: On 6/13/18 Resident # 6 was given a shower and his preferences regarding shower days and times were updated. On 6/11/18 Resident #8 was given a shower and her preferences regarding shower days and times were updated.	er of od ue hat h	
	I DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

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.

06/21/2018

			()(0)				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345183	B. WING			(
		345163	B. WING			06/	11/2018
NAME OF PI	ROVIDER OR SUPPLIER						
UNIVERS	AL HEALTH CARE & REH	НАВ			0 BROOKWOOD AVENUE NE DNCORD, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 677	Continued From page	- 1	F 67	77			
		ohysical help in part of	1.07	1	Identification of others:		
		e person. The resident was			Effective 6/18/18 interviews were		
	coded as having had			conducted with all alert and oriented			
	U			residents to determine preferred show	er		
	Review of Resident # been most recently re			dates and times.			
	resident had problem	/need areas which included:			All newly admitted or re-admitted		
		of ADLs related to (R/T)			residents will be interviewed regarding		
		ia. A quarterly review note			their preferences at the time of admiss	ion.	
		ented the resident needed					
		with ADLs and required total functional quadriplegia. An			Systemic Changes:		
	approach listed for the			Effective 6/18/18 all scheduled nursing staff were re-educated by the Assistan			
		echanical lift for transfer to			Director of Nursing regarding the	L I	
	an electric wheelchai				residents right to choice including daily	,	
		ied regarding the resident			schedules regarding showers.		
		ulcer to the right foot and a			Nursing staff members who did not		
	pressure ulcer to the	right heel.			receive the re-education will not be allowed to work until they are re-education	ited.	
	A review of the Bath I	Report Roster for Resident					
		h 6/11/18 revealed the			All newly hired nursing staff will be		
		nented as having received			educated regarding resident preferenc	es	
	-	the time period. One			at the time of hire.		
		nted on 5/7/18 and the other			Monitoring		
	on 5/18/18.				Monitoring: Effective 6/18/18 The facility		
	Review of the showe	r schedule provided by the			interdisciplinary team, which includes t	he	
		ealed Resident #6's room			Director of Nursing, MDS Nurse #1, Ur		
		shower each Tuesday and			Coordinator #2, Social Worker #1, and		
	Friday.	,			Activity Director # 1 will perform daily		
	-				rounds and audit the shower schedule		
	· ·	ssignment sheets from			the previous days showers to ensure the		
	÷	8 revealed the resident had			showers were given as scheduled, and	l to	
		or a shower. Further review			validate that the documentation is	for	
		8 through 6/10/18 revealed umber was not scheduled			complete for showers given as well as		
	for a shower.				showers refused. This daily monitoring continue for 4 weeks, then weekly x 4	WIII	
	101 8 3110101.				weeks and then monthly for three mon	ths	
		mental notes for Resident #6			or until a pattern of compliance is		

Facility ID: 923114

If continuation sheet Page 2 of 13

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/09/201 MAPPROVEI D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		E SURVEY PLETED C
		345183	B. WING				/11/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE & REI	НАВ		43	30 BROOKWOOD AVENUE NE		
CHIVENO				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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From page	a 2		677			
1 0/7				011	aphioved		
	from 5/4/18 through 6 documentation for the				achieved.		
		ng showers, or refusing to be			Effective 6/18/18 Weekend Superviso	r	
		t of his bed or chair. The			and/or designated nurse will review th		
	resident was docume	•			previous days scheduled showers to		
	discharged to the hos				ensure that the showers were given a		
	returned on 5/28/18 a hospitalized for pneur				documentation is in place for showers given as well as refused. This daily		
	nospitalized for pried	monia.			monitoring will continue for 4 weeks, t	hen	
	An interview was con	ducted on 6/11/18 at 11:47			weekly x 4 weeks and then monthly for		
	AM with Resident #6.	. The resident stated he has			three months or until a pattern of		
	to be transferred into	and out of bed using a sling			compliance is achieved.		
	-	lained he had been going					
		ith staff assistance from 9:00			The Director of Nursing will review the	se	
		from 2:00 PM to 4:00 PM.			daily audits and report the findings		
		t took two staff members to f bed with the lift. The			monthly to the Quality Assurance and Performance Improvement (QAPI)		
		d been unable to get back			committee for recommendations or		
		of the interview because the			modifications until a pattern of complia	ance	
		isy and there was no one to			is achieved.		
		nt further explained it had					
		since he had not been able					
	-	and rest. The resident stated			Root Cause Analysis:		
		when he had gotten back			Based on the root cause analysis by t	he	
		ad been difficult to be able to ed from two staff members			administrative team and the facility Executive Director, it was determined	that	
		d. The resident stated he			staff did not follow the facility policy wi		
		out of bed at about 5:30 or			regards to allowing residents to choos		
		shift staff and returns to bed			their daily schedules. This was specifi		
	at about 9:30 or 10:0	0 PM with the assistance of			the ability to choose when to get up for	r the	
		. The resident further stated			day and when to go to bed.		
		all day without breaks to go					
		ad become the new norm.			Immediate Action:	wod	
		e returned from the hospital not received a shower since.			On 6/18/18 Resident # 6 was interview regarding his preferences and staff	veu	
		le did have a wound on his			re-educated to assist resident out of b	ed	
		had usually put a bag on his			and into bed per his preferences.		
	-	able to take a shower. The					
	resident stated he did	d not know what day or days			Identification of others:		

Facility ID: 923114

	S FOR MEDICARE &		0.00		0	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING			
		345183	B. WING		C	10040
	ROVIDER OR SUPPLIER	040100		STREET ADDRESS, CITY, STATE, ZIP CODE	06/11	/2018
	TOWDER OR SUFFLIER			430 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & RE	НАВ		CONCORD, NC 28025		
					FOTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 677	Continued From pag	e 3	F 67	7		
	his shower was assig			On 6/18/18 interviews were con	ducted	
				with all alert and oriented reside		
	An interview was cor	nducted on 6/11/18 at 2:11		determine preferred times to ge	t out of	
	PM with first shift Nu	rsing Assistant (NA #11).		bed and when to return to bed.		
		ssignment included the room				
	in which Resident #6	resided. The NA stated she		Newly admitted residents will be	e asked	
	had 12 residents on	her assignment for that day.		their preference regarding daily	schedules	
	The NA stated she h			at the time of admission.		
	-	PM because the other NA had				
		e NA stated she was not sure		Systemic Changes:		
		had been assigned had		Effective 6/18/18 all scheduled		
	-	ot. The NA stated the way		staff were re-educated by the A		
		heduled had changed and		Director of Nursing regarding th residents right to choice includir		
		ily assignment. The NA ad been assigned to receive		to get out of bed and when to get		
		tated she did not know how		bed.	D DACK IU	
		ed having gave a shower but		Nursing staff members who did	not	
		a shower on a resident, she		receive the re-education will not		
		next to the resident's room		allowed to work until they are re		
		ers portion of the assignment				
		e daily assignment sheet for				
		re were no initials next to any		Monitoring:		
		on the daily assignment		Effective 6/18/18 The facility ma	inagement	
	sheet for showers.			team, which includes the Busine	ess Office	
				Manager, MDS Nurse #1, Unit		
		nducted with the Director of		Coordinator #2, Social Worker #		
		11/18 at 6:05 PM. The DON		Activity Director # 1, Maintenand		
		a mechanism in which		Director, Admissions Coordinate		
		to be given were monitored		interview 5 residents per week		
		on assigned to monitor		honoring of preferences with rel		
		DON stated there was		daily schedules specific to the ti		
	-	he end of April and the first		want to get up and the time they		
		e no longer was a shower ere responsible for the		return to bed. This monitoring v continue for 4 weeks, then mon		
		ignments. The DON stated		months or until a pattern of com	-	
		the daily staffing assignment		achieved.		
		sidents' showers. She further				
	-	refused the shower, the NA		Effective 6/18/18 Weekend Sup	ervisor	

Facility ID: 923114

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STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OUNCEDITOR	IDENTIFICATION NOWIDER.	A. BUILDING	3	C
		345183	B. WING		06/11/2018
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP C	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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 677	Continued From page	e 4	F 67	77	
	responsible for docur of the shower. The E expectation that ever showers per week. 2. Resident #8 was a resident's admission failure, diabetes, and Review of the Minimu assessments for Res assessments for Res assessment with an <i>A</i> (ARD) of 4/23/18. Re revealed the resident cognitively intact. Th having had rejection assessment period. having required exter member for bed mob bed to a chair), dress personal hygiene. Th having had required bathing activity of one Review of Resident # been most recently re resident had problem Resident refused car extensive assistance ADLs included to ass grooming, washing h Review of the showe facility on 6/11/18 rev	menting the resident refusal DON stated it was her y resident receive two admitted on 7/25/17. The diagnoses included: Kidney l lower back pain. um Data Set (MDS) sident #8 revealed a quarterly Assessment Reference Date eview of the assessment t was coded as having been he resident was coded as of care 1-3 days during the The resident was coded as nsive assistance of 1 staff illity, transfer (such as from a sing, eating, toilet use, and he resident was coded as physical help in part of e person. #8's care plan revealed it had eviewed on 4/23/18. The n/need areas which included: e at times. She needed with ADLs. An approach for sist the resident with bathing, air, and other ADLs. r schedule provided by the vealed Resident #8's room		residents per weekend with preferences specific to the of bed and the time to retu monitoring will continue for monthly for 3 months or un compliance is achieved. The Director of Nursing will daily audits and report the monthly to the Quality Asso Performance Improvement recommendations or modif pattern of compliance is ac	time to get out rn to bed. This 4 weeks, then atil a pattern of I review these findings urance and t committee for fications until a
	facility on 6/11/18 rev was scheduled for a Wednesday, and Fric A review of the Bath	vealed Resident #8's room shower each Monday,			

If continuation sheet Page 5 of 13

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 07/09/2018 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345183	B. WING		06	C 5/11/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
	AL HEALTH CARE & REH			430 BROOKWOOD AVENUE NE		
UNIVERS	AL NEALTH CARE & REP			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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 677		nted as having received a	F 67	7		
	shower on 6/4/18 and Review of the daily as period of 6/1/18 throu Resident #8's room n shower on the followin At the top of the colur showers the column k initial." Neither date h room to indicate a sho Review of the departr from 5/26/18 through documentation for the noncompliant, refusin transferred into or out An interview was con AM with Resident #8. had received a shower in her last shower had b The resident stated sh a shower on Monday, The resident stated th shower schedule had had not seen the reside returned from dialysis was not made and the had not been picked of An interview was com PM with first shift NA had given Resident #	16/11/18. signment sheets for the gh 6/10/18 revealed umber was scheduled for a ng dates: 6/1/18 and 6/4/18. nn for the assigned resident abel stated, "Showers CNA had initials next to resident's ower had been completed. nental notes for Resident #8 6/11/18 revealed no resident being g showers, or refusing to be of his bed or chair. ducted on 6/11/18 at 11:13 The resident stated she er that morning but had not a week. The resident stated een on Monday, 6/4/18. he was supposed to receive Wednesday, and Friday. he NA had told her the been revised and the NA dent's name on the shower nt stated she went to Thursday, and Saturday ent stated when she in the afternoon her bed e towels in her bathroom				

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 PLETED
		345183	B. WING				_ 11/2018
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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	find the book so she of scheduled for a show unable to get the seco during her shift and sl shower after her shift showers had been div not responsible for all stated the showers we assignment and some book. An interview was come Nursing (DON) on 6/1 stated there was not a showers which were t nor was there a perso showers given. The D shower team up till the part of May but there team and the NAs we showers on their assig the scheduler made the and would assign resis stated if the resident r was to inform the nurs responsible for docum of the shower. The D expectation that every showers per week.	wised and she needed to could find out who else was er. The NA stated she was ond shower completed he would give the resident a ended. The NA stated the vided up so the first shift was of the showers. The NA ere listed on the daily etimes they were in the ducted with the Director of 1/18 at 6:05 PM. The DON a mechanism in which o be given were monitored on assigned to monitor DON stated there was e end of April and the first no longer was a shower re responsible for the gnments. The DON stated he daily staffing assignment idents' showers. She further refused the shower, the NA se and the nurse would be henting the resident refusal ON stated it was her y resident receive two		677			6/49/49
F 732 SS=C	Posted Nurse Staffing CFR(s): 483.35(g)(1)- §483.35(g) Nurse Sta	(4)	F	732			6/18/18
	§483.35(g)(1) Data re	quirements. The facility g information on a daily					

Facility ID: 923114

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					FORM	APPROVED 0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY LETED
		345183	B. WING				, 11/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732	 (ii) The current date. (iii) The total number by the following catego unlicensed nursing stresident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must perform the facility must perform the facility must perform the facility must perform the facility must be post (A) Clear and readabl (B) In a prominent plaresidents and visitors §483.35(g)(3) Public a staffing data. The face written request, make available to the public exceed the communit section of the facility nurse statist is greater. This REQUIREMENT by: Based on staff intervifacility failed to accurate the communit facility failed to accurate the community facility failed to accurate	and the actual hours worked ories of licensed and aff directly responsible for the second defined under State law). des. Inurses or licensed defined under State law). des. Inurses or licensed defined under State law). des. Inurses taffing data in (g)(1) of this section on a inning of each shift. ed as follows: le format. det as follows: e format. det as the posted nurse cility must, upon oral or e nurse staffing data to for review at a cost not to y standard. data retention cility must maintain the affing data for a minimum of uired by State law, whichever this not met as evidenced iews and record reviews the ately report care hours and unlicensed personnel	F	732	Root Cause Analysis: Based on the root cause analysis by th administrative team and the facility Executive Director, it was determined t staff did not follow the facility policy wit regards to correctly posting the nurse	hat	

Event ID: BSTK11

Facility ID: 923114

If continuation sheet Page 8 of 13

	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/09/201 FORM APPROVE OMB NO. 0938-039
TATEMENT OF DE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345183	B. WING		C 06/11/2018
NAME OF PROVID	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
UNIVERSAL H	EALTH CARE & REH	IAB		430 BROOKWOOD AVENUE NE CONCORD, NC 28025	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIC	DN (X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 732 Co	ntinued From page	8	F 732		
	idings included:	0	1 752	staffing information.	
req hou orig for thro sta day (RM nur as Nig 5/1 An Adu PM fror sta sta sta sta sta the ent ado the she sch Fric (Sa exp inte	juest was made to jurs sheets from 5/1 ginal daily staffing h review by the facili ough 6/9/18. Revie ffing hours sheets p ys which had the da Ns), licensed practi- rsing assistants to b 0.0 for the evening ght Shift (11 PM to 718 through 6/9/18. interview was cond ministrator on 6/11/ 1. The daily staffing m 5/1/18 through 6/ ted the census nun- ffing sheets were in ted there were staff days where there tered for staffing on dition the Administra- ecensus number or eets was accurate f e daily staffing hours e Administrator indi- eets were complete heduler during the w day) and by the cha aturday and Sunday plained the schedul erview due to being	ducted with the (18 at approximately 9:10 g sheets were reviewed (10/18. The Administrator nbers on several of the daily ncorrect. The Administrator f scheduled at the facility on had been no data or 0.0 a second and third shift. In ator stated, she did not feel in the daily staffing hours for multiple days for which is sheets were reviewed. cated the daily staffing ed and posted by the week (Monday through arge nurse on the weekends y). The Administrator er was unavailable for		Immediate Action: As of 6/12/18 The daily staffing sheet corrected and posted to include: Facility name The current date The total number and the actual hout worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care shift: A)Registered nurses B)Licensed practical nurses C)Certified nurse aides iv) Resident census Systemic Changes: Effective 6/18/18 all administrative st include administrative nurses were re-educated by the Administrator regarding Posted Nurse Staffing information. All newly hired administrative staff to include administrative nursing staff w educated regarding required Posted Nurse Staffing Information. Monitoring: Effective 6/18/18 The Assistant Direct Nursing will review the daily staffing posting to ensure that it is posted and correct. This monitoring will continue for 4 we then weekly x 4 weeks and then more	rs f f per taff to vill be ctor of d is eeks,

Event ID: BSTK11

Facility ID: 923114

If continuation sheet Page 9 of 13

ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345183	B. WING		C 06/11/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/11/2010
				430 BROOKWOOD AVENUE NE	
JNIVERS	AL HEALTH CARE & RE	НАВ			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE
F 732	Continued From page	e 9	F 732		
	 Continued From page 9 During an interview with the Corporate Consultant conducted on 6/11/18 at approximately 9:20 PM, she stated she would provide a copy of the daily staffing sheets for the dates of 5/1/18 through 6/9/18. The Corporate Consultant returned at approximately 9:40 PM and provided copies of the daily staffing hours sheets from 5/1/18 through 5/27/18 and 6/1/18 through 6/10/18, which were not the daily staffing hours sheets reviewed with the Administrator. She stated she provided copies of another set of daily staffing hours sheets which had been discovered in the scheduler's office. The Corporate Consultant stated she had not made copies of the original daily staffing sheets which had been reviewed in the presence of the Administrator. 			Effective 6/18/18 Weekend Super and/or designated nurse will review Posted Nurse Staffing Information ensure that it is posted and correct monitoring will continue for 4 week weekly x 4 weeks and then month months or until a pattern of compli- achieved. The Director of Nursing will review daily audits and report the findings monthly to the Quality Assurance Performance Improvement (QAPI) committee for recommendations of modifications until a pattern of corr is achieved.	w the to tt. This ks, then ly x 3 iance is / these s
F 867 SS=D	sheets provided by the revealed they were de 5/27/18 and 6/1/18 the corresponding daily a 5/1/18 through 5/27/1 The review revealed recorded on the daily of 36 daily staffing she compared to the daily Discrepancies were de for LPNs and NAs. QAPI/QAA Improvem CFR(s): 483.75(g)(2)	/ staffing sheets. discovered for all three shifts nent Activities	F 867		6/18/18

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		E SURVEY
		345183	B. WING _		0	C 6/11/2018
NAME OF P	ROVIDER OR SUPPLIER		_	STREET ADDRESS, CITY, STATE, ZI		
	AL HEALTH CARE & REI			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 PREFI) TAG	X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 867	Continued From page	e 10	F	367		
	(ii) Develop and imple action to correct idem This REQUIREMENT by: Based on record rev and staff interviews, t Assessment and Ass failed to maintain imp monitor the interventi into place following th survey. This was for of: ADL Care Provide which was originally of deficiency was recited complaint investigation failure of the facility d showed a pattern of t sustain an effective of Assurance program The findings included	ement appropriate plans of tified quality deficiencies; is not met as evidenced iew, observations, resident the facility's Quality urance (QAA) Committee demented procedures and ons that the committee put the 4/7/18 recertification one deficiency in the area d for Dependent Residents sited in April, 2018. The d again on the current on of 6/11/18. The continued uring two federal surveys he facility's inability to Quality Assessment and		Effective 6/18/18 Admin implemented a Quality A Performance Improveme monitoring tool to monitor to assure that residents a showers per their preferences their preferences are foll getting out of bed and ba Root Cause Analysis: Based on the root cause administrative team and Executive Director, it wa staff did not follow the fa regards to providing sho preferences nor was fact followed regarding reside related to getting out of the	Assurance and ent (QAPI) or documentation are receiving ences as well as lowed regarding ack into bed. e analysis by the the facility s determined that icility policy with wers per resident ility policy ents preferences	
	facility failed to provid (ADL) care by not pro- residents reviewed w showers (Resident #6 assist 1 of 1 resident into and out of bed (F During the recertificat facility was cited for fa	ervations, resident views and record reviews the le Activity of Daily Living oviding showers for 2 out of 5 ho required assistance with 5 and Resident #8) and for reviewed for transfers		bed. Effective 6/18/18 The fact interdisciplinary team, with Director of Nursing, MDS Coordinator #2, Social W Activity Director # 1 will p rounds and audit the sho the previous days showed showers were given as a validate that the docume complete for showers give showers refused. This m continue for 4 weeks, the weeks and then monthly until a pattern of complia	hich includes the S Nurse #1, Unit Vorker #1, and perform daily ower schedule for ers to ensure that scheduled, and to entation is ven as well as for nonitoring will en weekly x 4 y x 3 months or	

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	0: 07/09/2018 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		LETED
		345183	B. WING				C 11/2018
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE & RE	HAB			30 BROOKWOOD AVENUE NE		
	1			CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	Administrator stated a Administrator at the f	/18 at 9:20 PM. The	F	867	Effective 6/18/18 Weekend Supervisor and/or designated nurse will review the previous days scheduled showers to ensure that the showers were given ar documentation is in place for showers given as well as refused. This monitori will continue for 4 weeks, then weekly weeks and then monthly thereafter. The Director of Nursing will review the daily audits and report the findings monthly to the Quality Assurance and Performance Improvement (QAPI)committee monthly for three months or until a pattern of compliance achieved. Root Cause Analysis: Based on the root cause analysis by th administrative team and the facility Executive Director, it was determined to staff did not follow the facility policy wit regards to allowing residents to choose their daily schedules. This was specific the ability to choose when to get up for day and when to go to bed. Monitoring: Effective 6/18/18 The facility managem team, which includes the Business Off Manager, MDS Nurse #1, Unit Coordinator #2, Social Worker #1, and Activity Director # 1, Maintenance Director, Admissions Coordinator will interview 5 residents per week regard honoring of preferences with relation to daily schedules specific to the time the want to get up and the time they want return to bed. This monitoring will	e nd ing x 4 se e is he that th e c to r the nent ice ing o y	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED								
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII			с		
		345183	B. WING	B. WING			06/11/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
UNIVERSAL HEALTH CARE & REHAB				430 BROOKWOOD AVENUE NE				
UNIVERSAL REALTH CARE & RERAD				CONCORD, NC 28025				
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	x			COMPLETION DATE	
	,				DEFICIENCY)			
F 867	F 867 Continued From page 12		F 8	367	67 continue for 4 weeks, then monthly x 3 months or until a pattern of compliance is achieved.			
				Effective 6/18/18 Weeken		d Supervisor		
					and/or designated nurse will interview two			
					residents per weekend with regard to preferences specific to the time to get	out		
					of bed and the time to return to bed. The			
					monitoring will continue for 4 weeks, th			
					monthly x 3 months or until a pattern o	f		
					compliance is achieved.			
					The Director of Nursing will review the	se		
					daily audits and report the findings monthly to the Quality Assurance and Performance Improvement committee			
					recommendations or modifications unt	il a		
					pattern of compliance is achieved.			

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