		ID HUMAN SERVICES			FO	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
		345183	B. WING			C 7/02/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		1102/2013
	AL HEALTH CARE & REI	ΙΔR		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 CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	00		
F 585	Tags F550, F567, F56 F656, F657, F680, F7 F842, F849, and F92 7/2/19. Repeat tags were cited. New tags of the complaint inves conducted at the sam facility is still out of co	conducted 7/1/19 to 7/2/19. 84, F636, F637, F641, F655, 732, F761, F773, F808, 1 were corrected as of (F585, F812, and F865) 5 were also cited as a result stigation survey that was be time as the revisit. The compliance.	F 58	25		7/15/19
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-	(4)	F 58	15		//15/19
	grievances to the faci that hears grievances reprisal and without for reprisal. Such grievar respect to care and tr furnished as well as t furnished, the behavior	s. ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination or nees include those with eatment which has been hat which has not been or of staff and of other concerns regarding their LTC				
	facility must make pro	ident has the right to and the ompt efforts by the facility to e resident may have, in paragraph.				
		ility must make information ance or complaint available				
	of all grievances rega	ility must establish a nsure the prompt resolution rding the residents' rights graph. Upon request, the				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	Ē	TITLE		(X6) DATE
Electroni	cally Signed					07/18/2019

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 08/05/2019 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		345183	B. WING		_		C 02/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE & REF	IAB		430 BROOKWOOD AVENU CONCORD, NC 28025	JE NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	to the resident. The gri include: (i) Notifying resident in postings in prominent facility of the right to fi (meaning spoken) or i grievances anonymou of the grievance officia can be filed, that is, hi address (mailing and number; a reasonable completing the review to obtain a written dec grievance; and the co independent entities v be filed, that is, the pe Quality Improvement Agency and State Lor program or protection (ii) Identifying a Grieva responsible for overse receiving and tracking conclusions; leading a by the facility; maintai information associated example, the identity of grievances submitted written grievance deci 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	copy of the grievance policy rievance policy must advividually or through locations throughout the le grievances orally n writing; the right to file isly; the contact information al with whom a grievance s or her name, business email) and business phone expected time frame for 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 being the grievance process, grievances through to their any necessary investigations ning the confidentiality of all d with grievances, for of the resident for those anonymously, issuing sions to the resident; and e and federal agencies as pecific allegations; ing immediate action to ial violations of any resident	F 58	5			
	asass, moraling injun						

If continuation sheet Page 2 of 11

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345183	B. WING				C 02/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				4	30 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & REF	IAB		С	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 585	anyone furnishing ser provider, to the admir as required by State I (v) Ensuring that all w include the date the g summary statement of the steps taken to inv summary of the pertir regarding the residen as to whether the grie confirmed, any correct 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 revi facility failed to docum resident's grievance, findings or conclusion concern(s), a stateme was confirmed or not action taken or to be to result of the grievance decision was issued fi	on of resident property, by vices on behalf of the nistrator of the provider; and aw; vritten grievance decisions rievance was received, a of the resident's grievance, estigate the grievance, a nent findings or conclusions t's concerns(s), a statement evance was confirmed or not evance 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	F	585	The creation and submission of the Pl of Correction does not constitute an admission by this provider of any conclusion set forth by the survey tean of any violation of regulation. It is solel created to demonstrate our good faith attempt to continue to provide a quality life for all of our residents.	n, or y	

Facility ID: 923114

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/05/201 MAPPROVE O. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		E SURVEY PLETED
		345183	B. WING		07	C // 02/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				430 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & RE	НАВ		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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 585	Continued From page	e 3	F 58	35		
	investigate a grievan forms reviewed (Grie Findings include: A review was complet with an effective date review revealed the G defined as an individ overseeing the grieva tracking grievances t leading any necessa facility; maintaining th information associate example, the identity grievances submitted written grievance ded coordinating with star necessary in light of addition, it stated, the resolution to all griev and resident represe the investigation and	ce for one of three grievance evance Record #1). eted of the Grievances policy e of October 2017. The Grievance Official was ual who is responsible for ance process, receiving and hrough to their conclusions; ry investigations by the he confidentiality of all ed with grievances, for of the resident for those d anonymously, issuing cisions to the resident; and te and federal agencies as specific allegations. In e facility will ensure prompt ances, keeping the resident ntative informed throughout resolution process. The cess will be overseen by a		 6/24/19 (Grievance #1) regardin clothing was completed as of 7/⁷ the Housekeeping Director and the Administrator, to include the follor sections: Summary of the grieval steps taken to investigate, summ findings, if the grievance was concorrection actions and the signal grievance official. The resident winformed of the findings of the investigation and verbalized that grievance was resolved, the resident by the Housekeepe Manager as of 7/15/19. The Grievance/Concern form da 6/18/19 (Grievance #2) regardin missing phone was completed to the following sections: What othe was taken to resolve concern se Results of action taken, grievance resolved, steps taken to investig summary of findings, name, date 	I5/19 by the owing nce, nary of nfirmed, ture of the vas the dent did This olved per er ted g a o include er action ction. ce ate,	
	through their conclus investigations, maintainformation associate communicate with re- to resolution and coo- (including the Admini- designated Grievanc federal agencies as r allegations. 1. Review of Grievan 5/31/19, revealed the	aining the confidentiality of all ed with grievances, sidents through the process ordinate with other staff (strator, if he or she is not the e Official) and with state or may indicate by specific		 grievance received, summary of grievance, confirmation of grieva corrective actions, grievance offisignature. The resident did not whave a written decision. This grievance was verified to have resolved per the resident. The Grievance/Concern form da 6/24/19 (Grievance #3) regardin missing clear cup with a black to completed to include the following sections: Individual designated to action on the grievance, what other sections. 	ance, icial and vish to ave been ted g a up was ug o take	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/05/20 FORM APPROVE OMB NO. 0938-039
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345183	B. WING		C 07/02/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
				430 BROOKWOOD AVENUE NE	
UNIVERSA	AL HEALTH CARE & REI	НАВ		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 585	Continued From page	e 4	F 585		
1 000			F 560		lian
	individual designated			was taken to resolve concern sec	
	and it was assigned of	Dusekeeping Director (HD)		Results of action taken, grievance resolved, steps taken to investiga	
	•	he, What other action was		summary of findings, name, date,	,
		cern section, all clothing		grievance received, summary of	
		s located and returned to the		grievance, confirmation of grievan	ce.
	•	cumented the remaining		corrective actions, grievance offic	
		s still being looked for. The		well as contact information and si	
	•	ff member and signed as the		The resident's Responsible Party	-
	-	mpleted by her. Review of		wish to have a written decision.	
	-	revealed no information		This grievance was verified with th	ne
	documented on the b	ack of the form. The		Resident's Responsible Party to h	
	sections on the back	of the form included: Name,		been resolved by the Social Servi	
	date grievance receiv	/ed, summary of grievance,		Director as of 7/15/19.	
	steps taken to investi	gate, summary of findings,			
	grievance was confirm	med or not confirmed,			
	corrective actions, da	ate written decision issued,		An audit of Grievance/Concern fo	rms for
	grievance official, sig	nature, and contact		thirty days was completed by the	
	information.			Administrator as of 7/5/19 to deter	mine if
				they were completed in their entire	ety and
	An interview was con			the resolution was presented to the	
	Administrator on 7/2/			named Resident or the Resident's	
		she was currently and has		responsible party and a copy give	
		Official for the facility. The		resident per his/her wishes. Ther	
		the process was she would		14 other Grievance/Concern form	
	-	e, then assign the grievance,		missing information found during	inis
	and give the assigned			audit.	
		npletion of the grievance, the		Of those found to not be fully same	plotod
	grievance would be r			Of those found to not be fully com	
		ed Grievance #1 and stated		100% are completed as of 7/15/19 the resolution communicated to the	
	the HD had returned	en assigned to the HD and		complainant.	
		she was sure the HD had			
		g items with the resident		The Administrator was re-educate	d by the
		returned. The Administrator		Regional Nurse Consultant regard	-
		have asked the resident if		as of 7/15/19. This education inclu	-
				The Grievance/Concern policy an	
	they wanted a written				
	they wanted a written discussion would have			importance of completing the	

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<u>CENTER</u>	<u>S FOR MEDICARE &</u>	MEDICAID SERVICES			OMB NO. 0938	3-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		345183	B. WING		C 07/02/201	19
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & RE	H CARE & REHAB 430 BROOKWOOD AVENUE NE CONCORD, NC 28025				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMP	K5) LETIO ATE
F 585	Continued From pag	e 5	F 58	15		
F 363	documented on the f grievance, Steps tak of findings, if the grie Corrective actions, d issued, or the signat The Administrator sta for the resolution to b resident or the intere to be documented or the resident or family copy, a copy would b 2. Review of Grieva 6/18/19, revealed the regarding a missing individual designated grievance. There wa under the, What othe concern section. Th recorded under resu resolved, or complet right-hand corner of was hand written. R	orm: Summary of the en to investigate, Summary evance was confirmed, ate the written decision was ure of the grievance official. ated it was her expectation be communicated to the sted party and the resolution in the grievance form and if member desired a written be provided.	F 58	 resolving the concern, communic the resident and/or complainant a giving them a written resolution p wishes. Newly hired Administrators will be educated at the time of hire regar f585 and the Grievance/Concern 100% of Department Managers w re-educated as of 7/15/19 regard Grievance/Concern policy and the importance of completing the Grievance/Concern forms correct resolving the concern, communic the resident and/or complainant a giving them a written resolution p wishes. Department Managers m available for the re-education will allowed to work until the re-educa received. All newly hired Departm Managers will be educated at the hire. 100% of staff were re-educated re- 	and er his/her ding policy. /ere ing the e ly, ating to and er his/her ot not be ation is hent time of	
	steps taken to invest The information lister search laundry area. phone that may be a There was no inform sections on the back including: Name, dat summary of grievand or not confirmed, cor	igate, summary of findings. d was: 1) Housekeeping to 2) Maintenance has a match to missing phone. ation recorded in the other of the grievance form e grievance received, e, , grievance was confirmed rective actions, date written vance official, signature, and		 f585 and the importance of report documenting and resolving grieva of 7/15/19. Staff not available for re-education will not be allowed to until the re-education is complete hired staff will be educated regard Grievance policy at the time of hir The Social Services Director will that all Grievances/Concerns will logged, the resolution is accompl and the resolution is communicat resident/complainant. The Admin as the Grievance Official will revie 	ing, ances as o work d. Newly ding the re. ensure be ished ed to the istrator	

Facility ID: 923114

If continuation sheet Page 6 of 11

	S FOR MEDICARE &					. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
		345183	B. WING			02/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
UNIVERS	AL HEALTH CARE & RE	HAB		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 A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIOI DATE
F 585	Continued From page	e 6	F 58	85		
	Administrator stated a been the Grievance of Administrator stated a receive the grievance and give the assigned grievance. Upon com grievance would be m Administrator reviewe the phone which the had was the resident to the resident, but it Administrator stated a but there was no follo Administrator stated a investigated and they Administrator stated a resolution of the griev were being found and The Administrator stated on grievance, Summary was confirmed, Corre written decision was the grievance official. was her expectation a communicated to the party and the resoluti grievance form and if member desired a wr provided. 3. Review of Grievar 6/24/19, revealed the regarding a missing of and a metal straw. T designated to take ad	she was currently and has Official for the facility. The the process was she would a, then assign the grievance, d d staff member the inpletion of the grievance, the eturned to her. The ed Grievance #2 and stated Maintenance Department 's phone and it was returned was not documented. The the grievance was resolved, ow-up documented. The the grievances were being ' were being resolved. The the evidence of the vances was that the items d returned to the residents. Atted the following had not to the form: Summary of the of findings, if the grievance ective actions, date the issued, or the signature of . The Administrator stated it for the resolution to be resident or the interested on to be documented on the the resident or family titten copy, a copy would be the #3, a grievance dated e grievance was filed clear cup, with a black top, there was no individual ction on the grievance. There		Grievances/Concerns an the form is completed in it the results have been con the complainant. Upon va completion and resolution Administrator will sign the The Administrator will and Concern forms daily, Mon Friday on-going to ensure completed in its entirety a have been communicate complainant in the metho preference. The Administ a report on the findings of monthly and report to the Assurance and Performa Improvement committee The Quality Assurance an Improvement committee changes to the plan as m The facility Administrator of Nursing will be ultimate for the implementation of correction to ensure the f maintains substantial cor	its entirety and mmunicated to alidating the n, the e form. It Grievance and nday through e that the form is and the results d to the od of their trator will compile of these audits e Quality ince monthly nd Performance will make ecessary. and the Director ely responsible i this plan of facility attains and	
ORM CMS-256	and a metal straw. T designated to take ac was no information re other action was take	here was no individual ction on the grievance. There ecorded under the, What en to resolve concern no information recorded	11	Facility ID: 923114	If continuation she	at Page 7

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/05/2019 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345183	B. WING			C / 02/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
			4	30 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & REH	IAB	0	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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 585	or completion of the form revealed the documented on the back the section labeled, sit summary of findings. 1) Nurse Supervisor of item described. 2) Di was no information reon the back of the grievance, decision issued, griev contact information. An interview was completed to the grievance of the grievance of grievance. Upon complete grievance would be read give the assigned grievance would be read give the complete the Nurse Supervisor looking for the cup may Administrator stated to documented on the forgievance, Summary was confirmed, Correwritten decision was in the grievance official. was her expectation for communicated to the	taken, grievance resolved, orm. Review of the back of only information ack of the form was under teps taken to investigate, The information listed was: called to be on lookout for etary now involved. There corded in the other sections evance form including: e received, summary of e was confirmed or not actions, date written rance official, signature, and ducted with the 19 at 2:38 PM. The she was currently and has official for the facility. The he process was she would , then assign the grievance, d staff member the spletion of the grievance, the eturned to her. The ed Grievance #3 and stated and the dietary staff were not the cup may have been whave been replaced. The he following had not been orm: Summary of the of findings, if the grievance ctive actions, date the ssued, or the signature of The Administrator stated it or the resolution to be resident or the interested on to be documented on the	F 585			

Facility ID: 923114

If continuation sheet Page 8 of 11

TATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DA	NO. 0938-039 ATE SURVEY MPLETED
		345183	B. WING			C 07/02/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
	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 PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 585	Continued From page	e 8	F 5	85		
		itten copy, a copy would be				
F 812 SS=F	Food Procurement,St CFR(s): 483.60(i)(1)(tore/Prepare/Serve-Sanitary 2)	F 8	12		7/15/19
	§483.60(i) Food safet The facility must -	ty requirements.				
	state or local authorit (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p	ed satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable				
	(iii) This provision doe	s not procured by the facility.				
	serve food in accorda standards for food se	prepare, distribute and ance with professional rvice safety. is not met as evidenced				
	facility failed to air dry cups and failed to cle using it to check food	ns and staff interviews, the y plastic plate lids, bowls and an a thermometer prior to temperatures. This had the		The domes, cups, glasses were allowed to air dry follo prior to the dinner meal on	owing washing 7/1/19.	
	potential to affect 87 Findings included:			100% of thermometers we sanitized prior to the next u Certified Dietary Manager	use by the or the Assistant	
		ı room was observed on I. Dishwasher (DW) #1 was		Dietary Manager as of 7/1/	19	
		late lids that had just been I from the dishwasher and		An audit of dishes was con Certified Dietary Manager ensure that all dishes show	as of 7/15/19 to	

Facility ID: 923114

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION	. ,	E SURVEY
	OUNTEONON	DENTITIONTION NUMBER.	A. BUILDING	G		
		245492	B. WING			С
		345183	B. WING			7/02/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
UNIVERS	AL HEALTH CARE & REI	НАВ		430 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 PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 812	Continued From page	e 9	F 81	12		
	1.0		_	evidence cloth drying ar	nd that air drving	
	-	m was observed again on I and DW #1 was observed		was occurring.		
		water off plastic bowls and		100% of food thermome	ters were audited	
		ashed and sanitized in the		by the Certified Dietary		
	dishwasher.			7/5/19 to ensure that the		
	DW #1 was interview	ed on 7/1/2019 at 11:45 AM		The Certified Dietary Ma	anager was	
		e used a towel to wipe off		re-educated by the Adm		
	-	tic bowls and cups prior to		importance of allowing of		
	air-drying. DW #1 re	ported the plastic dishes had		and that they are not to	be towel dried as	
	a lot of water from the	e dishwasher and were very		well as the importance of	of cleaning	
	wet.			thermometers prior to us	Se.	
		(DM) was interviewed on		100% of Dietary staff me		
		and she reported the staff		re-educated by the Dieta		
		on air drying dishware and ve used a towel to remove		7/15/19 on the importan dishes to air dry prior to	-	
		n the dishwasher on the		Dietary staff including th		
	plastic plate lids, bow			Dietary Manager were r		
		xpectation all dishes would		Certified Dietary Manag	-	
	be air-dried prior to s			regarding the importanc		
		-		sanitizing thermometers		
		s interviewed on 7/2/219 at				
	· ·	orted it was her expectation		Dietary staff members u		
	the dishes were air-d	ried prior to use or storage.		re-training will not be all		
				they receive the educati		
	2 The facility feed	sonvice trav line was		Newly hired Dietary staf at the time of hire on the		
		service tray line was 9 at 12:26 PM. The Assistant		allowing dishes to air dr	•	
		M) was observed removing		importance of cleaning a		
		her pocket of her shirt from		thermometers prior to us	-	
	under her apron and					
		#1 and told her to use that				
		n temperatures of the foods				
	being served from the	e tray line. Cook #1 was		Effective 7/15/19 The C	ertified Dietary	
		e thermometer provided by		Manager or Assistant Di		
		n the tray line. Cook #1 did		audit dishes to ensure a		
	not clean or sanitize f	the thermometer prior to		use daily, Monday throu	gh Friday x two	

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CENTER STATEMENT (AND PLAN OF NAME OF P	ROVIDER OR SUPPLIER		A. BUILDING B. WING S 4	TREET ADDRESS, CITY, STATE, ZIP CODE 30 BROOKWOOD AVENUE NE CONCORD, NC 28025	FORI OMB NO (X3) DATE COMP 07	D: 08/05/2019 M APPROVED D. 0938-0391 E SURVEY PLETED C /02/2019
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 812	inserting it into the foo The ADM was intervie PM and she reported cleaned off the therm to Cook #1 for use. The Dietary Manager 7/1/2019 at 2:10 PM a expectation the therm to being used to chec Cook #1 was interview AM and she reported during the observation cleaned the thermom and Cook #1 had not use. The Administrator was 4:10 PM and she reported	od items. ewed on 7/1/2019 at 2:10 she thought she had ometer before she handed it r (DM) was interviewed on and reported it was her nometers were cleaned prior	F 812	 weeks. These audits will continue of x two weeks, then monthly x 11 monthly a report on the and ality x one week and monthly x 11 months. The Certified Dietary Manager will a report on the findings of these audits are prior to use. These audits will then continue weekly x three weeks and monthly x 11 months. The Certified Dietary Manager will a report on the findings of these audits are prime the quality Assurance and Perform Improvement committee monthly x year. The Quality Assurance and Perform Improvement committee will make changes to the plan as necessary. The facility Administrator and the D of Nursing will be ultimately resport for the implementation of this plan correction to ensure the facility attamaintains substantial compliance. 	onths. ometer hat hitized d then compile udits for hance one mance Director hsible of	

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