PRINTED: 09/15/2021 FORM APPROVED OMB NO. 0938-0391

INME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE & REHAB DIP SHORT SUMMARY STREAMS TO POEPICIBIOUS STREET ADDRESS, CITY, STATE, 2P CODE 499 BROOKOOD AVENUE NE COMMENT OF DEPICIBIOUS STATE AND PROVIDERS HAND PROPERTIES TAG STREET ADDRESS, CITY, STATE, 2P CODE 499 BROOKOOD AVENUE NE COMMENT OF DEPICEMENTS STATE AND PROVIDERS HAND PROPERTIES STATE AND PROVIDERS HAND PROPERTIES SHOULD BE CONSENDED TO THE APPROPRIATE DEPICEMENT OF DEPICEMENT STATE AND PROPERTIES SHOULD BE CONSENDED TO THE APPROPRIATE DEPICEMENT OF DEPICEMENT STATE AND PROPERTIES SHOULD BE CONSENDED TO THE APPROPRIATE DEPICEMENT OF DEPCHALED OF DEPOCRATION OF DEPOCRATION OF DEPCHALED OF DEPOCRATION OF DEPOCRATI		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
UNIVERSAL HEALTH CARE & REHAB UNIVERSAL HEALTH CARE & REHAB SUMMARY STATEMENT OF DEFICIENCES GENCH DEVICENCY AUST BE PRECEDED BY FULL REGULATION OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced recertification and complaint survey were conducted on 7/12/21 through 7/15/21. The facility was found in complaince with requirement CPR 489.73, Emergency Preparedness, Event ID # QBPN11. F 000 A recertification and complaint survey were conducted from 7/12/21 through 7/15/21. Event ID #GBPN11. 9 of the 31 complaint allegations were substantiated resulting in deficiencies. F 551 Rights Exercised by Representative SSS=D CROSS-SEPERACED ID # QBPN11. F 551 8/12/21 8/12/21 8/12/21 F 1551 8/13/31(D)(3) in the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse of the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative, (ii) The resident representative, (iii) The resident representative, including the right to revoke a delegation of rights, except as limited by State law. \$483.10(D)(2) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent prevised by the court or			345183					
PREFIX (IEACH DEFICIENCY NUST BE PRECEDED B FULL TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REF			НАВ	1	430 BROOKWOOI	D AVENUE NE	,	
An unannounced recertification and complaint survey were conducted on 7/12/21 through 7/15/21. The facility was found in complaince with requirement CFR 483.73, Emergency Preparedness, Event ID # QBPN11. F 000 A recertification and complaint survey were conducted from 7/12/21 through 7/15/21. Event ID # QBPN11. 9 of the 31 complaint allegations were substantiated resulting in deficiencies. F 551 Rights Exercised by Representative F 551 S=D CFR(s): 483.10(b)(3)-(7)(i)-(iii) \$483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative, in the sex of the representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(d) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH	H CORRECTIVE ACTION SHOULD B -REFERENCED TO THE APPROPRIA		COMPLETION
survey were conducted on 7/12/21 through 7/15/21. The facility was found in complaince with requirement CFR 483.73. Emergency Preparedness. Event ID # QBPN11. F 000 A recertification and complaint survey were conducted from 7/12/21 through 7/15/21. Event ID #QBPN11. 9 of the 31 complaint allegations were substantiated resulting in deficiencies. F 551 Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) \$483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative, (ii) The resident representative has the right to exercise the resident representative, including the right to revoke a delegation of rights, except as limited by State law. \$483.10(b)(4) The facility must treat the decisions of the resident to the extent required by the court or	E 000	Initial Comments		EC	00			
conducted from 7/12/21 through 7/15/21. Event ID #QBPN11. 9 of the 31 complaint allegations were substantiated resulting in deficiencies. F 551 Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) \$483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or	F 000	survey were conducted 7/15/21. The facility were requirement CFR 483 Preparedness. Event	ed on 7/12/21 through vas found in complaince with 3.73, Emergency ID # QBPN11.	FC	00			
substantiated resulting in deficiencies. Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) \$483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or		conducted from 7/12/						
not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or		substantiated resulting Rights Exercised by F	g in deficiencies. Representative	F 5	51			8/12/21
of a resident representative as the decisions of the resident to the extent required by the court or		not been adjudged in court, the resident had representative, in account legal surrogate so the resident's rights to state law. The samemust be afforded treat to an opposite-sex specific valid in the jurisdiction (i) The resident represexercise the resident' rights are delegated to (ii) The resident retain rights not delegated to including the right to the resident to the court of the resident retain rights not delegated to the right to the right to the resident right to the right to the resident right right right to the resident right rig	competent by the state s the right to designate a cordance with State law and o designated may exercise to the extent provided by sex spouse of a resident atment equal to that afforded couse if the marriage was in in which it was celebrated. sentative has the right to s rights to the extent those to the representative. The state of the state of the sexual country is the right to exercise those of a resident representative, revoke a delegation of rights,					
		of a resident represer the resident to the ex	ntative as the decisions of tent required by the court or			TITLE		(X6) DATE

Electronically Signed 08/08/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		345183	B. WING		C 07/15/2021		
	ROVIDER OR SUPPLIER		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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 551	applicable law. §483.10(b)(5) The faresident representation decisions on behalf content required by the resident, in accordant shadows a resident represor taking actions that of a resident, the faction concerns when and in the state law. §483.10(b)(7) In the sincompetent under the faction of the resident representative appoin on the resident representation in the representation in the representation in the representative in the representative. (ii) The resident's wis be considered in the representative. (iii) To the extent praciprovided with opportion care planning process.	cility shall not extend the we the right to make of the resident beyond the ecourt or delegated by the ce with applicable law. acility has reason to believe sentative is making decisions are not in the best interests lity shall report such in the manner required under case of a resident adjudged are laws of a State by a court tion, the rights of the resident exercised by the resident exercised by the resident inted under State law to act alf. The court-appointed we exercises the resident's dged necessary by a court of in, in accordance with State exident representative whose nority is limited by State law in the resident retains the right ons outside the ority. Shes and preferences must exercise of rights by the citicable, the resident must be unities to participate in the	F 55	51			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			l	C 15/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	13/2021
					80 BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & RE	HAB			ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 551 Continued From page 2		F t	551				
F 551	Based on record revinterviews, the facility guardian of a dischar residents reviewed for Findings Included: Resident #31 was ad 10/30/20 with diagnostenosis and malignal Resident #31's face of family member as the A review of guardians Resident #31's family on 3/31/21 and listed incompetent person. A phone call was place to Resident #31's guawas involved in a car Social Worker (SW) and 14th, 2021 and there moving Resident #31 was member stated that so 5/18/21 and did not respoken with but was discharged out of the had let her know Resident (SW) on 7/15 that she could not resident was conducted to the could not resident was conducted to t	iew, guardian and staff of failed to notify in writing the age from the facility for 1 of 2 or discharge. (Resident #31) mitted to the facility on ses which included spinal ant neoplasm unspecified. Sheet listed Resident #31's e medical representative. Ship papers revealed that or member became guardian Resident #31 as an ced on 7/15/21 at 12:30 PM ardian who stated that she e plan meeting with the and Resident #31 on April was discussion about to an assisted living facility anted to leave. The family she called the facility on emember who she had told Resident #31 had of facility on 5/11/21 and no sident #31 had left the facility. Inpleted with the Social of facility on 5/11/21 and no sident #31 had left the facility.	F	551	This plan of correction constitutes as 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 or alleged, or the correctness of the conclusions set for othe statement of deficiencies. This plan correction is prepared and submitted solely because of the requirement undestate and federal law and to demonstrate the good faith attempts by the provider improve the quality of life of each resident. Facility failed to notify in writing the guardian of a discharge from the facility for Resident #31. Resident did not retute to the facility. 2. An audit was conducted on 8/11/2 by the Social Worker of discharges from the last 30 days (7/12/21-8/10/21) to ensure that the guardian was included the discharge process. 3. Social Worker and Nurse Manager were educated by the Administrator on 8/5/2021 on knowing the rights of the guardian and involvement in the discharge process. Discharging residents will be discussed morning Stand up (Monday-Friday) with the Interdisciplinary Team (Administrator Discharge of Nursing Team (Admin	er of on on of er ate to ent. e y urn 021 m in rs arge	
	Resident #31's guardian about the resident's discharge on 5/11/21 and thought Resident #31 called his guardian. The SW then stated that she did not talk with the guardian as she would not				Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Leadership, Social Worker, and Dietary to ensure appropriate planning and		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		345183	B. WING				C / 15/2021
	ROVIDER OR SUPPLIER AL HEALTH CARE & REI			43	TREET ADDRESS, CITY, STATE, ZIP CODE 30 BROOKWOOD AVENUE NE CONCORD, NC 28025	1 07	713/2021
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 551	(MDS) dated 5/11/21 cognition as being codischarged to the condischarged condition. A record review reveat communication was a guardian regarding his on 5/11/21. On 7/15/21 at 4:24 Pl completed with the act the discharge process and be a team effort of the condischarge conditions.	arge Minimum Data Set coded the resident's gnitively intact and numerity. Set edated 5/11/21 revealed ged home on 5/11/21 in alled no written or verbal completed to Resident #31's sedischarge out of the facility	F	5551	notifications are completed prior to discharge. The Administrator or designee will conduct audits of all discharges to ensithat guardians/Responsible Parties are involved in the discharge process weel x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns a trends and reported to Quality Assuran and Performance Improvement by the Director of Nursing monthly x 3 months At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	kly nd ce	
F 561 SS=D	CFR(s): 483.10(f)(1)- §483.10(f) Self-deterr The resident has the promote and facilitate through support of re- not limited to the right (1) through (11) of thi §483.10(f)(1) The res activities, schedules (waking times), health	mination. right to and the facility must resident self-determination sident choice, including but its specified in paragraphs (f) is section. ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other	F	561	5. Person Responsible: Administrato		8/12/21

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			C 07/15/2021	
NAME OF PI	ROVIDER OR SUPPLIER	1	•	STREET ADDRESS, CITY, STATE, ZIP CODI	•		
				430 BROOKWOOD AVENUE NE			
UNIVERSA	AL HEALTH CARE & RE	HAB		CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 561	Continued From pag	e 4	F 5	61			
	choices about aspect facility that are signiff §483.10(f)(3) The rewith members of the	sident has a right to make ts of his or her life in the icant to the resident. sident has a right to interact community and participate in both inside and outside the					
	religious, and comminterfere with the right facility. This REQUIREMEN by: Based on record revistaff interviews, the fresident who was as	ctivities, including social, unity activities that do not hats of other residents in the T is not met as evidenced views, resident interview, and facility failed to permit a sessed as a safe smoker to rantine for 1 of 5 residents		F561 1. The facility failed to perm who was assessed as a safe somewhen on quarantine for #49. Facility arranged for Resonoke.	smoker to r Resident		
	Resident #49 was ac 4/27/2021 and read for Resident #49 incl disease, and kidney The most recent adm assessment dated 5, #49 to be cognitively A nursing note dated Resident #49 was ur allowed to go outside	nitted 7/10/2021. Diagnoses uded lung disease, heart disease. nission Minimum Data Set /18/2021 assessed Resident intact. 16/14/2021 documented that shappy about not being		 Social Worker conducted 8/11/21 of all residents on quawere assessed as a safe smoensure they can smoke if desiadditional safe smokers on quawere identified and no further identified. All nursing staff are to be the Administrator and Director regarding residents that are as a safe smoker to be allowed to when on quarantine if they de nicotine patch, accommodatio will be made. All newly hired expressions as a safe smoker to be allowed to when on quarantine if they de nicotine patch, accommodatio will be made. All newly hired expressions as a safe smoker to be allowed to when on quarantine if they de nicotine patch, accommodatio will be made. All newly hired expressions as a safe smoker to be allowed to the nicotine patch, accommodation will be made. All newly hired expressions as a safe smoker to be allowed to the nicotine patch. 	erantine that ker to ired. No larantine issues educated by of Nursing ssessed as to smoke lars to smoke large		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	` ′	E SURVEY PLETED
		345183	B. WING _			07	C 7/ 15/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01	71072021
				4:	30 BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & R	EHAB			ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC 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 561	Continued From pa	ge 5	F 5	561			
	to encourage Residuesignated smoking smoking materials and A smoking assessm	tus and included interventions dent #49 to smoke only in the g areas and to store her at the nursing station. nent dated 7/11/2021 #49 to be a safe and			will receive the education in new hire orientation. No employee will be allowe to work without the education. Education to be completed by 8/11/2021. An audit will be conducted weekly by the Social Worker to ensure that residents that are assessed as safe smokers and	on ne	
	independent smoke Resident #49 was i 4:03 PM. Resident hospitalized and rea	er. nterviewed on 7/12/2021 at #49 reported she had been admitted to the facility on			on quarantine are able to smoke if desired. This audit will be conducted weekly x 12 weeks.		
	7/10/2021. Resident #49 reported she was in quarantine for 2 weeks and she had been told she was not allowed to go out to smoke during the quarantine. Resident #49 reported the facility offered her a nicotine patch, but she did not want it. Resident #49 reported it upset her to not be able to smoke while on quarantine.				4. Data obtained during the audit process will be analyzed for patterns a trends and reported to QAPI by the Director of Nursing monthly x 3 months At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain		
	PM. Nurse #3 reported her multiple times to #3 reported Reside was restricted from after her hospitalize	viewed on 7/14/2021 at 4:02 orted Resident #49 had asked to go out and smoke. Nurse nt #49 was very upset she smoking while on quarantine ation. Nurse #3 reported that tts could go out and smoke quarantine.			compliance. 5. Person Responsible: Social Work and Administrator	er	
	7/15/2021 at 10:21 Resident #49 had e	NA) #2 was interviewed on AM. NA #2 reported that expressed she was very not allowed to go outside to					
	7/15/2021 at 10:41 Resident #49 had o allowed to go out to	onducted with Nurse #4 on AM. Nurse #4 reported complained to him she was not o smoke when she was nis was upsetting to her. Nurse					

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25.			(c	
		345183	B. WING			07/	15/2021	
	ROVIDER OR SUPPLIER AL HEALTH CARE & REI	НАВ	·	430 B	ET ADDRESS, CITY, STATE, ZIP CODE BROOKWOOD AVENUE NE CORD, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 565 SS=E	nicotine patch. The Administrator wa at 3:59 PM. The Adn facility had prevented outside to smoke dur hospitalization and not about the process. Texpected the facility the and make accommod Resident/Family Group (FR(s): 483.10(f)(5)(5)(5)(5)(5)(6)(6)(6)(6)(7)(6)(7)(7)(7)(7)(7)(7)(7)(7)(7)(7)(7)(7)(7)	s interviewed on 7/15/2021 ninistrator reported the residents from going ing their quarantine after oresidents had complained the Administrator reported he to honor residents wishes dations for their choices. up and Response ii)-(iv)(6)(7) iident has a right to organize ident groups in the facility. rovide a resident or family with private space; and take the the approval of the group, d family members aware of n a timely manner. ther guests may attend filly group meetings only at is invitation. Forovide a designated staff and who is responsible for and responding to written form group meetings. Consider the views of a fully and act promptly upon form and act promptly upon form and resident care and life for able to demonstrate their		565			8/12/21	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345183	B. WING			1	D 15/2021
	ROVIDER OR SUPPLIER	НАВ	•	4	TREET ADDRESS, CITY, STATE, ZIP CODE 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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565	family member(s) or representative(s) mer families or resident reresidents in the facility. This REQUIREMENT by: Based on record revinterviews, and staff it to protect resident 's residents reviewed for #50, Resident #61, Resident #79). Findings included: 1. The resident council 1/26/2021 noted resident from laundry. The resident council 2/23/2021 noted resident pack from the The grievance responsively staff reported resident names, or the unreadable. The grievance resident names or the unreadable of the grievance resident names or the unreadable. The grievance resident names or the unreadable of the grievance resident names or the unreadable. The grievance resident names or the unreadable of the grievance residents of the resident council 3/30/2021 noted residents.	ident has a right to roups. ident has a right to have other resident et in the facility with the expresentative(s) of other y. is not met as evidenced etws, observations, resident etws, ob	F	565	F565 1. The facility failed to protect resident s property from loss (Residen #50, #61, #59, #69 and #79) when reviewed for missing clothing. Resident #50, #79, and #59 clothes has been returned or are no longer missing. Residents #61 and #69 are still missing clothes. Administrator has informed Resident and/or Responsible Party that facility will reimburse for missing clothin. 2. An audit was conducted by Social Worker and Housekeeping Manager to ensure that current residents were not missing any clothing. This audit will be completed by 8/6/2021. 3. Administrator educated Social Worker, Housekeeping Manager, receptionist, ambassadors, and admissions coordinator on 9/10/2021 regarding the need to follow up with all residents to ensure they are not missin any clothing and returning clean clothin timely. Upon admission when new residents enter the facility, the reception.	t t ng.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	1, ,	E SURVEY PLETED
		345183	B. WING _			C / 15/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	· · · · · · · · · · · · · · · · · · ·	/ 13/2021
				430 BROOKWOOD AVENUE NE	0022	
UNIVERSA	AL HEALTH CARE &	REHAB		CONCORD, NC 28025		
				· · ·		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE
F 565	Continued From p	page 8	F 5	565		
	noted to report he	had sent clothing to the laundry		will complete an invento	orv log, if facility	
		name on the bag and the		does their laundry the re		
	_	een returned to him.		will be taken by the rece		
				labeled in the collar of the	he clothing with	
	The resident cour	ncil meeting minutes dated		black magic marker. Up	on admission the	
		esidents reported laundry was		admissions coordinator		
		or lost. The grievance response		residents closet in room		
		clothing that was lost had no		with their name, what be		
		thing. The laundry manager		whether the facility or fa		
	noted a bin of clothing was used for all clothing			laundry. The ambassad	•	
	without names.			an audit of their assigne		
	Λ Λ grievance/σ	concern form dated 3/31/2021		resident name tags on on name, bed number, and		
		e grievance form was		facility or the family doe		
		sident #50 and reported he was		the resident⊡s laundry i		
		The grievance form reported		ambassadors will label		
		lothing was not found.		sharpie, this is to be cor 9/10/21.	mpleted by	
	Resident #50 was	admitted to the facility on		An audit will be conduct	ted by Social	
	11/13/2017 with d	iagnoses to include heart failure		Worker to ensure that re	esidents are not	
	and stroke. The m	nost recent quarterly Minimum		missing any clothing an		
		nent dated 4/15/2021 assessed		being returned timely.		
	Resident #50 to b	e cognitively intact.		consist of 20 residents		
				weeks, 15 residents per		
		ncil was interviewed on		and 10 residents per we		
		PM. Resident #50 was in dent #50 reported he was		The Administrator will retail the weekly audits to ens		
		and it had not been replaced by		process s effectivenes		
	the facility.	ind it had not been replaced by		•		
	The Activities Diss	ector was interviewed on		Data obtained durir process will be analyzed	•	
		PM. The AD reported missing		trends and reported to (
		an ongoing issue for residents.		and Performance impro	_	
		she completed grievances for		Director of Nursing mon	-	
		cil and gave to the Social		At that time, the QAPI c		
		ld then give the grievance to the		evaluate the effectivene		
	department mana			interventions to determi		
	,	-		auditing is necessary to		
	An interview was	conducted with Laundry Aide		compliance.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345183	B. WING				C 15/2021
	ROVIDER OR SUPPLIER	НАВ		430	REET ADDRESS, CITY, STATE, ZIP CODE O BROOKWOOD AVENUE NE ONCORD, NC 28025	1 011	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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
F 565	Continued From pag (LA) #1 and LA #2 or #1 and LA #2 reported laundry frequently with clothing. LA #1 and L without a resident nathlinen room on a rack they received 1-2 continued in the laundry. The Laundry manage 7/14/2021 at 9:45 AN received frequent conclothing. The LM reported and linen room names was stored attributed in the laundry interview 7/15/2021 at 10:29 A reported a label mak would use the label reclothing to prevent me The Housekeeping E Consultant (HD) was 2:04 PM. The HD re at the facility for several and the laundry interview aware there was an interview are there was an interview and the laundry interview and the l	e 9 n 7/14/2021 at 9:16 AM. LA ed clothing came to the thout a resident name in the LA #2 reported the clothing me was stored in the clean LA #1 and LA #2 reported mplaints per week related to er (LM) was interviewed on M. The LM reported she mplaints related to missing orted there was a section in where clothing without and staff were encouraged to hing. was conducted on lM with the LM. The LM er was ordered and she maker to identify resident		665			
	at 3:54 PM. The Adr clothing had been an laundry. The Adminis clothing had not beel facility was planning machine. The Admir	ns interviewed on 7/15/2021 ninistrator reported missing ongoing issue for the strator reported the resident n labeled correctly and the to purchase a labeling nistrator reported he straff to identify clothing that					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	-	(X3) DATE COMP	SURVEY LETED
		345183	B. WING _				C 15/2021
	ROVIDER OR SUPPLIER	нав		STREET ADDRESS, CITY, ST 430 BROOKWOOD AVENU 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 ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565	2/14/2018 with diagnor vascular disease. The assessed Resident #4 The resident council variation of the resident council variation of the resident missing multiple pairs one could find the cloop of the Activities Director 7/13/2021 at 2:38 PM laundry had been and the AD reported the residents. An interview was con (LA) #1 and LA #2 on #1 and LA #2 reported laundry frequently with clothing. LA #1 and La without a resident nare linen room on a rack, they received 1-2 commissing laundry. The Laundry manage 7/14/2021 at 9:45 AM received frequent conclothing. The LM reported the clean linen room on a rack.	eturn all clothing to s admitted to the facility oses to of hypertension and e most recent quarterly MDS of to be cognitively intact. vas interviewed on . Resident #61 was in #61 reported he was of shorts and shirts and no thing. The AD reported missing ongoing issue for residents. dryer in the laundry room this set back the return of ducted with Laundry Aide 7/14/2021 at 9:16 AM. LA d clothing came to the hout a resident name in the A #2 reported the clothing me was stored in the clean LA #1 and LA #2 reported hiplaints per week related to or (LM) was interviewed on . The LM reported she hiplaints related to missing orted there was a section in where clothing without d staff were encouraged to	F 5	65			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345183	B. WING	 		C 07/15/2021	
	ROVIDER OR SUPPLIER AL HEALTH CARE & RE	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	- 1		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 565	reported a label mak would use the label reclothing to prevent m. The Housekeeping E. Consultant (HD) was 2:04 PM. The HD reat the facility for seve aware there was an The HD reported the clean linen room that The Administrator was 1:54 PM. The Administrator was 1:54 PM. The Administrator was 1:54 PM. The Administrator was planning had not been facility was planning machine. The Administration was not labeled and residents. c. Resident #59 was 03/27/19. The most recent quassessment dated 0: #59 was moderately An interview was cor 07/12/21 at 12:30 PM stated when she had to get her clothes bar	was conducted on M with the LM. The LM er was ordered and she maker to identify resident dissing clothing. Department Corporate or interviewed on 7/15/2021 at ported she had not worked eral months, but she was issue with missing clothing. The was no clothing in the at was unlabeled at this time. As interviewed on 7/15/2021 ministrator reported missing a ongoing issue for the estrator reported the resident in labeled correctly and the to purchase a labeling distrator reported he at staff to identify clothing that return all clothing to admitted to the facility on the strator reported Resident cognitively impaired. Inducted with Resident #59 on M regarding her laundry. She dirty laundry, it took forever ck. Resident #59 said she of clothes missing to the	F 56				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		\ ' '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345183	B. WING_			C 07/15/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025		77713/2021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 565	02/21/21, 03/30/21, 06/04/21. Resident in 5/21/21 meeting. Review of the Januar missing clothes and there was 1 grievand February, 5 for Marchard An observation was AM of the closet acrost rack of unmarked or An interview was corrack of unmarked or An interview was corrack of unmarked or Am with a family meresident #192. The fawith the current admishoes, a comforter, 3 that still had tags on, resident's belongings had been profession the facility a list of minand never heard backwas not responsible by a staff member the wearing clothes with An interview was corract Manager #2 on 7/13/1 laundry concerns. So complaints about misencouraged resident thought moving room Unit Manager said the	s a concern on 01/26/21, 04/27/21, 05/12/21 and 479 was present at the ry-April grievance logs for laundry concerns indicated the for January, 2 for the and 3 for April. Idone on 07/14/21 at 09:16 the properties of a discharged samily stated she had spoken inistrator regarding missing all being missing from the season of the same clothes. In the same clothing items all being missing from the season of the same clothes are said that the items ally labeled. She had given is sing items after discharge the residents were the resident's name. Inducted with the Unit 121 at 03:46 PM regarding the stated she had heard season clothes, and she had so to submit grievances. She has contributed to this. The the Administrator was aware of	F 5	65		
	through the clothes t them. She was aske	had each resident look o see if they could locate ed if she had heard about s on being taken and she				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345183	B. WING			1	C / 15/2021	
	ROVIDER OR SUPPLIER			430	EET ADDRESS, CITY, STATE, ZIP CODE BROOKWOOD AVENUE NE NCORD, NC 28025	<u> </u>	13/2021	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 565	stated she had not he acknowledged it was The Activity Director of at 03:57 PM about mushe heard something missing items or that on." She would also be their clothes to the lar prevent loss. She not bagged there was be loss. She noted she if for six months and concevery day and in every day an	eard that. She an ongoing issue. was interviewed on 07/14/21 issing clothing. She stated almost every day about "so and so has my clothes be asked if she would take undry and bag them to died when the clothes were atter turn around and less helped with Resident Council omplaints had been going on any monthly meeting. ducted on 07/14/21 at 09:16 at #1 and Laundry Aide #2 othes. Laundry Aide #1 ents don't have clothes and Laundry Aide #2 stated 9 ans were not marked. The asked about Resident #69's uplaint of missing clothes and member had not spoken a stated missing clothes was and that they heard it 1-2 andry Aide #1 said there were	F	565				
	with the Laundry Mar	e on 07/14/21 at 09:45 AM nager regarding missing e heard a lot of complaints						

	O T OIT MEDIO, II LE C	MEDIO/ ND CEITTIGEC				<u> </u>	. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(2
		345183	B. WING				15/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
I INIVEDS	AL HEALTH CARE & REI	LIAD		4	30 BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALIH CARE & REI	ПАВ		C	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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565	resident came to the any clothes. The ma complaints, she place her list, and she woult tried to find them. She returned often, due to She said they had a rwould look through. Tresidents with no clot said the NAs came be the no name rack for Manager noted that sthese clothes belong take them to them bu were no families in to and the family could reveral months. She were recognized by hmark them. She was other residents wear stated this was becaus no name rack. She we for this and stated she maker and have a promanager said she was for new admissions to they were labeled consend a letter out to the together a resident and Activity Coordinator at the residents. The Housekeeping D Consultant (HD) respinterviewed on 7/15/2 reported she had not	clothes. She noted when a facility, often they don't have nager stated if she heard ed the concern on the top of d ask for a description and he noted if clothes were not on name, or faded names. The name rack in a closet she she was asked about the hes on admission and she ack and used the clothes on them. The Laundry some NAs would say, "I know to this person" and would to take the laundry out for a said if someone's clothes her laundry staff, they would asked about complaints of the ingential she was asked about solutions was asked about clothes. The inted them to pass clothes ther, so she could ensure crectly. They were hoping to be Responsible Party and get and family event with the and help to label clothing with	F	565			

		OATE SURVEY COMPLETED			
	345183	B. WING _			C 07/15/2021
	ЕНАВ		STREET ADDRESS, CITY, STATE, ZIP C 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	CODE	01110/2021
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFII TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
there was no clothin		F t	565		
at 3:54 PM. The Addiction of the Administration of the Administrat	ministrator reported missing in ongoing issue for the strator reported the resident en labeled correctly and the it to purchase a labeling inistrator reported he y staff to identify clothing that return all clothing to admitted to the facility on arterly Minimum Data Set 16/08/21 noted Resident #69 tively impaired. Inducted on 07/12/21 at 1:05 ember visiting at the facility. In the stated that Resident #69 was in so of clothing from his closet in they visited before COVID. It was missing half of his member stated she had not sent Council minutes indicated the ern on 01/26/21, 02/21/21, 05/12/21 and 06/04/21. The sent at the 5/21/21 meeting.				
there was 1 grievan	ce for January, 2 for				
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page there was no clothin unlabeled. The Administrator w at 3:54 PM. The Ad clothing had been a laundry. The Adminic clothing had not bee facility was planning machine. The Admin expected the laundr was not labeled and residents. d. Resident #69 was 04/30/19. The most recent qua assessment dated 0 to be severely cogni An interview was co PM with a family me The family member missing several item that were there whe It was stated that he clothes. The family i filed a grievance. Review of the Resid laundry was a conce 03/30/21, 04/27/21, Resident #79 was p Review of the Janua missing clothes and there was 1 grievance	AL HEALTH CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 there was no clothing in the laundry that was unlabeled. The Administrator was interviewed on 7/15/2021 at 3:54 PM. The Administrator reported missing clothing had been an ongoing issue for the laundry. The Administrator reported the resident clothing had not been labeled correctly and the facility was planning to purchase a labeling machine. The Administrator reported he expected the laundry staff to identify clothing that was not labeled and return all clothing to residents. d. Resident #69 was admitted to the facility on 04/30/19. The most recent quarterly Minimum Data Set assessment dated 06/08/21 noted Resident #69 to be severely cognitively impaired. An interview was conducted on 07/12/21 at 1:05 PM with a family member visiting at the facility. The family member stated that Resident #69 was missing several items of clothing from his closet that were there when they visited before COVID. It was stated that he was missing half of his clothes. The family member stated she had not	ROVIDER OR SUPPLIER AL HEALTH CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 there was no clothing in the laundry that was unlabeled. The Administrator was interviewed on 7/15/2021 at 3:54 PM. The Administrator reported missing clothing had been an ongoing issue for the laundry. The Administrator reported the resident clothing had not been labeled correctly and the facility was planning to purchase a labeling machine. The Administrator reported he expected the laundry staff to identify clothing that was not labeled and return all clothing to residents. d. Resident #69 was admitted to the facility on 04/30/19. The most recent quarterly Minimum Data Set assessment dated 06/08/21 noted Resident #69 to be severely cognitively impaired. An interview was conducted on 07/12/21 at 1:05 PM with a family member visiting at the facility. The family member stated that Resident #69 was missing several items of clothing from his closet that were there when they visited before COVID. It was stated that he was missing half of his clothes. The family member stated she had not filled a grievance. Review of the Resident Council minutes indicated laundry was a concern on 01/26/21, 02/21/21, 03/30/21, 04/271/21, 05/12/21 and 06/04/21. Resident #79 was present at the 5/21/21 meeting.	ROVIDER OR SUPPLIER AL HEALTH CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 there was no clothing in the laundry that was unlabeled. The Administrator was interviewed on 7/15/2021 at 3:54 PM. The Administrator reported the resident clothing had not been labeled correctly and the facility was planning to purchase a labeling machine. The Administrator reported the resident clothing had not been labeled correctly and the facility was planning to purchase a labeling machine. The Administrator reported he resident assessment dated 06/08/21 noted Resident #69 to be severely cognitively impaired. An interview was conducted on 07/12/21 at 1:05 PM with a family member visiting at the facility. The family member stated that Resident #69 was missing several items of clothing from his closet that were there when they visited before COVID. It was stated that he was missing half of his clothes. The family member stated she had not filed a grievance. Review of the Resident Council minutes indicated laundry was a concern on 01/26/21, 02/21/21, 03/30/21, 04/27/21, 05/12/21 and 06/04/21. Resident #79 was present at the 5/21/21 meeting. Review of the January-April grievance logs for missing clothes and laundry concerns indicated there was 1 grievance for January, 2 for	A BUILDING 345183 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 439 BROOKWOOD AVENUE NE CONCORD, NC. 28025 SUMMARY STATEMOTO DEFICIENCES BUILDING BUILDING SUMMARY STATEMOTO DEFICIENCES BUILDING BUILDING BUILDING BUILDING SUMMARY STATEMOTO DEFICIENCES BUILDING BUILDING BUILDING BUILDING BUILDING CONCORD, NC. 28025 BUILDING BUILDING BUILDING CONCORD, NC. 28025 BUILDING BUILDING BUILDING CONCORD, NC. 28025 BUILDING BUILDING BUILDING BUILDING CONCORD, NC. 28025 BUILDING BUILDING BUILDING BUILDING BUILDING BUILDING CONCORD, NC. 28025 BUILDING BUILDING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345183	B. WING		C 07/15/2021	
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 COMPLETION	
F 565	Continued From pag	ge 16	F 56	5		
	AM of the closet acre	done on 07/14/21 at 09:16 oss from laundry with a long faded name clothes.				
	AM with a family me resident #192 .The f with the current adm shoes, a comforter, that still had tags on resident's belonging had been profession the facility a list of m and never heard bac was not responsible by a staff member the	mber of a discharged amily stated she had spoken inistrator regarding missing 3 outfits and clothing items, all being missing from the s. She said that the items hally labeled. She had given issing items after discharge ck. They were told the facility for lost items. She was told hat other resident's name.				
	Manager #2 on 7/13 laundry concerns. S complaints about mi encouraged resident thought moving room Unit Manager said the concerns. They through the clothes them. She was asked new clothes with tag stated she had not hacknowledged it was The Activity Director.	s an ongoing issue. was interviewed on 07/14/21				
	at 03:57 PM about n she heard something missing items or tha on." She would also	nissing clothing. She stated g almost every day about t "so and so has my clothes be asked if she would take aundry and bag them to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			C
NAME OF P	ROVIDER OR SUPPLIER	343103	B. W.KO	STREET ADDRESS, CITY, STATE, ZIP CO		07/15/2021
				430 BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & REI	HAB		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 C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 565	Continued From page	e 17	F 5	565		
	bagged there was be loss. She noted she h for six months and co every day and in ever	ed when the clothes were tter turn around and less helped with Resident Council mplaints had been going on my monthly meeting. ducted on 07/14/21 at 09:16				
	AM with Laundry Aide regarding missing clo stated that new reside they wanted clothes.	e #1 and Laundry Aide #2 thes. Laundry Aide #1 ents don't have clothes and Laundry Aide #2 stated 9				
	Laundry Aides were a family member's com they stated the family	ns were not marked. The asked about Resident #69's plaint of missing clothes and member had not spoken a stated missing clothes was				
	a common complaint times per week. Laur many no name clothe	and that they heard it 1-2 ndry Aide #1 said there were				
	residents with no cloth clothes from the close	e clothes are available for hes. The NAs obtained et for residents that don't admission. They said that				
	that other residents w	laints from residents also were wearing their clothes.				
	with the Laundry Man clothing. She said she about missing or lost	e on 07/14/21 at 09:45 AM lager regarding missing he heard a lot of complaints clothes. She noted when a facility, often they don't have				
	any clothes. The man complaints, she place her list, and she woul tried to find them. Sh	nager stated if she heard ed the concern on the top of d ask for a description and e noted if clothes were not				
	She said they had a r	no name, or faded names. no name rack in a closet she She was asked about the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			C 07/15/2021	
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	•	7771072021	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 565	said the NAs came the no name rack Manager noted the these clothes belotake them to them were no families if and the family conseveral months. Were recognized I mark them. She no ther residents we stated this was been on name rack. So for this and stated maker and have a Manager said she for new admission they were labeled send a letter out together a resident Activity Coordinate the residents. The Housekeepin Consultant (HD) interviewed on 7/2 reported she had several months, be issue with missing there was no cloth unlabeled. The Administrator at 3:54 PM.	clothes on admission and she e back and used the clothes on for them. The Laundry at some NAs would say, "I know ong to this person" and would but said, with COVID there in to check for names in clothing alld not take the laundry out for She said if someone's clothes by her laundry staff, they would was asked about complaints of earing their clothes and she ecause of clothes taken from the ne was asked about solutions I she wanted to have a label a process to label clothes. The e wanted them to pass clothes ns to her, so she could ensure correctly. They were hoping to to the Responsible Party and get at and family event with the or and help to label clothing with g Department Corporate responsible for Laundry was 15/2021 at 2:04 PM. The not worked at the facility for out she was aware there was an g clothing. The HD reported ning in the laundry that was was interviewed on 7/15/2021 Administrator reported missing an ongoing issue for the inistrator reported the resident ween labeled correctly and the ng to purchase a labeling	F	565			

NAME OF PROVIDER OR SUPPLIER WINVERSAL HEALTH CARE & REHAB (X4) ID PREFIX TAG CONCORD, NC 28025 (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 565 Continued From page 19 machine. The Administrator reported he expected the laundry staff to identify clothing to residents. e. Resident #79 was admitted to the facility on 10/12/18. The most recent quarterly Minimum Data Set assessment dated 05/27/21 indicated Resident #79 was conducted on 07/12/21 with Resident #79 was conducted on 07/12/21 with Resident #79 at 03:02 PM. He stated the for last couple months he took his laundry out when he visited a friend and his friend did it there as he had complained multiple times in Resident Council meetings and was tired of nothing being done. He stated the facility would not keep up with the laundry and he was missing several items. Review of the Resident Council minutes indicated laundry was a concern on 01/26/21, 02/21/21, 03/30/21, 04/27/21, 05/12/21 and 06/04/21. Resident #79 was present at the 5/21/21 meeting.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	OMPLETED
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES TAG)			345183	B. WING _			
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 565 Continued From page 19 machine. The Administrator reported he expected the laundry staff to identify clothing that was not labeled and return all clothing to residents. e. Resident #79 was admitted to the facility on 10/12/18. The most recent quarterly Minimum Data Set assessment dated 05/27/21 indicated Resident #79 was cognitively intact. An interview was conducted on 07/12/21 with Resident #79 at 03:02 PM. He stated the for last couple months he took his laundry out when he visited a friend and his friend did it there as he had complained multiple times in Resident Council meetings and was tired of nothing being done. He stated the facility would not keep up with the laundry and he was missing several items. Review of the Resident Council minutes indicated laundry was a concern on 01/26/21, 02/21/21, 03/30/21, 04/27/21, 05/12/21 and 06/04/21.			ЕНАВ		430 BROOKWOOD AVENUE NE	I	01710/2021
machine. The Administrator reported he expected the laundry staff to identify clothing that was not labeled and return all clothing to residents. e. Resident #79 was admitted to the facility on 10/12/18. The most recent quarterly Minimum Data Set assessment dated 05/27/21 indicated Resident #79 was cognitively intact. An interview was conducted on 07/12/21 with Resident #79 at 03:02 PM. He stated the for last couple months he took his laundry out when he visited a friend and his friend did it there as he had complained multiple times in Resident Council meetings and was tired of nothing being done. He stated the facility would not keep up with the laundry and he was missing several items. Review of the Resident Council minutes indicated laundry was a concern on 01/26/21, 02/21/21, 03/30/21, 04/27/21, 05/12/21 and 06/04/21.	PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETION
Review of the January-April grievance logs for missing clothes and laundry concerns indicated there was 1 grievance for January, 2 for February, 5 for March and 3 for April. An observation was done on 07/14/21 at 09:16 AM of the closet across from laundry with a long rack of unmarked or faded name clothes. An interview was conducted on 07/13/21 at 10:25 AM with a family member of a discharged	F 565	machine. The Admexpected the launding was not labeled and residents. e. Resident #79 was 10/12/18. The most recent quassessment dated 0 #79 was cognitively. An interview was concept and the complained much and complained mu	inistrator reported he ry staff to identify clothing that d return all clothing to as admitted to the facility on arterly Minimum Data Set 05/27/21 indicated Resident intact. Inducted on 07/12/21 with 02 PM. He stated the for last book his laundry out when he his friend did it there as he altiple times in Resident and was tired of nothing being the facility would not keep up to the was missing several Ident Council minutes indicated there on 01/26/21, 02/21/21, 05/12/21 and 06/04/21. Independent of the facility on the facility would not keep up to the was missing several Ident Council minutes indicated there on 01/26/21, 02/21/21, 05/12/21 and 06/04/21. Independent of the facility on the facility would not keep up to the was missing several Ident Council minutes indicated there on 01/26/21, 02/21/21, 05/12/21 and 06/04/21. Ident Council minutes indicated the facility of the	F 5	65		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345183	B. WING			C 07/15/2021
	ROVIDER OR SUPPLIER	ЕНАВ	,	STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 565	shoes, a comforter, that still had tags on resident's belonging had been professior the facility a list of mand never heard bac was not responsible by a staff member the wearing clothes with An interview was con Manager #2 on 7/13 laundry concerns. So complaints about ming encouraged residenthought moving roor Unit Manager said the concerns. They through the clothes them. She was asknew clothes with tag stated she had not hacknowledged it was the heard something missing items or that on." She would also their clothes to the lagreyent loss. She noted she for six months and convery day and in every day and in eve	sinistrator regarding missing 3 outfits and clothing items , all being missing from the s. She said that the items leally labeled. She had given lissing items after discharge ck. They were told the facility for lost items. She was told leat other residents were the resident's name. Inducted with the Unit //21 at 03:46 PM regarding the stated she had heard ssing clothes, and she had test to submit grievances. She has contributed to this. The lead of she had heard about to see if they could locate lead if she had heard about as on being taken and she leard that. She is an ongoing issue. Was interviewed on 07/14/21 hissing clothing. She stated galmost every day about to see asked if she would take aundry and bag them to obted when the clothes were letter turn around and less helped with Resident Council omplaints had been going on	F 56			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		345183	B. WING _			C 07/15/2021
	ROVIDER OR SUPPLIER	ЕНАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	'	01110/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 565	stated that new residence they wanted clothes out of 10 clothing ite Laundry Aides were family member's conthey stated the family with them. They bo' a common complaint times per week. Laumany no name cloth designated closet at They both noted the residents with no clothes from the clothave any clothes on they had heard comthat other residents. An interview was dowith the Laundry Maclothing. She said slabout missing or los resident came to the any clothes. The macomplaints, she place her list, and she wout tried to find them. Seturned often, due	dents don't have clothes and Laundry Aide #2 stated 9 ms were not marked. The asked about Resident #69's implaint of missing clothes and y member had not spoken th stated missing clothes was t and that they heard it 1-2 undry Aide #1 said there were les on a long rack in a cross the hall from laundry. se clothes are available for othes. The NAs obtained set for residents that don't admission. They said that plaints from residents also were wearing their clothes. ne on 07/14/21 at 09:45 AM inager regarding missing ne heard a lot of complaints t clothes. She noted when a e facility, often they don't have anager stated if she heard ized the concern on the top of ald ask for a description and he noted if clothes were not too no name, or faded names.	F	DEFICIENCY)		
	would look through. residents with no close said the NAs came of the no name rack for Manager noted that these clothes belong take them to them be were no families in the second	no name rack in a closet she She was asked about the othes on admission and she back and used the clothes on r them. The Laundry some NAs would say, "I know g to this person" and would ut said, with COVID there o check for names in clothing not take the laundry out for				

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			(3) DATE SURVEY COMPLETED	
		345183	B. WING				C
	ROVIDER OR SUPPLIER			430	EET ADDRESS, CITY, STATE, ZIP CODE BROOKWOOD AVENUE NE NCORD, NC 28025	1 077	15/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	several months. She were recognized by hark them. She was other residents wear stated this was becaused no name rack. She was for this and stated she maker and have a property of the war labeled cosend a letter out to the together a resident and a Activity Coordinator at the residents. The Housekeeping Document of the maker and not several months, but a sissue with missing clothere was no clothing unlabeled. The Administrator was at 3:54 PM. The Administrator was at 3:54 PM. The Administrator was at 3:54 PM. The Administrator was planning and not beer facility was planning machine. The Administrator. The Administrator.	e said if someone's clothes her laundry staff, they would he asked about complaints of high their clothes and she has of clothes taken from the has asked about solutions he wanted to have a label hocess to label clothes. The her them to pass clothes her, so she could ensure hor trectly. They were hoping to he Responsible Party and get had family event with the hand help to label clothing with he partment Corporate honsible for Laundry was hour to be the was aware there was an hothing. The HD reported high in the laundry that was high in the laundry that was high instrator reported missing hongoing issue for the her trator reported the resident had beled correctly and the hopurchase a labeling high instrator reported he had staff to identify clothing that	F	565			
F 584 SS=E		ble/Homelike Environment (7)	F	584			8/12/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345183	B. WING _			1	C / 15/2021
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025			13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B OSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	but not limited to recesupports for daily living. The facility must prov §483.10(i)(1) A safe, homelike environment use his or her person possible. (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall ethe protection of the roor theft. §483.10(i)(2) Housek services necessary to and comfortable interestand comfortable interestan	conment. Ight to a safe, clean, elike environment, including eliving treatment and ing safely. Inde- clean, comfortable, and it, allowing the resident to all belongings to the extent ring that the resident can vices safely and that the facility maximizes resident it is not pose a safety risk. Exercise reasonable care for resident's property from loss eeping and maintenance of maintain a sanitary, orderly, ior; ineed and bath linens that are	F	584			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED	
		345183	B. WING _		0.	C 07/15/2021	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		7.072021	
				430 BROOKWOOD AVENUE NE			
UNIVERSA	AL HEALTH CARE & RE	НАВ		CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE ACTIV	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 584	by: Based on observati	T is not met as evidenced ons, resident interviews and	F 5	F584			
	keep furniture in good the front lobby, 1 of 8 of 8 dining room of in the dining room, 3 and 1 of 1 vinyl chai station. Findings included: An observation was of the 2 chairs and 2 outside of the dietary 2 overbed tabletops chairs had multiple scushion. The game room chairs of the dietary 10 overbed tabletops chairs had multiple scushion.	facility failed to clean and od repair for 2 of 2 chairs in 2 overbed tables in the lobby, hairs, 3 of 3 cabinet drawers 3 of 5 chairs in the game room r in the 100-Unit nursing done on 07/12/21 at 9:15 AM 2 overbed tables directly y door in the front lobby. 1 of sloped downward and both shades of stains on the seat irs were observed on M and it was noted that 3 of 5 dried stains in the fabric on		 The facility failed to clefurniture in good repair for 2 the front lobby, 1 of 2 overb the lobby, 8 of 8 dining room cabinet drawers in the dinin of 1 vinyl chair in the 100-ur station. All stained and browere removed from the facility. Maintenance Director a Housekeeping Manager audensure that furniture was clegood repair. This audit was 8/6/2021. Administrator educated Director and Housekeeping ensuring that the facility furrand in good repair on 8/6/20 	2 of 2 chairs in ed tables in in chairs, 3 of 3 g room and 1 nit nursing ken furniture lity. and dited facility to ean and in a conducted on I Maintenance Manager on niture is clean		
	completed of 2 chair Both chairs had the stains on the seat co 07/12/21. An observation was chairs on 07/13/21 a of 5 fabric chairs stil the seat cushions. An observation was of the 2 chairs locate	AM an observation was as located in the front lobby. Is same multiple shades of ushion that were seen on a completed of the game room at 08:45 AM and noted that 3 I had multiple dried stains on a done on 07/14/21 at 9:00 AM and in the front lobby. Both a multiple shades of stains on		All stained chairs were removed. Cabinet drawers in dining recrepaired on 7/21/21 New chairs were purchased on 8/11/21 Maintenance Director and Hanager will conduct weekl weeks to ensure that facility clean and in good repair. Ar furniture will be attempted to	oved 7/21/21 from were I by the facility Housekeeping ly audits x 12 furniture is ny stained		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345183	B. WING		0.	C 7/ 15/2021
NAME OF PI	ROVIDER OR SUPPLIER	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/13/2021
				430 BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & RE	HAB		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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
F 584	Continued From page	e 25	F 58	34		
F 584	An observation was of AM of a gray vinyl change of the chair had multiple scattered throughout areas of white and brareas was present allon 07/14/21 at 10:21 observed sitting in the station and the chair Activity Assistant #1 at 09:38 and stated the residents to sit near the An observation was of 09:43 AM of the dining chairs observed had stains on the seat cut dark reddish brown some of the 3 drawer wooders ink in the dining room 2 of the 3 drawers stit handle was also mission.	completed on 07/14/21 09:35 air at the outer wall of the ion for residents to sit in. e areas of dried matter, both armrests had dried rown stains, and dried brown ong the seams of the chair. AM a resident was e gray chair at the nursing had not been cleaned. Was interviewed on 07/14/21 the chair was used by the nursing station. Conducted on 07/14/21 at an or own chairs and 8 of 8 multiple large and small shions, and 2 chairs had pots on the seat cushion. In cabinet built around the mount was noted to have the top cking out and crooked. The sing from the middle drawer.	F 58	by housekeeping, if not able to it will be discarded. 4. Data obtained during the a process will be analyzed for effe and reported to Quality Assurar Performance Improvement by t maintenance director x 3 month time, the QAPI committee will e the effectiveness of the interver determine if continued auditing necessary to maintain compliar 5. Responsible Person: Adm	udit ectiveness nce and he ns. At that evaluate ntions to is nce.	
	said the dining room would not sit in them. had a guest come se a towel down on the					
	with the Housekeepir and the Corporate Tr	ne on 07/14/21 at 09:45 AM ng Manager aining Manager about the d furniture. They were asked				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345183	B. WING_			C 07/15/2021
	ROVIDER OR SUPPLIER AL HEALTH CARE & RE			STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025		77713/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 584	resident's dining roon residents at the 100 noted that they were stains, and the Housnew administrator in replacing them. She disinfectant cleaner areas but had not prostained furniture was homelike environme Manager said the grashould have been cleaned the chair at the an issue and the furniture was anoticed the chair at the an issue and the furniture was concontrol (IC) nurse or regarding the dirty grant noticed the gray voiced concerns with dirty chairs, and staticlean furniture, and the front lobby, residents but was us it was in the front lob as the dining room was asked about residented table and she be a risk. She noted	airs in the front lobby, the m and the vinyl chair for Unit nursing station. It was aware they all had multiple tekeping Manager stated the dicated he was working on a said she was going to try a land brushes to clean these eviously. They stated the sont conducive with a lant. The Corporate Training lay chair at the nursing station leaned by housekeeping. The larger stated they had not he nursing station as being landingers stated they had not landingers stated they had not	F 5	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345183	B. WING _			C 15/2021
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	, <u>u.,</u>	10/2021
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 584	Continued From page	e 27	F 5	84		
	Nursing (DON) on 07 regarding the concern homelike environment furniture in the dining game room and the restains and discolorationate tables and cabinets in they had been asking not sure why it was a survey, as the furnitury years. She was asked spots on the dining reshe would expect the					
F 641 SS=D	with the Administrator the facility for 1 month wanted residents to hand feel comfortable heard direct complair lobby or dining room to look at it or sit on the acknowledged he had Manager and he was another facility. He was another facility. He was another facility handles. He stated the broken and if mainter it, he would see about Accuracy of Assessm CFR(s): 483.20(g)	d spoke with the Regional hoping to get furniture from was asked about the broken e dining room and missing the drawer tracks were mance was unable to repair at removal.	F 6	41		8/12/21
	§483.20(g) Accuracy The assessment mus	of Assessments. st accurately reflect the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	(X3) DATE SURVI COMPLETED		
			A. BUILDIN	NG		l c	
		345183	B. WING		_	.24	
NAME OF P	ROVIDER OR SUPPLIER	0.10.100	1	STREET ADDRESS, CITY, STATE, ZIP CO	07/15/20	121	
TVAIVIL OF T	NOVIDEN ON OUT FIEN			430 BROOKWOOD AVENUE NE	DL .		
UNIVERS	AL HEALTH CARE & F	REHAB					
	T			CONCORD, NC 28025	1		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COM IE APPROPRIATE	(X5) IPLETION DATE	
F 641	Continued From pa	age 28	F 6	641			
	resident's status.	.9					
		NT is not met as evidenced					
	by:	TT 10 Not mot up ovidenced					
	'	eviews, staff interviews,		F641			
		and observations the facility		1. The facility failed to cor	rectly code		
		ode Minimum Data Set (MDS)		MDS assessments in the ar	-		
	assessments in the	e areas of bowel and bladder		and bladder for Resident #7	6 and range		
	and (Resident #76), and range of motion		of motion Resident #88 for 2	? of 30		
		2 of 30 residents reviewed for		residents reviewed for MDS	-		
	MDS accuracy.			The MDS for resident #76 w			
				on 8/9/2021. The MDS for r	esident #88		
	Findings included:			was modified on 8/9/2021.			
	1. Resident #76 w	as admitted to the facility on		2. MDS will review resider	nts that		
		noses that included		currently have an indwelling	urinary		
	cerebrovascular ad	ccident, incomplete paraplegia,		catheter(foley) and residents	s that have		
	pressure ulcer, pai	n, congestive heart failure,		splints to ensure MDS are a	ccurate. If		
	hypertension and	coronary artery disease.		discrepancies are found MD			
				modify assessments. This r	eview will be		
		Resident #76 initiated on		completed by 8/11/2021.			
		interventions for an indwelling					
	urinary catheter.			3. Regional MDS Consulta			
				MDS nurses on completing			
		the Physician's orders for		assessments accurately who			
	been discontinued	ated the urinary catheter had		resident has an indwelling u catheter(foley) and residents			
	been discontinued	011 03/06/21.		splints. This education will b			
	Resident #76's qua	arterly MDS assessment dated		by 8/11/2021.	e completed		
		e resident as being cognitively		by 6/11/2021.			
		21 MDS for Resident #76 was		Director of Nursing will audi	5 MDS to		
		an indwelling catheter.		ensure assessment accurac			
		C		resident has an indwelling u	-		
	An observation of	Resident #76 was conducted		catheter(foley) and residents	-		
	on 07/12/21 at 01:	15 PM. He was resting in bed		splints. This audit will be co			
	and no urinary catl	neter was observed.		weekly x 12 weeks.			
	An interview with F	Resident #76 was conducted on		4. Data obtained during th	e audit		
	07/12/21 at 01:16	PM. He stated he was		process will be analyzed for	patterns and		
	receiving good car	e, his wounds had healed, and		trends and reported to Qual	ty Assurance		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3)	(X3) DATE SURVEY COMPLETED C 07/15/2021	
		345183	B. WING _	B. WING			
	ROVIDER OR SUPPLIER	нав		STREET ADDRESS, CITY, STATE, ZIP CO 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	DE	01/13/2021	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 641	An interview was cor 07/15/21 at 03:29 PM He stated Resident # removed a long time without it. He noted with him for a long tir The Corporate MDS 07/15/21 at 4:45 PM Resident #76. She s made a mistake whe catheter was coded f An interview was dor Nursing (DON) on 07 regarding the accura would expect the MD 2). Resident #88 was 2/15/20 with a diagnod Dementia, spinal stelland right elbows. The annual MDS assindicated Resident # impairment, required with all Activities of D functional limitation in upper extremity. An Activities of Daily 2/27/20 read in part; extensive to total star related to left sided with interview of an Occup.	nducted with Nurse #1 on M regarding Resident #76. 175 had the urinary catheter ago and was doing well he had worked consistently me. Nurse was interviewed on regarding the MDS for haid the MDS nurse had in the indwelling urinary for Resident #76. The with the Director of 17/15/21 at 11:45 AM cy of the MDS. She said she	F 6	and Performance Improvem Director of Nursing monthly At that time, the QAPI commevaluate the effectiveness of interventions to determine if auditing is necessary to main compliance. 5. Responsible Person: A	x 3 months. nittee will f the continued ntain		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(С
		345183	B. WING			07/	15/2021
	ROVIDER OR SUPPLIER AL HEALTH CARE & REH	HAB		43	TREET ADDRESS, CITY, STATE, ZIP CODE 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	An observation was on PM revealed Resident contracted and was with An interview was comply with the MDS cool did not complete this last Physical Therapy have contractures in It. An interview was comply with the Rehabilit that Resident #88 had elbows. On 7/15/21 at 4:24 PI completed with the Admos assessments not Care Plan Timing and CFR(s): 483.21(b)(2) A completed with the Admos assessments not CFR(s): 483.21(b)(2) A completed with the Admos assessments not CFR(s): 483.21(b)(2) A completed with the comprehensive as (ii) Prepared by an intincludes but is not limit (A) The attending phyte (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food	elbows and poor tolerance to ion. completed on 7/13/21 at 4:43 at #88 had both elbows yearing hand splints. Inpleted on 7/15/21 at 3:28 ordinator who stated that she MDS but according to the mote that Resident #88 did both elbows. Inpleted on 7/15/21 at 3:40 ation Director who stated discontractures in both If an interview was diministrator who stated that beed to be accurate. If Revision (i)-(iii) If a care Plans orehensive care plan must or days after completion of seessment. It is a care plan in the cardisciplinary team, that in ited to resician. If with responsibility for the interdisciplinary team, that in the care is a care in the care in th		641			8/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			C 07/15/2021	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		0771072021	
				430 BROOKWOOD AVENUE NE			
UNIVERSA	AL HEALTH CARE & REI	1AB		CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
F 657	Continued From page	e 31	F 6	57			
F 657	the resident and the r An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and cassessments. This REQUIREMENT by: Based on record reviobservations the facil catheter care plan for for urinary catheters. Findings included: Resident #76 was ad 02/08/21 with diagnos cerebrovascular accidents.	resident's representative(s). be included in a resident's participation of the resident resentative is determined be development of the staff or professionals in ined by the resident's needs resident. ised by the interdisciplinary ssment, including both the quarterly review is not met as evidenced riews, staff interviews, and rity failed to revise a urinary 1 of 2 residents reviewed (Resident #76) mitted to the facility on ses that included dent. sident #76 initiated on a area for indwelling urinary erventions of securing the	F 6	F657 1. Facility failed to revise a urir catheter care plan for Resident # reviewed for urinary catheters. C revised on 8/9/2021. 2. An audit was conducted for facility residents to ensure care p were accurate for residents with catheters. This audit will be com 8/10/2021. 3. MDS Coordinator and interdi	erre plan current blans urinary upleted by		
	and catheter removal shift. No further care A record review of the	t for tubing kinks, infection , and catheter care each plan updates were noted. Physician's orders for ed the urinary catheter had 103/08/21.		team will be educated by the Reg MDS Consultant regarding ensure plans are accurate for residents urinary catheters. This education completed by 9/10/2021. Regional MDS Consultant will auresidents per week to ensure the	re care with will be udit 5 t care		
		erly MDS assessment dated e resident was cognitively		plans are accurate for residents urinary catheters x 12 weeks. Administrator will review the resu			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			C 07/15/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 011	13/2021
					OOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & REI	HAB			ORD, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	e 32	F 6	57			
	intact. The 04/05/21 Resident #76 had a u	MDS assessment indicated rinary catheter.		me	eekly audit to ensure that care plan eetings are conducted within the quired timeframes.		
	on 07/12/21 at 01:15 and no urinary cathet An interview was con 07/15/21 at 03:29 PM He stated Resident # removed a long time without it. The facility's MDS Nu 07/14/21 at 03:50 PM updates. She noted i meetings if there were wounds or urinary cat update the care plan. update care plans aft quarterly reviews. The Corporate MDS I	ducted with Nurse #1 on I regarding Resident #76. 75 had the urinary catheter ago and was doing well Irse was interviewed on I regarding care plan In the daily morning I changes such as healed Itheter removal, she tried to She stated she would also I regarding care plan I the daily morning I changes such as healed I changes such as healed I changes or a change or		4. pro tre an Dii At ev int	Data obtained during the audit ocess will be analyzed for patterns a ands and reported to. Quality Assura d Performance Improvement by the rector of Nursing monthly x 3 months that time, the QAPI committee will aluate the effectiveness of the erventions to determine if continued diting is necessary to maintain mpliance. Person Responsible: Administrate	nce s.	
F 684 SS=D	07/15/21 at 4:45 PM Resident #76. She sa expected the MDS no updated his care plan. An interview was don Nursing (DON) on 07 regarding the revision she would expect the the care plans to be updated at the Care plans to be updated at the Care CFR(s): 483.25 § 483.25 Quality of care	regarding the care plan for aid she would have urse or nursing to have it. e with the Director of /15/21 at 11:45 AM its of care plans. She said MDS to be accurate and updated.	F 6	84			8/12/21

CIES N	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
	345183	B. WING _			1	C 1 5/2021
	НАВ		4	30 BROOKWOOD AVENUE NE	1 017	10/2021
CH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFII TAG	x	· ·		(X5) COMPLETION DATE
all treatments and treatments are sidents. Basent of a residents received the compression of the compression of the comply of and failed physician of the care (Residents of the hospinal orders of the hospin	ant and care provided to sed on the comprehensive dent, the facility must ensure the treatment and care in ressional standards of thensive person-centered sidents' choices. This not met as evidenced riews and staff interviews, the ray wound vac on arrival to to contact Infectious or intravenous (IV) for 1 of 1 resident reviewed esident #398). Indimitted to the facility on the argument of the hospital resident #398 and abdominal wall reviewed and the wound redges without granulation, as noted. It al discharge orders dated the instructions for the mid-lower contact (a device used to assist in wounds) to be replaced upon replaced upon resident and the wound responsible to the mid-lower contact (a device used to assist in wounds) to be replaced upon replaced upon replaced upon replaced and order dated rether midline abdominal reanser, apply black foam	F	684	arrival to the facility and failed to conta infectious diseases physician for IV antimicrobial orders for Resident #398. Resident #398 was discharged to the hospital on 6/19/2021 and did not retur the facility. 2. An Audit was conducted by the Nu Leadership team (Director of Nursing, Assistant Director of Nursing and Unit Managers) of the prior 30 days admiss to ensure accuracy of order and suppli This audit was completed on 8/11/2022 3. Licensed Nurses will be re-educat on inputting admission orders and havia a second nurse perform 2nd check of discharge /summary and orders by the Assistant Director of Nursing. Education included to ensure that Administrator of Nursing Leadership was notified of any supplies needed at that of admission. I supplies cannot be obtained by time resident admits to the facility, then Medical Director should be notified for alternate order. This education will be	on to lirse lion es. l. ed ng	
o I GO OSSELLATION TILLATION OF THE SECURITIES	SUPPLIER SUMMARY STACH DEFICIENCE GULATORY OR d From page of all treatments idents. Base ent of a resistents received the compression of the compression of the compression of the poly y and failed to apply y and failed included: #398 was at and discharacter of the compression of the compression of the compression of the complete included: #398 was at and discharacter of the compression of the complete included: #398 was at and discharacter of the complete included: #398 was at and discharacter of the complete included: #398 was at and discharacter of the complete included: #398 was at and discharacter of the complete included	SUPPLIER I CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) d From page 33 o all treatment and care provided to sidents. Based on the comprehensive ent of a resident, the facility must ensure lents receive treatment and care in noce with professional standards of the comprehensive person-centered a, and the residents' choices. QUIREMENT is not met as evidenced In record reviews and staff interviews, the filled to apply a wound vac on arrival to y and failed to contact Infectious a physician for intravenous (IV) Ibial orders for 1 of 1 resident reviewed y of care (Resident #398).	SUPPLIER J CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) Deficiency for the facility must ensure lents receive treatment and care in loce with professional standards of the comprehensive person-centered and the residents' choices. DUIREMENT is not met as evidenced In record reviews and staff interviews, the lided to apply a wound vac on arrival to by and failed to contact Infectious aphysician for intravenous (IV) bial orders for 1 of 1 resident reviewed by of care (Resident #398). Included: #398 was admitted to the facility on 1 and discharged to the hospital 1. Diagnoses for Resident #398 hypertension and abdominal wall Ital wound care documentation note 16/2021 was reviewed and the wound pink, viable edges without granulation, unneling was noted. Of the hospital discharge orders dated 1 revealed instructions for the mid-lower all wound vac (a device used to assist in large, open wounds) to be replaced upon facility. Additionally, the admission resident #398 included an order dated 1 to cleanse the midline abdominal ith wound cleanser, apply black foam are foam to the wound bed, drape to	SUPPLIER I CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) I F 684 I CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) I F 684 I CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) F 684 I CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) F 684 F 684 F 684 F 684 F 684 F 684 F 685 F 685 F 686 F 686 F 686 F 687 F 687 F 687 F 687 F 688 F 689 F 684 F 684	SUPPLIER I CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL SULLATORY OR L.SC IDENTIFYING INFORMATION) I F 684 TAG TAG TAG TAG TAG TAG TAG TA	SUPPLIER 345183 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SULATORY OR LSC IDENTIFYING INFORMATION) d. From page 33 F 684 d. From page 36 d. From page 37 d. From page 37 d. From page 38 d. From page 38 d. From page 38 d. From page 38 d. From page 39 d. From

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345183	B. WING			C	
NAME OF B	20,4252.02.01221.52	343163	D. WING		TDEET ADDRESS SITE STATE TO SODE	07/	15/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE & RE	HAB		4	30 BROOKWOOD AVENUE NE		
O.M. C. C.	12 112 12 11 1 3 1 1 2 G 1 1 2 1			C	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	A review of the treath for Resident #398 revinot been reapplied at A nursing note dated Resident #398 was tr 6/19/2021 by the required the wound vac had not facility. The emergency room 6/19/2021 were revied the mid-lower abdom (wound extended und that was not noted or date). The wound care (WC 7/14/2021 at 11:26 A when Resident #398 did not have white would not apply the white foam. The WC Supply staff member new admissions, inclusive that the could not apply the word of the wor	of mercury) suction on any and Friday. Inent administration record vealed the wound vac had a her admission to the facility. 6/19/2021 documented ansferred to the hospital on uest of the family because of been applied by the In admission notes dated wed. The note documented inal wound had tunneling der the surface of the skin) in the previous exam (no In ourse was interviewed on the previous exam (no In ourse was interviewed on the facility, they bund vac foam in stock, and the WC Nurse explained the wound vac without the nurse reported the Central ordered supplies needed for uding wound vac supplies needed for uding wound vac supplies and the Central Supply staff she had missed the order admission orders for the white foam would be and the wound vac sesident #398. The WC would have returned to the land would have applied the	F	684	ensure new admissions have the propesupplies or any special equipment upor admission. And if supplies are unable to be obtained Central Supply with notify Nursing Leadership so that they can not Medical Director. Nursing Leadership will review new admission orders/discharge summary/additional supplies to ensure delivery of for verification of 2nd nurse and accurate of orders x 12 weeks. Nursing Leadership will monitor new admission for supply deliveries 4. Data obtained during the audite process will be analyzed for patterns attrends and reported to Quality Assurant and Performance Improvement by the Director of Nursing monthly x 3 months At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	n o otify and laily acy nd ce	
	Supply staff member new admissions, including the WC nurse report member told her that for white foam on the Resident #398 and the ordered on 6/18/2021 was not working on 6 was not applied to Renurse indicated she was facility on 6/21/2021 and the working on 6 was not applied to Renurse indicated she was facility on 6/21/2021 and the working on 6 was not applied to Renurse indicated she was not applied	ordered supplies needed for uding wound vac supplies. ed the Central Supply staff she had missed the order admission orders for he white foam would be 1. The WC nurse stated she 1/19/2021 and the wound vac esident #398. The WC would have returned to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345183	B. WING			C 07/15/2021
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CO 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	DDE	01710/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	7/14/2021 at 11:12 A entered the admission UM #1 reported she Supply staff member foam for Resident #3 not discussed the succentral Supply staff. The Director of Nurson 7/14/2021 at 11:4 the Central Supply swhite foam on the ad #398 and had place on 6/18/2021 at 11:4 delivered to the facil. The Admissions staff 7/14/2021 at 1:23 Pl member reported shorders and emailed and all department houghly. The Admission Central Supply staff orders to order supply available for intervier.	apply wound vacs. JM) #1 was interviewed on AM. UM #1 reported she on orders for Resident #398. was not aware Central r had not ordered the white 398. UM #1 reported she had applies needed with the member. ing (DON) was interviewed 44 AM. The DON reported taff member had not seen the dmission orders for Resident d an order for the white foam 42 AM. The foam was ity on 6/18/2021 at 11:24 PM. If member was interviewed on M. The Admissions staff e received hospital discharge a copy to both unit managers heads, including Central ion staff member reported member used the discharge lies for residents.	F	684	()	
	at 3:49 PM. The Adnot certain how adm vac white foam were reported it was his e for new admissions	as interviewed on 7/15/2021 ministrator reported he was ission orders for the wound e missed. The Administrator xpectation that all supplies were ordered timely and in nt was admitted to the facility.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			C 7/15/2021	
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	dated 6/17/2021 spephysician was to mare (includes antibiotic, a medications) therapy directions to contact physician and the IV skin) was to be de-ached been completed. A nursing note dated Resident #398 was to 6/19/2021 by the requirection A review of the emer 6/19/2021 revealed FIV site had been de-ached admission to the facil documented the facil Infectious Diseases pantimicrobials. Nursing notes for Rether was no committee Infectious Disease was not documented. The Unit Manager (UT/14/2021 at 11:12 Ache entered the admission UM #1 reported she in the Infection of the Infec	pospital discharge orders cified the Infectious Diseases mage the IV antimicrobial intifungal and antiviral of the Infectious Diseases port (IV access under the accessed after antimicrobials of the family. 6/19/2021 documented the properties of the family. gency room notes dated accessed (removed) upon lity. The note further ity had not contacted only in the IV sident #398 were reviewed. See physician to commented with the physician. The IV port	F 6	84			
	known Resident #39 explained she had er orders into the electr #398 's admission to	UM #1 reported she had not 8 had an IV port. UM #1 ntered the hospital discharge onic system prior to Resident of the facility. UM #1 reported orders she entered prior to harmacy.					

PRINTED: 09/15/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			C 07/1	5/2021
	ROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	'	<u> </u>	0/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	on 7/14/2021 at 11:44 she was not aware In should have been cormedication orders for reported she was not hospital discharge ordedications ordered Diseases physician stupdate the IV medical #398. The Administrator was at 3:49 PM. The Administrator was not contacted for The Administrator reported that all hospital discharge of Care CFR(s): 483.25(b)(2) Foot care and care to maintain the health, the facility mu (i) Provide foot care a with professional start to prevent complication medical condition(s) as (ii) If necessary, assist appointments with a carranging for transport appointments. This REQUIREMENT by: Based on observation resident interviews, the should be a single provide the condition of the carranging for transport appointments.	ng (DON) was interviewed A.A. The DON reported fectious Diseases physician intacted to update the IV Resident #398. The DON aware Resident #398 's ders had IV antimicrobial for specified the Infectious hould be contacted to tion orders for Resident is interviewed on 7/15/2021 inistrator reported he was fectious Diseases physician forders for Resident #398. forted it was his expectation farge orders were followed. (i)(ii) are. Ints receive proper treatment mobility and good foot st: Ind treatment, in accordance ideards of practice, including ons from the resident's and st the resident in making		F687 1. Facility failed to provide or	arrange		3/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			71. 501251			١ ,	c
		345183	B. WING				15/2021
NAME OF P	ROVIDER OR SUPPLIER		_	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	10/2021
				43	30 BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & REI	НАВ			ONCORD, NC 28025		
(V4) ID	QUIMMADV QT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 687	Continued From page	e 38	F	687			
	long toenails (Reside	nt #42) for 1 of 1 resident			foot care for a resident with thick and lo	ong	
	who was reviewed for	· · · · · · · · · · · · · · · · · · ·			toenails for Resident #42. Foot care w	-	
					provided for Resident #42 on 7/15.		
	The findings included	:					
					2. A foot care audit was conducted for	or all	
		mitted on 4/22/21. The			current residents to determine if foot ca	are	
	_	s of included left sided			is needed. If it is determined that a		
	· •	ke, seizures, arthritis, and			resident needs to be seen by a podiatr		
	anxiety.				the appropriate referral will be made.	This	
					audit will be conducted by 8/11/2021.		
	I .	nt titled, Southeast Skilled			0 All		
	_	ent, dated 4/27/21, revealed			3. All nursing staff was educated	_	
		onsible Party, who had i, had not checked a box to			regarding the expectation that resident receive the proper foot care if needed.	S	
		ot Care services to include			This education was completed on		
	management of preven				8/11/2021.		
	management of provi	shave reet eare.			Director of Nursing and/or Nurse		
	Review of Resident #	42 ' s Electronic Medical			Managers will conduct audit on current	-	
		ed no documentation			residents to ensure they ensure they a		
	regarding a podiatry				receiving proper foot care or if foot care		
					needed. All residents identified will be	put	
	The Minimum Data S	et (MDS) admission			on the podiatrist list for their next visit		
	comprehensive asses	ssment with an Assessment			which is scheduled for 10/01/21. This		
		D) of 4/29/21 indicated			audit will consist of 20 residents per we	eek	
	Resident #42 was co	gnitively intact. The resident			x 4 weeks, 15 residents per week x 4		
	· ·	ng extensive assistance of			weeks, and 10 residents per week x 4		
		Activities of Daily Living			weeks.		
		ygiene, including bathing.			4. Data obtained during the audit		
	The resident was ide	•			process will be analyzed for patterns a		
		range of motion to one side			trends and reported to Quality Assuran	ce	
	hand) and no impairn	y (shoulder, elbow, wrist,			and Performance Improvement by the Director of Nursing monthly x 3 months		
	extremities.	ient on the lower			At that time, the QAPI committee will	o.	
	GAUGIIIIUGS.				evaluate the effectiveness of the		
	The care plan for Res	sident #42 had a care plan			interventions to determine if continued		
		scribed the resident as			auditing is necessary to maintain		
		are performance deficit			compliance.		
	_	jed hospitalization, debility					
	secondary to her hos	· · · · · · · · · · · · · · · · · · ·			5. Person Responsible: Director of		

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		, ,	TE SURVEY MPLETED
	345183	B. WING			C 7/15/2021
ROVIDER OR SUPPLIER	EHAB		430 BROOKWOOD AVENUE NE		7713/2021
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
weakness, right kneimpaired Range of Marcare plan goal for the improvement in her return to baseline plan was dated 5/11 Review of Resident Record (EMR) reveative by Unit Manatimed 5:33 PM, which was seen by the Nu order for Ciclopirox at bedtime for 48 we with alcohol weekly. Party was made aw Resident #42's phyreviewed, and an or 5/17/21 for Ciclopiro apply to the toenails for nail fungus. Review of Resident 's progress note da PM which document areas to her skin an anti-fungal cream to An observation was an interview with Resident During the resident back the sheet at th her feet. The resident	de pain, and left-hand Motion (ROM). There was a se resident to demonstrate ADL self-care ability and hysical functioning. The care /21. #42 's Electronic Medical aled a nurse 's progress note ager #1, dated 5/17/21 and ch documented the resident rse Practitioner (NP); a new to her toe nails every evening eeks and to wash her toenails. The resident 's Responsible are of the new orders. ysician 's orders were der was discovered dated by 8%, a topical treatment, a every bedtime for 48 weeks #42 's EMR revealed a nurse ted 5/29/21 and timed 3:40 ted the resident had no new d the resident received her toes. conducted in conjunction with resident #42 on 7/12/21 at the time of the bed and exposed ent stated she was worried her	F 687	Nursing		
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF REGULATORY O	ROVIDER OR SUPPLIER AL HEALTH CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 weakness, right knee pain, and left-hand impaired Range of Motion (ROM). There was a care plan goal for the resident to demonstrate improvement in her ADL self-care ability and return to baseline physical functioning. The care plan was dated 5/11/21. Review of Resident #42 's Electronic Medical Record (EMR) revealed a nurse 's progress note written by Unit Manager #1, dated 5/17/21 and timed 5:33 PM, which documented the resident was seen by the Nurse Practitioner (NP); a new order for Ciclopirox to her toe nails every evening at bedtime for 48 weeks and to wash her toenails with alcohol weekly. The resident 's Responsible Party was made aware of the new orders. Resident #42's physician's orders were reviewed, and an order was discovered dated 5/17/21 for Ciclopirox 8%, a topical treatment, apply to the toenails every bedtime for 48 weeks for nail fungus. Review of Resident #42's EMR revealed a nurse 's progress note dated 5/29/21 and timed 3:40 PM which documented the resident had no new areas to her skin and the resident received anti-fungal cream to her toes. An observation was conducted in conjunction with an interview with Resident #42 on 7/12/21 at 12:29 PM. Resident #15 was resting in bed. During the resident interview the resident pulled back the sheet at the foot of the bed and exposed her feet. The resident stated she was worried her toenails would catch on the sheet, or be caught,	ROVIDER OR SUPPLIER AL HEALTH CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 weakness, right knee pain, and left-hand impaired Range of Motion (ROM). There was a care plan goal for the resident to demonstrate improvement in her ADL self-care ability and return to baseline physical functioning. The care plan was dated 5/11/21. Review of Resident #42 's Electronic Medical Record (EMR) revealed a nurse 's progress note written by Unit Manager #1, dated 5/17/21 and timed 5:33 PM, which documented the resident was seen by the Nurse Practitioner (NP); a new order for Ciclopirox to her toe nails every evening at bedtime for 48 weeks and to wash her toenails with alcohol weekly. The resident 's Responsible Party was made aware of the new orders. Resident #42 's physician 's orders were reviewed, and an order was discovered dated 5/17/21 for Ciclopirox 8%, a topical treatment, apply to the toenails every bedtime for 48 weeks for nail fungus. Review of Resident #42 's EMR revealed a nurse 's progress note dated 5/29/21 and timed 3:40 PM which documented the resident had no new areas to her skin and the resident received anti-fungal cream to her toes. An observation was conducted in conjunction with an interview with Resident #42 on 7/12/21 at 12:29 PM. Resident #15 was resting in bed. During the resident interview the resident pulled back the sheet at the foot of the bed and exposed her feet. The resident stated she was worried her toenails would catch on the sheet, or be caught,	ROVIDER OR SUPPLIER 345183 STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 39 weakness, right knee pain, and left-hand impaired Range of Motion (ROM). There was a care plan goal for the resident to demonstrate improvement in her ADL self-care ability and return to baseline physical functioning. The care plan was dated 5/11/21. Review of Resident #42's Electronic Medical Record (EMR) revealed a nurse's progress note written by Unit Manager #1, dated 5/17/21 and timed 5:33 PM, which documented the resident was seen by the Nurse Practitioner (NP); a new order for Ciclopirox to her toe nails every evening at bedtime for 48 weeks and to wash her toenails with alcohol weekly. The resident's Responsible Party was made aware of the new orders. Resident #42's physician's orders were reviewed, and an order was discovered dated 5/17/21 for Ciclopirox 8%, a topical treatment, apply to the toenails every bedtime for 48 weeks for nail fungus. Review of Resident #42's EMR revealed a nurse 's progress note dated 5/29/21 and timed 3:40 PM which documented the resident had no new areas to her skin and the resident received anti-fungal cream to her toes. An observation was conducted in conjunction with an interview with Resident #42 or 7/12/21 at 12:29 PM. Resident #15 was resting in bed. During the resident stated she was worried her	ROWIDER OR SUPPLIER 3.45183 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 439 BROWOOD A NENUE TO CONCORD, NC 28025 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH ORDERCINE) WAIS TO PROFICE WAIS (EACH ORDERCINE) WAIS TO PROPORTIATE CONTINUED From page 39 CONTINUED FROM PROFINE IT AND OF CORRECTION CONTINUED FROM PROFINE IT AND OF CORRECTION CONTINUED FROM PROFINE IT AND OF CORRECTION CONCORD, NC 28025 F 687 Nursing F 688 Nursing F 687 Nursing F 687 Nursing F 687 Nursing F 688 Nursing F 687 Nursi

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345183	B. WING			C 07/15/2021	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	1 ,	J7/19/2021	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 687	toenail on the left for significantly beyond and the nail was curvitip of the toe. The rehad some visible evinails but were not as right foot all of the frobserved to have be beyond the tip of the were curling back to hook manner. The retrimmed her toenails been at the facility, a see the podiatrist for An observation was on 7/14/21 at 9:29 At toenails was unchan 7/12/21. During an interview of AM with Nurse #2 she to Resident #42 and the podiatrist had conthe podiatrist would compodiatrist would compodiatrist would see stated she was awar a fungal treatment to aware of any concert. An interview was con AM with the Nurse P stated she had observed and they were very lease to the podiatrist would see and they were very lease to trim or cut	w. The free edge of the big of was observed to extend hail bed and the tip of the toe wed, hooking back toward the sident's other four toenails dence of thickening of the long as the big toe. On the ee edges of nails were en thick and extended toe and the nail bed and ward the tip of the toes, in a esident stated no one had the whole time she had not she would not be able to another two months. Conducted of Resident #42 M and the appearance of her ged from the observation on Conducted on 7/14/21 at 9:31 The stated she was assigned she was not aware of when me to the facility, when the enterty of the facility again, if the Resident #42. She further the the resident was receiving the roenails but was not an regarding her toenails. The conducted on 7/14/21 at 9:40 aractitioner (NP). The NP are toenails on the stated the enterty applications. She stated the enterty applications of the stated the enterty applications.	F 6	87			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345183	B. WING _			C 07/15/2021
	ROVIDER OR SUPPLIER	:HAB		STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025		07713/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 687	F 687 Continued From page 41		F	687		
	because the resident and so thick, an elect most likely be needed as toenails back so the manageable length and of the nail catching on ail off. She stated at the resident and had the topical antifungather topical antifu	t's toenails were so long, stric mini rotary tool would ed to cut or trim the resident ' ey would be more of a and there would not be a risk on something and pulling the she had just started seeing I not ordered the Ciclopirox,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUC		' '	E SURVEY PLETED
		345183	B. WING			07	C //15/2021
	ROVIDER OR SUPPLIER	REHAB		430 BROOK	ORESS, CITY, STATE, ZIP CODE (WOOD AVENUE NE D, NC 28025	1 0,	71072021
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL PROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 687	toe nail, the thickness condition of the toconcern that it may off, the resident resident resident resident resident of the toenail on the left well and the right toenails on the right toenails on the right toenails on the right toenails on the right of the toenails on the right of the toenails on the right of the toenails and her considerable and the resident. The she did not know here a podiatrist had not because they wou trimming the resident. The she did not know here a podiatrist had not because they wou trimming the resident. Weekly skin asses but there was not condition of Resident to address the toenails, or they she needed to see toenails, or they she needed to see toenails trimmed.	stated due to the length of the less of the toe nail, the le nail, and the resident 's y catch on something and tear eeded to see a podiatrist. She is left foot big toe was the most le toes, but there was one more foot which needed attention as foot big toenail, and three other that foot. She said even though ked better than others, they led some attention from the lid the resident had not been trist when he was in the facility he podiatry consent form had by the responsible party. She the condition of the resident 's concern her toenail may be torn inge a podiatry appointment for Unit Manager further explained how come an appointment with lot been set up for the resident of the how come an appointment with led have been unable to manage ent 's toenails at the facility due. She said the nurses completed sments on all of the residents, ning documented regarding the lent #42's toenails and the leneir condition. She said the leneir condition. She said the leneir condition of the resident 'were unable to trim them, and the hold the podiatrist to have her	F	587			
	Resident #42 's R	Administrator he stated Responsible Party had not					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE S COMPL	
		345183	B. WING _			07/1	; 5/2021
	ROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	CODE	, 0,,,	0,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 687	resident could not recopodiatrist contracted administrator did not how come alternate provided for the resid in place to follow up to receive the service podiatrist. During an interview of 11:57 AM with the Dir said if Resident #42 hwith her toenails, she podiatrist to have her stated the condition of should have been picked up assessment, but have been picked up assessment if it were did not provide informal ternate podiatry ser for the resident or if the with the responsible preconsidering the conresident due to the contact of the resident or 7/15.	process therefore the seive the services of the by the facility. The provide information as to sodiatry services were not ent or if there were systems on residents who elected not as of the contracted conducted on 7/15/21 at sector of Nursing (DON) she had wanted something done could have asked to see a stoenails trimmed. The DON of the resident 's toenails ked up on the admission she did not know if it would on the weekly skin not a new issue. The DON section as to how come vices were not considered there was a plan to follow up county to discuss stracted podiatrist to see the condition of her toenails.	F	687			
	podiatrist because the consented to their po- admission paperwork the resident 's need to been followed up on.	e responsible party had not diatrist as part of the . He further stated, he felt for toenail care should have					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	, ,	ATE SURVEY MPLETED
		345183	B. WING _			C 07/15/2021
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CO	•	7771072021
				430 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & F	REHAB		CONCORD, NC 28025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETION DATE
F 760 SS=D	Residents are Free CFR(s): 483.45(f)(e of Significant Med Errors 2)	F 7	60		8/12/21
	medication errors. This REQUIREME by: Based on record representation of the facility failed to prescribed IV antibresident reviewed for the facility failed to prescribed IV antibresident reviewed for the facility failed in the failed	dents are free of any significant NT is not met as evidenced eviews, and staff interviews, administer 2 doses of a piotic (metronidazole) for 1 of 1 for IV orders (Resident #398). Is admitted to the facility on charged to the hospital poses for Resident #398 pion and abdominal wall spital discharge note dated metronidazole (antibiotic) 500 metronidazole (antibiotic)		F760 1. Facility failed to adminis a prescribed IV antibiotic (m for Resident #398 reviewed Resident #398 no longer resfacility. 2. An Audit was conducted Leadership team (Director of Assistant Director of Nursing Managers) of current facility IV medications to ensure no doses. This audit completed with no additional concerns. have the potential to be affect as a Licensed Nurses will be on transcribing admission or having a second nurse perfor of discharge /summary and Assistant Director of Nursing education will be completed Nursing Leadership will revie admission orders/discharge daily for verification of 2nd naccuracy of orders x 12 weee 4. Data obtained during the process will be analyzed for trends and reported to Quali	detronidazole) for IV orders. sides at the d by the Nurse of Nursing, g and Unit residents on omissed d 8/11/2021 All residents octed. e re-educated orders and orm 2nd check orders by the g. This by 8/11/2021. ew new summary ourse and oeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i i		(X3) DATE SURVEY COMPLETED	
		345183	B. WING			C 07/15/2021
NAME OF P	ROVIDER OR SUPPLIER	0.0100		STREET ADDRESS, CITY, STATE, ZIP CO		77/15/2021
				430 BROOKWOOD AVENUE NE		
UNIVERS	AL HEALTH CARE & F	REHAB		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 760	not include metroni 8 hours. A review of the eme 6/19/2021 revealed IV site had been de admission to the fa Resident #398 had that were positive f bacterial infection retreatment). The not facility had not admilligrams every 8 The Unit Manager 7/14/2021 at 11:12 entered the admission UM #1 reported she #398 had an IV or therapy. UM #1 re hospital discharge system prior to Rest the facility. UM #1 orders she entered pharmacy.	ergency room notes dated It Resident #398 reported the e-accessed (removed) upon cility. The note documented blood cultures on 6/7/2021 for Bacteroides fragilis (a requiring metronidazole for the further documented the ninistered metronidazole 500 hours. (UM) #1 was interviewed on AM. UM #1 reported she sion orders for Resident #398. We was not aware Resident orders for antimicrobial ported she had entered the orders into the electronic sident #398' s admission to reported no one reviewed the prior to transmitting to the	F 7		x 3 months. mittee will of the f continued intain	
	on 7/14/2021 at 11 she was not aware discharge orders in	rsing (DON) was interviewed :44 AM. The DON reported Resident #398 hospital icluded IV antimicrobial administered at the facility.				
	at 3:49 PM. The Ac not certain how the antimicrobial medic Resident #398. The	was interviewed on 7/15/2021 Iministrator reported he was admission orders for the IV cation were missed for Administrator reported it was t all hospital discharge orders				

DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		_	(X3) DATE SURVEY COMPLETED
	345183	B. WING _			C 07/15/2021
ROVIDER OR SUPPLIER			430 BROOKWOOD AV	ENUE NE	07/13/2021
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CO	RRECTIVE ACTION SHOULD B	
Continued From page 46 were followed.		F 7	60		
Food Procurement,S		F 8	12		8/12/21
§483.60(i) Food safe The facility must -	ty requirements.				
approved or consider state or local authorit (i) This may include for from local producers, and local laws or regulation of (ii) This provision does facilities from using progradens, subject to consider and fool (iii) This provision does (iii) This provision does	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 d-handling practices. es not preclude residents				
serve food in accorda standards for food se This REQUIREMENT by: Based on record rev observations the facil plastic ceiling light co oven, 8 of 8 oven knot failed to label items in walk-in refrigerator as stored 5 of 5 frozen for floor. These practice food served to reside	ince with professional rvice safety. is not met as evidenced siews, staff interviews and ity failed to clean 40 of 40 vers, 1 of 1 microwave obs and 1 of 1 fryer, and in the dry storage room, and the walk-in freezer, and bood boxes on the freezer is had the potential to affect ints.		covers, a micro fryer. Facility a the dry storage and the walk-in food boxes on were corrected was cleaned or covers were or have been insta assistant dietar	owave, oven doorknobs also failed to label items a room, walk-in refrigerate freezer, and stored from the freezer floor. Labels on 7/13/2021, microwan the 7/13/2021, light buildered on 7/13/2021 and alled on 8/11/2021, ry director audited the	and in cor zen ve
i. a. Air iiilliai louf Of	THE MICHELL WAS COMMUCIED		waik-iii reiiiger	ator and wark-in neezer	io
	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page were followed. Food Procurement, Si CFR(s): 483.60(i)(1)(1)(§483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authorit (i) This may include form local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and food (iii) This provision doe facilities from using p gardens, subject to co safe growing and food (iii) This provision doe from consuming food \$483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on record revolutions the facil plastic ceiling light co oven, 8 of 8 oven known failed to label items in walk-in refrigerator ar stored 5 of 5 frozen for floor. These practice food served to reside Findings included:	AL HEALTH CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 were followed. Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not proclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations the facility failed to clean 40 of 40 plastic ceiling light covers, 1 of 1 microwave oven, 8 of 8 oven knobs and 1 of 1 fryer, and failed to label items in the dry storage room, walk-in refrigerator and the walk-in freezer, and stored 5 of 5 frozen food boxes on the freezer floor. These practices had the potential to affect food served to residents.	ROVIDER OR SUPPLIER AL HEALTH CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 were followed. Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) \$483.60(i) Food safety requirements. The facility must - \$483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. \$483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations the facility failed to clean 40 of 40 plastic ceiling light covers, 1 of 1 microwave oven, 8 of 8 oven knobs and 1 of 1 fryer, and failed to label items in the dry storage room, walk-in refrigerator and the walk-in freezer, and stored 5 of 5 frozen food boxes on the freezer floor. These practices had the potential to affect food served to residents. Findings included:	A BUILDING 345183 345183 345183 345183 345183 345183 345183 345183 345183 345183 345183 345183 345183 345183 3578EET ADDRESS, CIT 430 BROOKWOOD AV CONCORD, NC 280 CONCORD, NC	A BUILDING 345183 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 were followed. Continued From page 46 were followed. CFR(s): 483.60(i)(1)(2) \$483.60(i) Food safety requirements. The facility must- \$483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (ii) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (iii) This provision does not problibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not procured by the facility. \$483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations the facility failed to clean 40 of 40 plastic ceiling light covers, 1 of 1 microwave oven, 8 of 8 oven knobs and 1 of 1 fryer, and failed to label items in the dry storage room, walk-in refrigerator and the walk-in freezer, and stored 5 of 5 frozen food boxes on the freezer floor. Labels were corrected on 7/13/2021, inpit bu covers were ordered on 7/13/2021 and have been installed on 8/11/2021, assistant dietary director audited the

OE: VIEIV	C . C	· · · · · · · · · · · · · · · · · · ·					0. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	' '	E SURVEY PLETED
			7 501251				С
		345183	B. WING				/15/2021
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
I INIVEDS	AL HEALTH CARE & REI	LAD		43	30 BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & REI	HAD		С	ONCORD, NC 28025		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 812	Continued From page	F	812				
	on 07/12/21 at 9:35 A			ensure no boxes were stored on the fl	oor		
		observation was done of the			Sheare he bekee were etered on the h	561.	
	_ , ,	at covered each of the 40			2. An audit conducted by the Dietary	/	
		noted that 40 of the 40			Manager and/or Maintenance Director		
		overs between the stoves and			ensure there were no other dirty		
		scattered black speckled			area/equipment in the kitchen, items v		
	areas on the surface			labeled and dated in the dry storage re			
	tubes were yellow. T			walk-in refrigerator, walk-in freezer an			
	knobs and 8 of the 8			also to ensure there are no boxes stor			
	black areas and grea			on the freezer floor. This audit conduction 8/9/2021.	ciea		
	had multiple food splate top. The burners			011 6/9/2021.			
	crumbs and burnt und			3. Dietary staff were educated on			
		and had multiple dried pieces			ensuring that the kitchen area and		
		e fried food particles along			equipment are kept clean, items are to	be	
	the edges of the fryer	r and in the 2 fry baskets.			labeled and dated in the dry storage;		
		ne with Cook #1 on 07/12/21			walk-in refrigerator, walk-in freezer are	∍ not	
		ig the oven knobs, dirty			to have boxes stored on the floor.		
		crowave. He stated the			Education completed by 8/11/2021.		
		g shift if responsible to clean			Dietary Manager and/or Asst. Dietary		
	the microwave and st	tove after dinner was			Manager will conduct and an audit to		
	prepared daily.				ensure that the kitchen area is kept cleans labeled and dated in the dry	∌an,	
	 Dietary aide #1 was i	interviewed on 07/15/21 at			storage; walk-in refrigerator, walk-in		
		the microwave was cleaned			freezer are not to have boxes stored of	n	
		he 1st shift cook and 2nd			the floor. This audit will be conducted		
	, ,	an the microwave after the			per week x 4 weeks, 3x per week x 4		
	cooking was done.				weeks and weekly x 4 weeks.		
					Administrator will review the results of		
		Assistant Dietary Manager			weekly audits to ensure that the kitche	n	
		d on 7/12/21 at 9:55 AM.			area is kept clean, items labeled and		
		nad been in the role for 4			dated in the dry storage, walk-in		
		t manager acknowledged			refrigerator, walk-in freezer and that		
		black speckled spots on the			boxes are not stored on the freezer flo	or.	
		ne grease and grime on the			4 Data obtained during the guidit		
		/ burners and microwave. not sure when the fryer was			 Data obtained during the audit process will be analyzed for patterns a 	and	
		ning protocol, but it was not			trends and reported to Quality Assurate		
	used for breakfast an	- :			and Performance Improvement by the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345183	B. WING			C 07/15/2021	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025		7771372021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	she was not aware of light covers or the mit they cleaned the burn degreaser they spray they tried to clean the other week. An interview with the done on 07/15/21 at light covers in the kitt stated he only cleaned dietary requested, ar since they had requested the best thing to do where they were done with the Administrator of the stated he had been and he had a new Container they are cleaned to the covers were cleaned to	ant Dietary Manager stated If the cleaning process for the Icrowave. The ADM stated Iners daily and had a Ived on everything. She said Ived the plastic tubes when Ived the plastic tubes when Ived on everything. He said normally, Ived on everything. He said he had Ived on everything. She said Ived on every	F 81	Director of Nursing monthly x 3 At that time, the QAPI committe evaluate the effectiveness of th interventions to determine if col auditing is necessary to mainta compliance. 5. Person Responsible: Dieta Manager and Asst. Dietary Mar	ee will le ntinued iin ary		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345183	B. WING				C 15/2021
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE & REHAB			1	43	TREET ADDRESS, CITY, STATE, ZIP CODE 30 BROOKWOOD AVENUE NE CONCORD, NC 28025		10,202
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	O6/05/21 -Approximately 150 pindividual jelly container that had ardiscard date was listic. Approximately 26 putter crackers in an prepared date of 06/07/02/21 on the plass-Approximately 20 papre-packaged sugara prepared date labed date. Refrigerator/Freezer-A 48 oz plastic contate with an opened of A sealed plastic zipprepared date or disciplated date. Refrigerator/Freezer-A 48 oz plastic zipprepared date or discipprepared package of without an opened discipprepared package of without an opened discipprepared dates-Approximately 50 dipacks in an open box date-2 unopened whippeloose in freezer with	the clear open container of packets per the ADM of ners in a clear open in opened date of 7/2/21, no ed. acks per the ADM of peanut open plastic container with a 08/21 and a use by date of tic bin ackets per the ADM of free shortbread cookies, with all of 7/2/21 and no expiration ainer of nectar thickened iced late of 07/06/21 bag with potato salad-no card date Caesar dressing opened and date mall bowls covered with American cheese 100 slices	F	812			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345183	B. WING		C 07/15/2021		
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION		
F 812	was asked if they he labeling items and so Dietary Manager or regarding the pre-pestorage area without these items should date on the clear pleasked how long the be in the clear contand she stated, "she were good for." An interview was dowith the Administrat He stated he had be He noted the kitche previously and he he Manager starting the c. On the initial tour cardboard boxes of directly on the freeze An interview was downager (ADM) on was not aware that stored directly on the these were not item delivered. An interview was downthe Administrat He stated he had be He noted the kitche and he had a new Costarting the following the starting the following the following the starting the following	ad a policy or procedure for she was not aware of one. Onducted with the Assistant of 7/12/21 at 10:20 AM ackaged items in the dry at a discard label. She stated have an opened and discard astic containers. She was individual jelly packets should ainer in the dry storage area are was not sure how long they one on 07/15/21 at 09:49 AM for regarding Dietary Services. Seen in the role for 1 month. In had been in rough shape ad a new Certified Dietary e following Monday. on 07/12/21 at 09:35 AM, 5 frozen food were stored	F 81:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			1	C 15/2021	
NAME OF PROVIDER OR SUPPLIER				STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 017	10/2021	
UNIVERSAL HEALTH CARE & REHAB					DI BROOKWOOD AVENUE NE DINCORD, 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 812	doing better. He noted them on the cleaning,	d he would work more with	F E	312				
F 925 SS=D	throughout the dietary	department on the floor.	FS	925			8/12/21	
	program so that the farodents. This REQUIREMENT by: Based on observation interviews, the facility effective pest control multiple flies observed room reviewed for performings included: Review of an exterming provided for pests on of room B234 having An observation was compared to the far pests on of room b234 having the far pests on the far pests o	program as evidenced by d in one of one resident st control (room B234). nator record of treatments 5/26/21 revealed no record been treated for flies. onducted of room B234 on An observation of the I small flies on the walls and			F925 1. The facility failed to maintain an effective pest control program as evidenced by multiple flies observed in Resident #234 room. Pest control company was contacted on 7/14/2021 made an onsite visit to treat for flies on 7/15/2021. 2. An audit was conducted of all reside rooms to ensure multiple flies are not present. This audit was conducted by Maintenance Director by 8/10/2021. A issues will be addressed by having housekeeping clean the room thorough and called acalled contracted past cent	and dent the ny		
	flying. Further observed on the floor behind the it and it had an addition were not observed me. An observation was compared to 7/13/21 at 9:33 AM. A bathroom revealed 5	onducted of room B234 on			and called ecolab(contracted pest cont service) to treat the room. 3. Administrator educated the Maintenance Director of the expectatio that the facility remains free from flies a that the Maintenance Director is to call pest control company between schedu visits should the flies reappear. Nursing staff and housekeeping will be educate on contacting the maintenance director.	n and the led g		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			١,	C 07/15/2021
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	3171072021
				4	30 BROOKWOOD AVENUE NE		
UNIVERSA	AL HEALTH CARE & F	REHAB			CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 925	7/13/21 at 4:34 PM bathroom revealed ceiling of the bathr flying. Further obsin the resident 's rewhich were crawling. An observation was 8:53 AM, of room interview with the resident stated the for a while and he coming from. During an interview #1 on 7/14/21 at 9:10t of flies in the roof room B234. She report the flies in the because she thoughof the flies. An observation was outside of room B234. The observation redoor of room B234.	s conducted of room B234 on I. An observation of the 10 small flies on the walls and com which were crawling and ervation revealed 6 small flies com on the walls and ceiling	FS	925	, , , , , , , , , , , , , , , , , , ,	r rs ed ts not 0 us x the nins and ce s.	
	was conducted in of the bathroom ar 9:18 AM. The obs	Housekeeper #1 was conducted conjunction with an observation and of room B234 on 7/14/21 at ervation revealed multiple flies t room, resident bathroom, and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345183	B. WING		07/15/2021	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	1 01/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 925	room. The houseke flies in the bathroom would use his routin clean the bathroom consistently in the bexplained no matter room and in the bath with the flies. He sa an exterminator, but s room nor bathroom. An interview with the conducted was conducted was conducted was conducted multiple flieresident bathroom, a wall near the resident been informed by the flies were fruit flies a had been treated for unaware of there had he stated he was not been treated by the An interview with the was conducted in confidence of the bathroom and at 1:37 PM. The obflies both in the resident's room. The observed flies were were coming from the had treated the colarge number of flies the source would determined.	n the wall near the resident 's eper stated he saw a lot of in room B234. He said he e housekeeping cleaners to each day, but the flies were athroom and room. He what he seemed to do in the proom, nothing would help id the facility did contract with he hadn't seen the resident '	F 92			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		345183	B. WING _			C 07/15/2021	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 430 BROOKWOOD AVENUE NE CONCORD, NC 28025	<u> </u>	07/13/2021	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 925	could have been alm went down the drain fruit flies would feed did not have to be just feed on. He said the treated room B234. An interview was con administrator on 7/15 Administrator stated	ost anything organic which or was in the room which the on. He further explained, it of fruit for the fruit flies to re was no record of having ducted with the 1/21 at 4:16 PM. The it insect issues needed to be exterminator could come to	FS	925			