STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 04/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		5/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2024

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record reviews, and Administrator interview, the facility failed to update their Emergency Preparedness Plan annually. The findings included: The facility Emergency Preparedness Plan was documented as last updated and reviewed on 6/7/2022 by the former Administrator. The facility staff list was not updated with the current Administrator, Director of Nursing, Social Worker, or Activities Director. The Administrator was interviewed on 4/18/2024 at 4:02 PM. The Administrator reported he recalled reviewing the Emergency Preparedness Plan, but he was unable to locate the electronic file and did not have an updated hard copy of the plan. The Administrator reported the Emergency Preparedness Plan should have been updated in June 2023 and he was not sure why it was not updated.	E 004	2024 Concord – Plan of Correction – April Annual Survey – Latest Compliance Date May 16; Must be submitted by May 9 E004 Develop EP Plan, Review and Update Annually: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: As of 5/9/2024 the Administrator has updated the Emergency Preparedness Plan (EPP). 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Administrator has reviewed the complete plan to ensure all components are up to date for the current year. 3. Address what measures will be put in place or systemic changes made to ensure the deficient practice will not recur: Regional Director of operations has re-educated the Administrator and Maintenance Director on Emergency Preparedness for quality review of EPP. This education was completed on 5/6/24.	

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E 004	Continued From page 2	E 004	4. How the facility will monitor its performance to ensure the deficient practice does not recur: The administrator will take the EPP to Quality Assurance Performance Committee (QAPI) at least annually for review and updates, and quarterly as needed for any changes for three months. QAPI committee will review plan for any needed changes quarterly. 5. Compliance Date: 5/16/2024	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/15/24-4/18/24. Event ID# UKQQ11. The following intakes were investigated NC00215185, NC00215046, NC00213267, NC00212906, NC00211698, and NC00211345. 2 of the 5 complaint allegations resulted in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		5/8/24

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F 578	Continued From page 3 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to maintain accurate advance directive information (code status) throughout both the electronic medical record and paper medical record for 1 of 6 residents reviewed for advance directives (Resident #37). The findings included:	F 578	F578 Request/Refuse/Discontinue Trmt/Advance Directive: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 37 electronic medical record was updated by the Director of Nursing to a full code status to match the resident's	

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F 578	Continued From page 4 Resident #37 was admitted to the facility on 7/1/23. Resident #37's electronic medical record (EMR) revealed a physician's order dated 7/1/23 that read code status Do Not Resuscitate (DNR). Resident #37's Care Plan dated 7/7/23 revealed Resident #37 elected to be a DNR. Review of Resident #37's paper medical record located at the nurse's station revealed Resident #37 had a Medical Orders for Scope of Treatment (MOST) form that indicated to attempt Cardiopulmonary Resuscitation (CPR) with limited additional interventions dated 9/25/23. Resident #37's quarterly Minimum Data Set (MDS) dated 3/30/24 revealed Resident #37 was moderately cognitively impaired. Resident #37's EMR showed a communication banner on the top of Resident #37's opened EMR indicated DNR. An interview was conducted with Nurse #1 on 4/17/24 at 10:03 AM. During the interview, Nurse #1 indicated she normally had a paper that has code status, but she didn't have a sheet on 4/17/24. Nurse #1 checked the hard chart for Resident #37 and the hard chart indicated to start CPR. An interview was conducted with the Director of Nursing (DON) on 4/17/24 at 10:11 AM. During the interview, the DON revealed that code status is in the computer and the front of the hard chart. Code status should be checked in the computer and hard chart and in an emergency, check the	F 578	Most form and the physician order on 4/24/24. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A 100% audit was completed by the Social Woker on the current residents' Advance Directive Status, any resident identified, status was verified, and order was entered in the resident's medical record by the Unit Manager. Audit was completed by 5/2/24. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: As of 5/2/24 the Administrator educated the Director of Nursing, the Unit managers, Social Worker, and the Admissions coordinator on the process for completing the Advance Directive upon admission. The admissions coordinator will verify upon admission and obtain signed paperwork regarding Advance Directive status, give it to the unit manager, the unit manager will obtain an order and enter into the resident's electronic record. Nurse management will review Advanced Directive status on new admissions, changes in status, and that the Most form matches the order during clinical meeting daily. The Social worker will review the resident's Advanced Directive status during the resident's 72-hour meeting. Education was completed by 5/6/24. The Staff development coordinator educated the licensed nurses to enter the resident's Advanced Directive status upon	

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F 578	Continued From page 5 hard chart. Interview further revealed that DON indicated Unit Manager #1 knew correct code status for Resident #37 as she worked on that unit. An interview was conducted on 4/17/24 at 10:23 AM with Unit Manager #1 and revealed Resident #37's daughter signed DNR upon admission and then Resident #37's husband signed for CPR with limited interventions a few months later. Interview further revealed that in September of 2023 and today she talked to Resident #37's husband and he still wanted his wife to have CPR with limited interventions. Unit Manager #1 believed that Resident #37's husband was the decision maker and she indicated he had the mental capabilities to do so. An interview was conducted with Business Office Manager (BOM) on 4/17/24 at 11:08 AM and revealed upon admission that Resident #37's husband was in the hospital, so Resident #37's daughter filled out the paperwork. A few months later, Resident #37's husband moved in the facility and changed advance directives. An interview was conducted on 4/17/24 at 3:45 PM with the Administrator. During the interview, the Administrator indicated that the interdisciplinary teams should have looked at the information about advance directives and made sure changes were updated and both sources of information need to match.	F 578	admission in the resident's electronic record. Education was completed by 5/6/24. Staff will not be permitted to work until education is complete. New hires will be educated on topic during orientation. The Staff Development coordinator will verify education completion. 4. Indicate how the facility plans to monitor its performance to make ensure the deficient practice does not recur: As of 5/2/24 the Social Worker will audit new admissions and changes in orders for verification of Advanced Directive status, verify that order has been entered in the electronic record, and all matches the most form. Audit will be completed 5xper x4weeks; 3xperweek for 4weeks; then 1xper for 4 weeks. The Social worker will report audit results monthly to the Quality Assurance and Performance Improvement Committee (QAPI) until substantial compliance is obtained and maintained. 5. Compliance Date: 5/16/2024	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice	F 585		5/8/24

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grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of

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independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in

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F 585	Continued From page 8 accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, and staff interviews the facility failed to resolve a grievance for 1 of 1 resident reviewed for grievances (Resident #63). Findings included: Resident #63 was admitted to the facility on 7/31/2024 with cumulative diagnoses of renal failure which required dialysis treatments and diabetes. A quarterly Minimum Data Set (MDS) assessment dated 12/6/2024 indicated Resident #63 was cognitively intact. The facility's Grievance/Concern Forms were reviewed, and a Grievance/Concern Form dated 2/13/2024 indicated Resident #63 had a concern regarding his snack/meal for dialysis not being sent when he was transported to his dialysis treatments. The concern form further documented when he returned to the facility after dialysis the kitchen would be closed, and he had discussed the issue with the Dietary Manager, and nothing had changed. The	F 585	F585 Grievances 1. Address how corrective action will be accomplished for those residents found to been affected by the deficient practice: On Date 4/16/24 resident # 63 filed a grievance regarding not receiving a meal bag for dialysis. The Administrator completed a grievance form and initiated an investigation. Grievance was addressed with the dietary and nursing departments. The concern was resolved as of 5/9/2024. The Results of the investigation with resolution was reviewed with resident #63 by the administrator. Resident #63 received a snack/ meal bag on next dialysis day on 4/23/24. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The facilities Social Worker interviewed current interviewable dialysis residents and the responsible parties of the non-interviewable if they were receiving a meal bag before going to dialysis. Interviews were completed by 5/6/24. Any concerns identified were reviewed with the	

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F 585	Continued From page 9 Grievance/Concern Form was signed by the Dietary Manager as the individual that followed up and resolved Resident #63's grievance. The Grievance/Concern Form's resolution section indicated a list of residents who needed bagged meals for dialysis would be posted in the kitchen and Resident #63 was satisfied with the resolution. On 4/16/2024 at 9:02 am Resident #63 was observed at the facility's kitchen door and he was knocking on the door. He stated he was hungry because he goes to dialysis early and they do not always fix him breakfast to take with him and he had not eaten since the dinner the day before. He stated he complained about not getting a meal to take to dialysis before and it had not changed. On 4/18/2024 at 2:32 pm the Director of Nursing was interviewed by phone and stated she was aware of the grievance Resident #63 had on 2/13/2024 regarding not getting a meal sent to dialysis when he was there during a mealtime. She stated the Dietary Manager was responsible for ensuring the resolution of the grievance. During an interview with the Administrator on 4/18/2024 at 2:58 pm he stated Resident #63's grievance regarding meals and snacks should have gone to both the nursing and dietary and they should have worked together to ensure the resident had a sustained resolution to the issue.	F 585	dietary manager and the Director of Nursing. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Regional Nurse consultant educated the administrator on the facility's grievance policy. Education was completed on 4/30/24. The Administrator educated 100% of the facility's staff on the Grievance policy. The administrator educated 100% of dietary staff that dietary must provide each dialysis resident with a snack/ meal bag before the resident leaves the facility for dialysis. Place the meal bag in the refrigerator on the appropriate unit for each resident on the night before scheduled dialysis. Inform the nursing staff that meal bags have been provided. Education was completed by 5/6/24. Staff will not be permitted to work until education is complete. New hire will be educated on topic during orientation. The administrator will verify education completion. The Director of Nursing and/or the staff development Coordinator educated 100% of nursing staff and transportation to ensure each dialysis resident is provided with a meal bag before going to dialysis. The licensed nurse will document in the resident's electronic record that a meal bag was provided for the resident before leaving for dialysis. The weekend nursing Supervisor will ensure that a meal bag is sent with each resident. Education was	

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F 585	Continued From page 10	F 585	completed by 5/6/24. Staff will not be permitted to work after 5/6/24, until education is completed. All new hires will be educated on topic during orientation. The Staff development coordinator will verify completion of education. 4. Indicate how the facility plans to monitor its performance to ensure the deficient practice does not recur: The Unit manager will audit and ensure that a meal bag is provided for each or completed 5xperweek for 4 weeks; 3xper week for 4weeks; Then 1xper week for 4 weeks. The Director of Nursing will report the results of the audit to the Quality Assurance Performance Committee monthly for suggestions and/or recommendations until substantial compliance is obtained and maintained. 5. Compliance Date: 5/16/2024	
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to protect the resident's right to be free from misappropriation of resident property. This deficient practice was	F 602	F602 Free from Misappropriation/Exploitation 1. Address how corrective action will be accomplished for those residents found to	5/8/24

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F 602	Continued From page 11 for 6 of 7 residents reviewed for misappropriation of resident property (Resident #3, Resident #63, Resident #86, Resident #89, Resident #4 and Resident #41). Findings included: A review of the initial facility report dated 2/8/24 at 10:30 AM documented that a resident (Resident #89) complained of giving money to a staff member to purchase items, no items were purchased, and no money was returned. A facility investigation report revealed that after investigation it was discovered that this was not an isolated event as there were three more residents (Resident #63, Resident #41 and Resident #3) with the same circumstance. The employee (Activities Assistant #1) who was accused by Resident #89, Resident #63, Resident #41 and Resident #3 was brought in the office and was questioned about the allegations against her and was terminated on 2/12/24. A quarterly Minimum Date Set (MDS) dated 2/17/24 revealed that Resident #3 was cognitively intact. An interview was conducted with Resident #3 on 4/18/24 at 10:42 AM and revealed that she had a preloaded credit card with $100.00 and was unable to get the card to work. Resident #3 asked Activities Assistant #1 for assistance and Activities Assistant #1 took her card and never returned it. Resident #3 revealed she reported the incident and the Administrator came and talked to her about it. Interview further revealed when the incident happened, she felt "ticked off," but she indicated she was a Christian and the Activities Assistant #1 must have needed the	F 602	have been affected by the deficient practice: On 2/8/24 It was reported to the administrator that a staff member had taken several residents' money. The administrator initiated an investigation and sent a report to DHHS regarding misappropriation of residents' property for residents #63, #41, #3, and #89 on 2/8/24, the police and APS were also notified on 2/28/24. The employee involved was suspended during the investigation. The Social worker interviewed all residents with a BIMs score higher than a 9 if they have had an occurrence of anyone in the facility taking money or personal items from them? The residents with a BIMs below a 9 the responsible party was notified and interviewed. During that process, 3 other residents were identified. They were included in the 5-day report. On 4/23/24 an addendum was added to the original report on 2/8/24 regarding residents #4 and #86 and sent to DHHS. The Police and APS were also notified on 4/23/24 regarding misappropriation of resident's property. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/1 the social worker-initiated interviews with current residents with a BIMs score higher than a 9 if they had an occurrence of anyone in the facility within the last 30 days taking money or personal items from them? The residents with a Bims below 9 the responsible party was notified and interviewed. Any concerns identified were reported to the facility'	

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	345183	A. BUILDING _____ B. WING _____	C 04/18/2024

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F 602	Continued From page 12 money. Resident #3 is "satisfied" now that she received her money back. A quarterly MDS dated 3/6/24 revealed that Resident #63 was cognitively intact. An interview was conducted with Resident #63 on 4/18/24 at 11:08 AM and revealed that Resident #63 gave Activities Assistant #1 $50.00 for some jogging pants, and she never gave Resident #63 his pants or his money back. Interview further revealed that at the time it happened he "wasn't happy about it," but now that Resident #63 received his money back, he's "okay and feels bad for Activities Assistant #1." A quarterly MDS dated 1/23/24 revealed that Resident #86 was cognitively intact. An interview was conducted with Resident #86 on 4/18/24 at 10:55 AM and revealed that she gave Activities Assistant #1 $6.00 to purchase items for her. Activities Assistant #1 never returned with her items or returned her money. Interview further revealed that Activities Assistant #1 asked to borrow between $34.00 and $35.00 from Resident #86. Resident #86 never received her money back. Resident #86 revealed that initially she was upset because she thought they were "friends." Resident #86 was okay now that she received her money back and indicated that Activities Assistant #1 must have been going through "hard times" to have taken the money. A quarterly MDS dated 2/22/24 revealed that Resident #89 was cognitively intact. An interview was conducted with Resident #89 on 4/18/24 at 11:21 AM and revealed he gave	F 602	administrator. Interviews were completed on 5/2/24. 3. Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur: The Director of Nursing and /or the Staff development coordinator educated 100% of the facility's staff on the facility's policy on Abuse prevention with emphasis on misappropriation of residents' property. Staff were reminded that they cannot take money, borrow money, or use any of the residents' personal property. Employees must report all occurrences to the administrator immediately. Education was completed by 5/3/24. Staff will not be permitted to work until education is complete. New hires will be educated on topic during orientation. The staff development coordinator will verify education completion. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Social Worker will interview 5 residents and 5 responsible parties weekly to identify any misappropriation of residents' property. Audits will be completed 5xper for 4weeks; 3xper week for 4 weeks; then 1xper week for 4 weeks. The Social worker will report findings to the Quality Assurance Performance committee for suggestions and/or recommendations until substantial compliance is obtained and maintained. 5. Compliance Date: 5/16/2024	

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Activities Assistant #1 $30.00 for some shirts, pants and candy and Activities Assistant #1 never gave him anything or his money back. Resident #89 couldn't believe that Activities Assistant #1 did that because he thought she was a "good person." Resident #89 couldn't exactly recall, but he thought he reported the incident to the former Activities Director. Interview further revealed the facility paid Resident #89 back. Resident #89 indicated he is "happy" and "satisfied" now that he received his money back and he also indicated he would have been "satisfied" even if he didn't get his money back.

A quarterly MDS dated 2/13/24 revealed that Resident #4 was moderately impaired.

An interview was conducted with Resident #4 on 4/18/24 at 11:02 AM and revealed that she couldn't recall any money being taken but she indicated by shaking her head that she did receive her money back. Resident #4 appeared to be happy and enjoyed her cigarette during interview.

A quarterly MDS dated 1/12/24 revealed that Resident #41 was cognitively intact.

An interview was conducted with Resident #41 on 4/17/24 at 5:00 PM and revealed that Resident #41 gave Activities Assistant #1 between $8.00 - $10.00 for cheerwine and piece of red velvet cake. Resident #41 never received her items from Activities Assistant #1 or her money back. Interview further revealed that she did receive her money back from the facility and was thankful the Administrator listened to her and she received her money back.

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An interview was conducted with the Administrator on 4/17/24 at 3:18 PM and revealed he investigated the incident that was reported on February 8, 2024, that involved misappropriation of property with 4 residents. The former Activities Director came to him and indicated the Activities Assistant #1 took money from a resident and didn't buy the resident the items. When the facility staff investigated the incident they found that more residents were involved. The Administrator further revealed that when he spoke to Activities Assistant #1 she would not comment on the incident. The Administrator indicated that Activities Assistant #1 was suspended and later terminated. Administrator also revealed they completed their reports and all residents were refunded their monies. The checks were delivered to the residents in batches and the last batches came to the office on April 15, 2024. He indicated it "takes a while" for a check request. Administrator also revealed that all staff were trained on resident abuse and misappropriation. A background check was completed for Activities Assistant #1 prior to hire and revealed no concerns. Activities Assistant #1 was terminated on 2/12/24.

On 4/17/24 at 4:05 PM a phone interview was attempted with the alleged perpetrator, Activities Assistant #1, but attempt was unsuccessful.

An interview was conducted on 4/18/24 at 11:44 AM with the former Activities Director and revealed she worked at the facility when the incident occurred. She indicated that Resident # 89 came to her and indicated that he gave Activities Assistant #1 money for some items, and he never received his money or the items back. Interview further revealed that another resident

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F 602	Continued From page 15 who she couldn't recall came to her about some jogging pants and then Resident #41 and Resident #3 came to her with similar concerns. Former Activities Director reported incident to human resources and Administrator, and she later learned after investigation that Activities Assistant #1 was terminated. On 4/18/24 at 8:44 AM a phone interview was attempted with the alleged perpetrator, Activities Assistant #1, but attempt was unsuccessful. A second interview was conducted with the Administrator on 4/18/24 at 3:26 PM and revealed that Activities Assistant #1 should not have taken money from residents without getting residents their items. Interview further revealed that Activities Assistant #1 was not following their policy and made a decision on her own to go outside of the policy.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		5/8/24

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F 607	Continued From page 16 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy in the area of reporting for an allegation of misappropriation of property for 2 of 7 residents reviewed for misappropriation of resident property (Resident #4 and Resident #86). Findings included: A review of the facility policy titled: "Abuse Prevention, Intervention, Reporting, and Investigation" dated February 2021 Revision read as follows: "Reporting/Response It is the policy of this facility that "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 607	F607 Develop/Implement Abuse/Neglect Policies 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: For residents #4 and #86 who reported money not being returned to them after giving it to the Activity's assistant to do shopping for them was reported to the administrator on 2/8 and 2/9. On 4/23/24, the administrator added an addendum to the original abuse report sent to 2/8/24 to report the above misappropriation of resident's property to DHHS. The police and APS were notified on 4/23/24. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the current deficiency, therefore a 100% audit was conducted by the Regional Nurse consultant of	

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F 607	Continued From page 17 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility." Review of grievance logs revealed the following: a. Resident #86 filed a grievance on 2/8/24 that indicated she gave Activities Assistant #1 money to purchase items and she never received her items or money back. The grievance was signed by the Administrator. b. Resident #4 filed a grievance on 2/9/24 that indicated Resident #4 gave Activities Assistant #1 money to purchase items and she never received items or her money back. The grievance was signed by the Administrator. There was no report filed to the State Agency for Resident #4 and Resident #86. An interview was conducted with the Administrator on 4/18/24 at 3:26 PM and revealed he wasn't aware that Resident #86 had money taken. He verified no report was completed for Resident #86. He further revealed he did not fill	F 607	reportable incidents within the last 30 days to verify timely reporting according to the facility's abuse policy and completing a thorough investigation. Any areas identified were addressed to the administrator. Audit was completed by 5/2/24. 3. Address what measures will be put in place or systemic changes made to ensure that deficient practice does not recur: The Administrator was educated on the facility's policy regarding reporting abuse timely by the Regional Nurse Consultant. Education was complete by 5/2/24. 100% of the facility staff were educated on the facility's policy of abuse and timely reporting by the Administrator and/or the Staff development Coordinator. Education was completed by 5/6/24. Staff will not be permitted to work until training is completed. New hires will be educated on topic during orientation. The Staff Development Coordinator will verify completion of education. The Regional Director of operations will review reportable incidents, weekly to verify timely reporting and completion of a thorough investigation. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The administrator and/or social worker will interview residents and/or responsible party weekly to ensure that abuse has not occurred by asking if any staff or visitors has used any of their money and/or property without permission, or if they have exhibited verbal or physical abuse	

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F 607	Continued From page 18 out a report for Resident #4. He explained he previously sent in an initial report and investigative report to the State Agency for 4 other residents related to misappropriation of property and wasn't aware of Resident #4 until after the report was completed.	F 607	toward them? Audit will be completed 5xper week for 4 weeks; 3xper for 4 weeks; then 1xper week for 4 weeks. The administrator will report the results of the monthly audit to the Quality Assurance Performance Committee for suggestions and/or recommendations until substantial compliance is obtained and maintained. 5. Completion Date: 5/16/2024	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		5/8/24

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(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part

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F 623	Continued From page 20 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide written notification for the ombudsman for residents who were transferred to the hospital for 2 of 3 residents reviewed for hospitalization (Resident #29 and Resident #145). The findings included: a. Resident #29 was admitted to the facility	F 623	F623 Notice Requirements Before Transfer/Discharge: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 5/3/2024 the facility's Social Worker faxed a list of residents discharged from the facility within the last 90 days to the	

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F 623	Continued From page 21 6/17/2021 with diagnoses including diabetes and respiratory failure. A nursing note dated 3/12/2024 documented Resident #29 was sent to the hospital for fever and a low oxygen saturation. The entry tracking record dated 3/21/2024 documented Resident #29 was readmitted to the facility from the hospital. b. Resident #145 was admitted to the facility on 2/23/2024 with diagnoses including diabetes and hypertension. A nursing note dated 3/16/2024 documented Resident #145 was transferred to the hospital after a change in status. The discharge, return not anticipated Minimum Data Set assessment dated 3/16/2024 documented Resident #145 was discharged to the hospital. The discharge summary for the Ombudsman for March 2024 documented Resident #29 transferred to the hospital on 3/12/2024 and Resident #145 was transferred to the hospital on 3/16/2024. The discharge summary was included with a fax coversheet dated 4/1/2024 with the Ombudsman's fax number. A review of the fax machine activity from 3/28/2024 to 4/18/2024 revealed that no fax attempts had been sent to the Ombudsman's fax number. The Ombudsman was interviewed on 4/11/2024 and she reported she had not received a	F 623	Ombudsman which included residents #29 and #145. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Administrator provided one on one education with the facility's Social Worker the process of notifying the Ombudsman of all facility discharges weekly. Education was complete by 5/6/24. 3. Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur: The administrator educated the Social Worker on the process of notifying the ombudsman of the facility discharges weekly and provide the administrator with a copy of a confirmation of sending report. The Social Worker will keep a file of notifications. The education was completed by 5/6/24. Staff will not be permitted to work until education is complete. New hires will be educated on topic during orientation. The administrator will verify completion of education. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Administrator will complete audits to verify that notifications of discharges from the facility are sent to the ombudsman. Audit will be completed weekly x 12 weeks: The Administrator will report results of audit monthly to the Quality Assurance Performance Committee for suggestions and/or recommendations until substantial compliance is obtained and maintained.	

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F 623	Continued From page 22 discharge summary from the facility since December 2023. The Social Worker (SW) was interviewed on 4/17/2024 at 4:29 PM. The SW reported she was responsible for communicating the facility discharges to the Ombudsman. The SW explained she had attempted to fax the discharge summary to the Ombudsman every month, but she was not certain if the fax was completed. The SW reported she had not checked the fax machine for a confirmation the faxes were delivered. The SW reported she was not aware the Ombudsman had not received any of the faxes. The Administrator was interviewed on 4/18/2024 at 4:02 PM. The Administrator explained he had asked the SW if she was sending the discharge summary list to the Ombudsman and had been told by the SW that she was, but he had never asked to see the fax confirmation. The Administrator reported he expected the Ombudsman to receive a monthly summary of all facility discharges and/or transfers with a fax or email confirmation of receipt.	F 623	5. Compliance Date: 5/16/2024	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		5/8/24

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F 644	Continued From page 23 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to refer a resident with a new mental health diagnosis for a Level II Preadmission Screening and Resident Review (PASRR) for 1 of 3 residents reviewed for PASRR (Resident #52). The findings include: Review of Resident #52's medical record revealed documentation of a Level I PASRR determination dated 4/20/23 prior to his admission on 5/16/23. His admission diagnoses included end stage renal disease and stroke. A diagnosis of major depressive disorder was added on 10/31/23. Further record review did not indicate a referral for a Level II PASRR review had been made. During an interview on 4/17/24 at 10:12 am, the Social Services Director (SSD) revealed she was not trained with PASRR and was still learning the process. She stated she checked PASRR levels during the resident admission process and made referrals for residents without PASRR determinations. She stated she was not aware of Resident #52's mental health diagnosis being added on 10/31/24. She explained she would	F 644	F644 Coordination of PASARR and Assessments 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 52 Level II PASARR screening and resident review have been completed by the SW as of 5/9/2024. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents could be affected by the same deficient practice of Level II PASARR screening. All current residents had medical records reviewed and PASARR screen completed if needed by Social Worker. Audit was completed as of 5/9/2024. 3. Address what measure will be put into place or systemic changes made to ensure that deficient practice will not recur: As of 4/26/24 the administrator re-educated the Social Worker on the PASARR screening and submission. As of 5/2/24 Social Worker will review all new	

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F 644	Continued From page 24 have referred the resident for Level II PASRR assessment if she had been notified. The SSD stated she was not sure why she was not notified. She explained she got information about changes with residents during morning meetings, emails, or telephone calls from the staff. During an interview on 4/17/24 at 3:39 pm with the Administrator, he explained the PASRR process was reviewed prior to resident admission and was important to determine the level of care a resident may need. The Administrator further explained the SSD kept track of PASRRs and referred residents for Level II when needed. He stated Resident #52 should have been referred for a Level II PASRR review with the new mental health diagnosis on 10/31/23.	F 644	admissions for need of PASARR screening upon admission referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for level II resident review upon significant change in status assessment. Staff will not be permitted to work until education is complete. The administrator will verify completion. 4. Indicate how the facility plans to monitor its performance to ensure the deficient practice does not recur: The Social Worker will audit new admissions and residents with new diagnosis medical record to verify if a new PASARR screening assessment is indicated. Audits will be completed 5xper for 4 weeks; 3xper week for 4 weeks; then 1xper week for 4 weeks. The Social Worker will report the results of the audit monthly to the Quality Assurance Performance committee for suggestions and/or recommendations until substantial compliance is obtained and maintained. 5. Compliance Date: 5/9/2024	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and responsible party interviews the facility failed	F 677	F677 ADL Care Provided for Dependent Residents	5/8/24

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F 677	Continued From page 25 to ensure a resident's hair was not greasy for 1 of 4 residents (Resident #44) who were dependent on staff for personal hygiene. Findings included: Resident #44 was admitted to the facility on 10/22/2019. His cumulative diagnoses included stroke, hemiplegia, and aphasia. An annual Minimum Data Set assessment dated 2/22/2024 indicated Resident #44 was moderately cognitively impaired and he sometimes understood and responded adequately to simple, direct communication only. The annual Minimum Data Set assessment further indicated Resident #44 had no behaviors, dependent for toileting and was always incontinent of bowel and bladder. Resident #44's Care Plan dated 2/22/2024 stated all care needs would be met by staff due to decreased mobility related to a stroke. The Care Plan also stated Resident #44 had disruptive behaviors. Resident #44's Care Plan had interventions of redirecting during behaviors, do not argue with resident, monitor and document target behaviors, notify Social Worker for evaluation, and speak to resident in a calm voice. The facility's shower schedule which was undated indicated Resident #44 received his showers on Mondays and Thursdays each week. A review of Resident #44's shower documentation and shower sheets (forms that are filled out by the Nurse Aides when a shower was either refused or completed) indicated Resident #44 did not have documentation of a shower on the	F 677	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 44 received a shower and hair was shampooed by the certified nursing assistant on April 16, 2024. Resident receives a shower twice a week and his hair is shampooed during his shower. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A 100% audit was conducted on all current residents by nurse management to verify that residents are receiving showers as scheduled and as desired by the resident and/or responsible party and that the resident's hair is shampooed during shower. Any residents identify the shower schedule was updated. Audit was completed by 4/26/24. 3. Address what measures will be put in place or systemic changes made to ensure the deficient practice will not recur: The Director of Nursing and/or the Administrator educated the interdisciplinary team to observe residents in need of a shower and/ or hair shampooed during their ambassador rounds and report findings during morning meeting Monday through Friday. Weekend Supervisor to complete random audits of 5 residents to verify that showers are being completed and report findings to the Director of Nursing. The Director of nursing and/or the Staff development coordinator educated the licensed nurses and the certified nursing assistant on the shower schedule for each resident. The	

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F 677	Continued From page 26 following dates: 2/5/2024, 2/8/2024, 2/12/2024, 2/15/2024, 2/19/2024, 4/1/2024, 4/8/2024, and 4/15/2024. An interview was conducted with the Responsible Party (RP) of Resident #44 on 4/16/2024 at 12:26 pm and she stated Resident #44's hair was not washed by staff as often as it should be washed, and it had been 3 to 4 weeks since his hair had been washed. The RP stated she unbraided Resident #44's hair every two weeks so that it could be washed when he was taken to the shower. She stated after he had his shower she braided his hair again. She stated since it had been 3 to 4 weeks since she had unbraided Resident #44's hair for it to be washed and it had been unbraided and she had waited for the staff to wash his hair and so she could braid his hair. During an observation and interview with Resident #44 on 4/16/2024 at 1:14 pm, he shook his head from side to side indicating a response of no, when asked if he had a shower or had his hair washed on his last shower days, Thursday, 4/11/2024 and Monday, 4/15/2024. Resident #44 shook his head from side to side indicating a response of no, when asked if he refused a shower on those days and nodded his head up and down and indicated a yes response when asked if he wanted a shower on 4/11/2024 and 4/15/2024. Resident #44's hair was unbraided and appeared to have an oily sheen at the time of the interview. Nurse Aide #9 was interviewed on 4/17/2024 at 10:12 am who was assigned to Resident #44 at 7:00 am and she stated she had worked at the facility since 2/8/2024 but had been on the 7:00 am to 3:00 pm shift for a couple of days she	F 677	staff is to verify residents' shower preferences on admission. The Certified Nursing Assistant is to notify the licensed nurse if a resident refuses a shower. Adjust resident's shower schedule at resident's or responsible party request. Residents must have showers as scheduled and as requested. Residents' hair must be shampooed during showers. Unit Managers and Weekend Supervisor to verify shower completion daily. Education was completed by 5/2/24. Staff will not be permitted to work until education is complete. New hires will be educated on topic during orientation. The Staff Development coordinator will verify education completion. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: Nurse managers will audit 5 residents daily to ensure that showers are completed as scheduled. Audits will be completed 5xper for 4 weeks; 3xper week for 4 weeks; then 1xper for 4 weeks. The Director of Nursing will report the results of audit monthly to the Quality assurance Performance Committee for suggestions and/or recommendations until substantial compliance is obtained and maintained. 5. Compliance Date: 5/16/2024	

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F 677	Continued From page 27	F 677		

stated she did not know when Resident #44 was scheduled for showers or when he should have his hair shampooed, but the residents should have been showered two times a week at least. She stated she would ask the Unit Manager when the residents' showers were scheduled. Nurse Aide #9 stated she was not aware of Resident #44 having behaviors or refusing care.

On 4/17/2024 at 11:38 am Nurse #2, who was assigned to Resident #44, was interviewed, and stated she did not know anything about when Resident #44 should be showered or have his hair washed.
The Unit Manager was interviewed on 4/17/2024 at 11:39 am and she stated the facility had a Nurse Aide call out on Monday so Resident #44 did not get his shower and have his hair shampooed that was scheduled on Monday, but he was showered on Tuesday. She stated she was not aware of Resident #44 had missed his shower before Monday.

A review of Resident #44's shower documentation and shower sheets (forms that were filled out by the Nurse Aides when a shower was either refused or completed) indicated Resident #44 did not have documentation of a shower on 2/5/2024.

Resident #44's electronic documentation summary of Resident #44's showers or baths (the documentation did not indicate Resident #44 had a shower or had his hair shampoo indicated Resident #44 was not bathed on 2/5/2024.

A phone interview was conducted with Nurse Aide #10 on 4/18/2024 and she stated she did care for Resident #44 on 2/5/2024 and she did not remember if he had a shower that day. She

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F 677	Continued From page 28	F 677		

stated Resident #44 was totally dependent for his personal care needs and he gets a shower 2 times a week on Mondays and Thursdays. Nurse Aide #10 stated Resident #44 did not refuse his to be showered or refuse having his hair shampooed.

A review of Resident #44's shower documentation and shower sheets (forms that are filled out by the Nurse Aides when a shower was either refused or completed) indicated Resident #44 did not have documentation of being showered or his hair shampooed on 2/8/2024 and 4/15/2024, his scheduled shower days.

The electronic documentation summary of Resident #44's showers or baths (the documentation did not indicate Resident #44 had a shower or had his hair shampooed) indicated he was not bathed on 2/8/2024 but was bathed on 4/15/2024.

During the survey attempts were made to reach Nurse Aide #11 by phone. Nurse Aide #11 cared for Resident #44 on 2/8/2024 and 4/15/2024, and there was no documentation of him receiving a shower on those dates, his scheduled shower day.

Nurse Aide #12 was interviewed on 4/18/2024 by phone and stated Resident #44 was total care for his shower and washing his hair. Nurse Aide #12 stated she cared for Resident #44 on 2/15/2024 and 2/19/2024. She stated Resident #44 did not have behavior and did not refuse care when she cared for him. She stated if he did not want a shower, she would have given him a bed bath and if he wanted a shower the shower team would have done the shower.

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F 677	Continued From page 29 During a phone interview with the Director of Nursing on 4/18/2024 at 2:34 pm she stated they had a hard time getting showers for Resident #44 because he would refuse a shower at times. She stated Resident #44 was care-planned for disruptive behaviors, but not refusing care. The Director of Nursing stated the electronic documentation summary for Resident #44 would not indicate if the resident had a bed bath or a shower and would not indicate if his hair was washed. On 4/18/2024 at 3:04 pm the Administrator was interviewed, and he stated staff should ensure all residents were showered and had their hair shampooed when they wanted. He stated Resident #44 should have been showered and his hair shampooed at least 2 days a week and whenever requested. The Administrator stated if a resident refused a shower the staff should go back and ask them again if they were willing to take a shower.	F 677		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to provide 1 of 1 resident (Resident #63) a meal for a resident who had dialysis. Resident #63 traveled to a dialysis	F 698	F698 Dialysis 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient	5/8/24

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F 698	Continued From page 30 center three days a week, leaving before breakfast was served and returning to the facility after breakfast was served. Findings included: Resident #63 was admitted to the facility on 7/31/2023 and his cumulative diagnoses included renal failure which required dialysis treatments and diabetes. A quarterly Minimum Data Set (MDS) assessment dated 12/6/2024 indicated Resident #63 was cognitively intact and required set up assistance with his meals. Resident #63's Care Plan dated 8/23/2023 was reviewed and stated he was at risk of nutritional decline related to his dialysis treatment. The facility's interventions included providing snacks and therapeutic diet as ordered. Resident #63's Care Plan stated his intake varied food but there was not a care plan for refusing meals. Physician's Orders for Resident #63 dated 8/24/2023 indicated he was on a regular no salt added, renal diet with double portions with breakfast and he received dialysis treatments every Tuesday, Thursday, and Saturday of each week. A review of the facility's Grievance/Concern Forms revealed a Grievance/Concern by Resident #63 on 2/13/2024 which stated he was not provided his snack and lunch bag for his dialysis treatments. On 4/16/2024 at 9:02 am Resident #63 was observed and interviewed at the facility's kitchen	F 698	practice: Resident #63 was provided a snack/meal bag for each dialysis day starting on 4/23/24 before leaving the facility for dialysis. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Social Worker interviewed interviewable residents and the responsible parties of non-interviewable residents if they were receiving a snack/meal bag before leaving the facility for dialysis. Interviews were completed by 5/6/24. Any concerns identified were reviewed with the dietary Manager and the Director of Nursing. 3. Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur: The administrator educated 100% of the dietary staff that dietary must provide each dialysis resident with a snack/meal bag before the resident leaves the facility for dialysis. Place the meal bag in the refrigerator on the appropriate unit the night before scheduled dialysis. Inform the nursing staff that meal bags have been provided. Nursing is to provide a list of residents and their schedule for dialysis to dietary and must update the list with changes in schedule or new dialysis residents. Education was completed by 5/6/24. Staff will not be permitted to work until education is complete. New hires will be educated on topic during education. The administrator will verify education completion. The Director of nursing and/or	

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F 698	Continued From page 31 door attempting to get assistance with getting his breakfast. Resident #63 stated he was hungry since he had left for dialysis at 4:30 am and no one had provided him with something to eat since the previous day at dinner. Nurse Aide #8 was interviewed on 4/17/2024 at 10:10 am and she stated the kitchen was supposed to fix Resident #63 a bagged breakfast meal since he leaves for dialysis treatment before breakfast was served in the morning. She stated sometimes it is not sent with him, but Resident #63 leaves before she arrives at 7:00 am. During an interview with Nurse #2 on 4/17/2024 at 11:34 am she stated Resident #63 leaves the facility by 6:00 am for dialysis and she does not know if he has a meal with him since she arrives at 7:00 am. On 4/17/2024 at 11:52 am the Dietician was interviewed by phone and stated Resident #63 should get a breakfast of eggs, fruit, bread, and juice to take with him to the dialysis center since he would miss the breakfast meal due to his dialysis treatments. She stated the kitchen should make the meal the night before and leave it in the refrigerator for the transportation driver to pick up before leaving the facility. The Assistant Dietary Manager was interviewed on 4/17/2024 at 4:56 pm and she stated she was not aware of Resident #63 not being provided a meal before he went to dialysis on 4/16/2024. She stated the transportation driver should have picked up Resident #63's breakfast before taking him to the dialysis center on 4/16/2024. On 4/18/2024 at 10:03 am the Transportation	F 698	the staff development coordinator educated the 100% nursing staff and transportation to ensure that each resident receives a snack/meal bag before leaving for dialysis. Provide dietary with an updated list of dialysis residents. The weekend supervisor will ensure that a snack/meal bag is sent with each dialysis resident on the weekends. The licensed nurse will document that snack/meal bag was provided. Education was completed by 5/6/24 Staff will not be permitted to work until education is complete. New hires will be educated on topic during orientation. The Staff development coordinator will verify completion of education. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The unit manager will audit and ensure that each dialysis resident was provided a snack/meal bag before leaving the facility for dialysis. Audit will be completed 5xper week for 4 weeks; 3xper week for 4 weeks; 1xper week for 4 weeks. The Director of Nursing will report the results of the audit monthly to the Quality Assurance Performance committee for suggestions and/or recommendations until substantial compliance is obtained and maintained. 5. Compliance Date: 5/16/2024	

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F 698	Continued From page 32 Driver was interviewed and stated Resident #63 does not transport to dialysis through the facility's transportation. She stated Resident #63 is taken to all his appointments though a contracted company and the contracted company must not have ensured he had his breakfast before transporting him. An interview was conducted by phone with the Director of Nursing on 4/18/2024 at 2:32 pm and she stated Resident #63 will refuse his meals when he is transported to dialysis. She stated she was aware Resident #63 had a Grievance/Concern on 2/13/2024 regarding his meals not being provided for his dialysis treatments. The Administrator was interviewed on 4/18/2024 at 2:58 pm and he stated the dietary and nursing staff should have ensured Resident #63 had a meal when he was transported to the dialysis center during a mealtime.	F 698		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a performance review every 12 months for 4 of 5 nursing assistants (NAs) reviewed to ensure in-service education	F 730	F730 Nurse Aide Perform Review □ 12 hr/yr In-Service 1. Address how corrective action will be accomplished for those residents found to	5/8/24

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UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

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F 730	Continued From page 33 was designed to address the outcome of the performance reviews (NA #4, NA #5, NA #6, and NA #7). The findings included: a. NA #4 date of hire was 2/12/2001. A review of her employment record revealed no performance evaluation had been completed in the past 12 months. NA #4 was interviewed on 4/18/2024 at 11:28 AM and she reported she did not recall the last time she had a performance evaluation completed. b. NA #5's date of hire was 8/12/2014. A review of the employment record revealed no performance evaluation had been completed for the past 12 months. NA #5 was not available for interview. c. NA #6's date of hire was 8/21/2014. A review of the employment record revealed no performance evaluation had been completed for the past 12 months. NA #6 was not available for interview. d. NA #7's date of hire was 4/18/1995. A review of the employment record revealed no performance evaluation had been completed for the past 12 months. NA #7 was not available for interview. The Staff Development Coordinator (SDC) was interviewed on 4/17/2024 at 1:47 PM. During the interview, the SDC explained she provided the education for the NA staff and the Director of Nursing (DON) was responsible for the performance evaluations for NA staff.	F 730	have been affected by deficient practice: Performance reviews were completed by the Director of Nursing and/or Staff Development coordinator for Certified Nursing Assistants #4, #5, #6, and#7 by 5/6/24. Six other employees are that are due will completed as of 5/14/2024. Additional 64 employees will be completed upon their anniversary date. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Human Resources Director reviewed the current employee roster for Certified Nursing Assistants, Medication Aides and Licensed nurses any identified without having an Annual Performance Review, the review was completed by 5/6/24 by the Director of Nursing. 3. Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur: The Human Resources Director and the Director of Nursing were educated by the facilities Administrator on the facilities process for completing Annual Performance Review on employees. Education was completed by 5/6/24. The Human Resources Director will access the employee roster on the 1st of each month by hire date. Performance Reviews will be given to the appropriate department head for completion and then returned to the Human Resources Director within 5 days of receipt. The Department head manager will review with each employee and obtain a signature of review. Any area of practice	

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F 730	Continued From page 34 The DON was interviewed on 4/17/2024 at 1:47 PM and she reported a staff member reported they had not received an annual raise and during the investigation in November 2023, it was discovered performance evaluations had not been completed for any staff. The DON reported she was working to complete 5 to 10 evaluations per week. The Administrator was interviewed on 4/18/2024 at 4:02 PM. The Administrator explained staff had inquired about annual raises in November 2023 and it was discovered the performance evaluations had not been completed. The Administrator reported the DON had been working on the performance evaluations.	F 730	found to be unfavorable will be addressed and education provided by the department head of the employee is assigned. 4. Indicate how the facility plans to monitor its performance to ensure the deficient practice does not recur: The Human Resources Director will audit to verify completion of annual performance reviews. Audit will be complete 5xper week for 4 weeks; 3xper week for 4 weeks; Then1x per week for 4 weeks. The Administrator will report the results of the audit monthly to the Quality Assurance Performance Committee for suggestions and/or recommendations until substantial compliance is obtained and maintained. 5. Compliance Date: 5/16/2024	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		5/8/24

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F 756	Continued From page 35 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Pharmacist and Medical Director interviews, the facility failed to act upon a pharmacy recommendation by failing to change the dose of atorvastatin (medication to decrease unhealthy fat in the body) from 40 milligram (mg) to 20 mg as ordered by the physician for 1 of 1 resident reviewed for drug regimen (Resident #88). The findings included: Resident #88 was admitted to the facility on 11/1/23 with a diagnosis of hyperlipidemia. Review of physician orders on 11/1/23 revealed an entry for atorvastatin 40 mg for hyperlipidemia	F 756	F756 Drug Regimen Review, Report Irregular, Act On 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. For resident# 88 the pharmacist's approved recommendation by the physician for atorvastatin 20mg at bedtime was processed and entered the resident' electronic record on 4/18/24 by the unit manager. The Resident is receiving atorvastatin 20mg as ordered and per pharmacy recommendation. 2. Address how the facility will identify other residents having the potential to be	

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F 756	Continued From page 36 one tablet daily at bedtime. Review of the Pharmacist's monthly medication review on 3/19/24 revealed a recommendation to decrease atorvastatin to 20 mg at bedtime if appropriate. The physician response section revealed the Medical Director checked the box indicating he agreed with the recommendation, and signed and dated the form on 4/1/24. The resident's medication administration record (MAR) revealed the nurses continued to offer atorvastatin 40 mg daily at bedtime as indicated by their initials from 4/1/24 through 4/17/24. During an interview on 4/18/24 at 9:12 am, the Unit Coordinator for A hall revealed she entered the physician orders in the electronic medical records. The pharmacy recommendations that were agreed upon and signed by the providers were considered physician orders. She stated the MAR got updated electronically once she entered the order. The Unit Coordinator for A hall revealed she did not recall receiving the pharmacy recommendation for Resident #88's atorvastatin. She stated the form may have been sent straight to medical records before it was given to nursing. The Unit Coordinator checked Resident #88's electronic medical records and reviewed the Pharmacist's recommendation to decrease the atorvastatin 40 mg to 20 mg that was signed by the Medical Director on 4/1/24. She stated it may have been put in the box for medical records to scan instead of giving it to her. During an interview on 4/18/24 at 10:02 am, the Medical Director stated hard copies of the pharmacy recommendations were printed and given to him by the Unit Coordinator. He handed	F 756	affected by the same deficient practice. Nurse management completed a 100% audit for current resident's pharmacy recommendation within the last 30 days to verify completion and the order was entered in AHT. Audit was completed by 4/26/24. 3. Address what measures will be put into place pr systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing and/or the Staff development coordinator educated the unit manager on completing pharmacy recommendations when received from the pharmacist. Once the recommendation is approved and signed by the physician the unit manager will process the order and enter the order in the resident's electronic record. Education was complete by 5/6/24. Staff will not be permitted to work until education is complete. New hires will be educated on topic during orientation. The staff development coordinator will verify completion of education. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Director of Nursing and/or the Staff development coordinator will audit transcription of pharmacy recommendations. Audits will be completed 5xper week for 4 weeks: 3xper week for 4weeks: then 1xper for 4 weeks. The Director of nursing will report the results of audits monthly to the Quality Assurance Performance Committee for suggestions and/or recommendations	

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F 756	Continued From page 37 the forms back to the Unit Coordinator after reviewing and signing the forms. The Medical Director stated it did not cause any harm for Resident #88 to continue receiving the atorvastatin 40 mg instead of the 20 mg. During an interview on 4/18/24 at 11:06 am, the Pharmacist stated she sent pharmacy recommendation forms to the Administrator, the Director of Nursing (DON), and the Unit Coordinators. They distributed the recommendations to the providers for them to review and sign as physician orders. The signed forms were scanned into the residents' electronic medical records and entered as physician orders. The Pharmacist stated the facility should have followed the atorvastatin order for Resident #88. During an interview on 4/18/24 at 2:40 pm, the Director of Nursing stated the nursing staff were responsible for entering the order once the pharmacy recommendation was signed by the provider.	F 756	until substantial compliance is obtained and maintained. 5. Compliance Date: 5/16/2024	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		5/8/24

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F 757	Continued From page 38 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Pharmacist and Medical Director interviews, the facility failed to change the dose of atorvastatin (medication to decrease unhealthy fat in the body) from 40 milligram (mg) to 20 mg as ordered by the physician for 1 of 6 residents reviewed for unnecessary medications (Resident #88). The findings included: Resident #88 was admitted to the facility on 11/1/23 with a diagnosis of hyperlipidemia. Review of physician orders on 11/1/23 revealed an entry for atorvastatin 40 mg for hyperlipidemia one tablet daily at bedtime. Review of the Pharmacist's monthly medication review on 3/19/24 indicated a recommendation to decrease atorvastatin to 20 mg at bedtime if appropriate. The Pharmacist revealed Resident #88's cholesterol was 89, triglyceride 26, high density lipoprotein 42 and low-density lipoprotein was 39 on 3/7/24. The physician response section revealed the Medical Director checked the box indicating he agreed with the recommendation, and signed and dated the form	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: For resident #88 the pharmacy's approved recommendation by the physician for atorvastatin 20mg at bedtime was processed and entered the resident's electronic record for administration on 4/18/24. Atorvastatin 40mg was discontinued on 4/18/24. Resident #88 is receiving medication as ordered. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Nurse management completed 1 100% audit for current resident's pharmacy recommendations within the last 30 days to verify completion and the order was entered into the resident's electronic record. Audit was completed by 4/26/24. 3. Address what measures will be put in place or systemic changes made to ensure that deficient practice does not	

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F 757	Continued From page 39 on 4/1/24. The resident's medication administration record (MAR) revealed the nurses continued to offer atorvastatin 40 mg daily at bedtime as indicated by their initials from 4/1/24 through 4/17/24. During an interview on 4/18/24 at 9:12 am, the Unit Coordinator for A hall revealed she entered the physician orders in the electronic medical records. The Unit Coordinator checked Resident #88's electronic medical records and reviewed the Pharmacist's recommendation to decrease the atorvastatin 40 mg to 20 mg that was signed by the Medical Director on 4/1/24. She stated it may have been put in the box for medical records to scan instead of giving it to her. During an interview on 4/18/24 at 11:06 am, the Pharmacist stated she sent pharmacy recommendation forms to the Administrator, the Director of Nursing (DON), and the Unit Coordinators. She recommended decreasing the atorvastatin to 20 mg because Resident #88's lipid levels were in the acceptable range as of 3/7/24. The Pharmacist stated the facility should have followed the atorvastatin order for Resident #88. During an interview on 4/18/24 at 10:02 am, the Medical Director stated it did not cause any harm for Resident #88 to continue receiving the atorvastatin 40 mg instead of the 20 mg. During an interview on 4/18/24 at 2:40 pm, the Director of Nursing stated the nursing staff were responsible for entering the order once the pharmacy recommendation was signed by the provider.	F 757	recur: The Director of Nursing and/or the staff development coordinator Educated the Unit Managers on completing pharmacy recommendations when received by the pharmacist. Once the recommendations have been approved by the physician, the unit manager will process the order and enter it into the resident’s electronic record for administration. Education was completed by 5/6/24. Staff will not be permitted to work util education is complete. New hires will be educated on topic during orientation. The Staff development coordinator will verify education completion. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Director of Nursing and/or the Staff development Coordinator will audit transcription of pharmacy recommendations. Audit will be completed 5xper week for 4 weeks; 3xper week for 4 weeks; then 1xper week for 4 weeks. The Director of nursing will report results of audit monthly to the Quality Assurance Performance Committee for suggestions and/or recommendations until substantial compliance is obtained and maintained. 5. Completion Date: 5/16/2024	

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to date five medications that had been opened and stored in 2 of 2 medication carts (2-hall cart and 3-hall cart) observed for medication storage. Findings included: 1a. During an observation of the 2-hall medication cart on 4/17/2024 at 2:09 pm the following	F 761	F761 Label/Store Drugs and Biologicals 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 4/17/24 Medications not dated when opened were removed from medication carts and medication storage area by the unit manager. 2. Address how the facility will identify	5/8/24

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F 761	Continued From page 41 medications were found opened and were not dated: -Chlorhexidine gluconate oral rinse 0.12 % (an antiseptic mouthwash) was found opened and undated. -Dextromethorphan/Guaifenesin (an over-the-counter cough suppressant medication) 20 milligrams/200 milligrams in 20 milliliters liquid was found opened and undated. -Lactulose solution 10grams in 15 milliliters (a laxative) was found opened and undated. An interview was conducted with Nurse #1 on 4/18/2024 at 8:25 am and she stated there were several nurses that work on the 2-hall medication cart, and someone must have opened the bottles and forgot to put the date on the bottle. She stated she thought it was just human error because the nurses and medication aides all know they should date the bottles when they were opened. 1b. During an observation of the 3-hall cart on 4/17/2024 at 2:34 pm the following medications were found opened and were not dated: -Therapeutic multi-vitamin supplement was found opened and undated. -Docusate Sodium (an over-the-counter stool softener) 100 milligram capsules was found opened and undated. On 4/18/2024 at 9:26 am Medication Aide #1 stated sometimes the medication aides and nurses that gave medications forgot to date	F 761	other residents having the potential to be affected by the same deficient practice: The unit managers audited all medications storage areas including med carts, med rooms, and refrigerators to verify that all medications are properly labeled when opened. Audit was completed by 4/26/24. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Staff Development Coordinator educated the licensed nurses and Med aides on the facility's med storage policy. All medication requiring an opened date when open must be dated upon opening. Remove all expired medication from the medication carts, med rooms and refrigerators on or before the date of expiration immediately. Education was completed by 5/6/24. Staff will not be permitted to work until education is complete. New hires will be educated on topic during orientation. The staff development coordinator will verify education completion. The Pharmacy nurse will complete a 100% audit of all medication storage areas monthly and report findings to the Director of Nursing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The unit manager will audit all medication storage areas including medication carts, medication rooms, and refrigerators for proper labeling and the removal of expired medications. Audit will be completed 5xper for 4 weeks; 3x per week for	

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F 761	Continued From page 42 the bottles when they were opened. A phone interview was conducted with the Director of Nursing by phone on 4/18/2024 at 2:34 pm and she stated the nurses and medication aides have been educated on dating the medications when they open the bottles, and the bottle should have been dated. During an interview with the Administrator on 4/18/2024 at 3:25 pm he stated the nursing staff should date any medication bottles when opened.	F 761	4weeks; then 1xper week for 4 weeks. The Director of Nursing will report the results of the monthly audit to the Quality Assurance Performance Committee for suggestions and or recommendations until substantial compliance is obtained and maintained. 5. Compliance Date: 5/16/2024	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews, the facility failed to honor a resident's preference for meals when they served him a double portion of peas when he had requested not to be served peas (Resident #69). This was for 1 of 2 residents reviewed for choices. The findings included: Resident #69 was admitted to the facility on	F 806	F806 Resident Allergies, Preferences, Substitutes 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: As of 5/9/2024 dietary director has reviewed resident # 69 for likes and dislikes and updated the meal service tray card.	5/9/24

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F 806	Continued From page 43 4/1/2022 . The most recent quarterly Minimum Data Set assessment dated 1/31/2024 noted Resident #69 had adequate vision and hearing, was able to understand and was understood by others, was cognitively intact, and without behaviors. A review of Resident #69's updated meal preferences and diet order dated 11/4/2023 revealed he was ordered a regular textured diet with thin liquids, controlled carbohydrates, and double portions of protein. The dietary choices included that Resident #69 disliked peas. Resident #69 was interviewed on 4/15/2024 at 12:09 PM and he reported there were instances where his dietary choices were not honored and provided a picture on his phone of one meal tray with a double portion of peas on the plate and his tray card which noted "no peas". Resident #69 was interviewed again on 4/18/2024 at 11:35 AM and he reported he received the double portion of peas on a lunch tray on 3/15/2024 and he told the nursing assistant staff he wanted something else, but no one came to replace his meal tray. Resident #69 reported he was frustrated that he was clear with his dietary preferences, the preferences were written down on his tray card, but he continued to receive food that he did not like. An interview was conducted with nursing assistant (NA) #13 on 4/17/2024 at 10:04 AM. NA #13 reported Resident #69 was often dissatisfied with his meals, but she did not recall getting him a new plate of food. The Registered Dietitian (RD) was interviewed on	F 806	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Dietary director will interview residents who are interview able and obtain their likes and dislikes for non-interview able residents interview their responsible parties; update their diet cards. 3. Address what measures will be put in place or systemic changes made to ensure that deficient practice does not recur: The Dietary consultant will re-educate Dietary Director on updating dietary cards as necessary on admission and during quarterly assessments. The Dietary Director will re-educate all dietary staff on the likes and dislikes of the meal service tray card. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Dietary Director will interview 5 tray residents' daily during meal service for likes and dislikes for 4 weeks then 5 trays weekly for 4 weeks. The Dietary Director will report the results of the monthly audit to the Quality Assurance Performance Committee for suggestions and or recommendations until substantial compliance is obtained and maintained. 5. Completion Date: 5/16/2024	

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	345183	A. BUILDING _____ B. WING _____	C 04/18/2024

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F 806	Continued From page 44 4/17/2024 at 11:42 AM. The RD explained the Dietary Manager position at the facility had been recently vacated, but the responsibility of updating food preferences was something the Dietary Manager would do quarterly and as needed. The RD reported she was not certain why Resident #69 received a double portion of peas, a vegetable he had asked not to be served. The RD explained that all residents should have their dietary preferences respected. An interview was conducted with NA #14 on 4/17/2024 at 4:54 PM and she reported Resident #69 was often unhappy with his meals, but she could not recall getting another meal for him. An interview was conducted with Nurse #3 on 4/18/2024 at 3:35 PM. Nurse #3 reported Resident #69 was frequently dissatisfied with his meals and would complain, but she was not certain he was provided with an alternative meal. The Administrator was interviewed on 4/18/2024 at 4:02 PM. The Administrator reported Resident #69 had shown him the picture of his meal with the double portion of peas with his tray card that read "no peas". The Administrator explained he was not certain why Resident #69 received a double portion of peas, but his preferences should have been honored. The Administrator reported he expected dietary preferences to be honored, and preferences to be reviewed quarterly and as needed for all residents.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		5/8/24

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F 812	Continued From page 45 §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 observations and staff interviews the facility failed to ensure milk and thickened juice for the lunch meal observation was within safe temperature range of 41 degrees Fahrenheit (F) or below and failed to maintain the wash temperature of the high temperature dishwasher according to manufacturer's recommendations for sanitation of dishware. The facility also failed to ensure soiled cups did not come in contact with the clean ice scoop used to refill residents' water cups. The practices had the potential to affect food served to residents. The findings included: 1. On 4/16/24 at 11:32 AM the temperature check for the lunch meal was observed. After all hot food was checked, dietary staff was requested to check cold beverages. Dietary Staff #1 used a digital thermometer to check the following cold	F 812	F812 Food Procurement, Store/Prepare/Serv-Sanitary 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Dietary Director has corrected the icing process for milk and thicken juices prior to meal service as of 5/9/2024. The Maintenance Director has repaired the dish machine to operate at the manufactures recommended temperature as of 5/9/2024. The dietary director removed contaminated glass from ice machine area as of 4/19/2024.Residents #40,and resident #53 have been given clean properly service ice and water as of 4/17/2024. 2. Address how the facility will identify	

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F 812	Continued From page 46 beverages: milk 49 degrees F, thickened orange juice 57 degrees F, and honey tea 60 degrees F. The Senior Culinary Manager threw out all milks and indicated fresh cold beverages would be given out. An interview was conducted on 4/17/24 at 9:26 AM with Dietary Staff #1 and revealed she didn't know the specifics on what food temperatures should be, although she felt like she had a general idea. Dietary Staff #1 also revealed that she had her safe serve certification. 2. An observation was made on 4/17/24 at 9:13 AM of two wash and rinse cycles of dishware in the facility's high temperature dish machine. The loaded dish rack washed in the dish wash machine was observed to have a wash cycle temperature that did not exceed 145 degrees F. A label was also observed on the dish machine that read "wash temperature 155 degrees - 160 degrees." Dietary staff used the dish machine, and it was observed that to have a wash cycle temperature of 145 degrees F and a final rise temperature of 190 degrees F. An interview was conducted on 4/17/24 at 4:45 PM with the Senior Culinary Manager and he revealed that cold food should be at 41 degrees F or below. An interview was conducted on 4/18/24 at 2:52 PM with the Administrator and Nurse Regional Consultant and revealed that they weren't very familiar with food temperatures or dishwasher temperatures. 3. On 4/17/24 at 9:25 am, Patient Care Assistants (PCA) #1 and 2 were observed passing out ice to residents in A hall. PCA #1 was observed coming out of room #220 with a white disposable cup. PCA #1 set the white cup down beside the ice cooler. Resident # 63 self-propelled his	F 812	other residents having the potential to be affected by the same deficient practice: Dietary will audit temperature logs for the last 30 days to ensure proper operating temperatures for cold liquids and dish machine as of 5/9/2024. The Nurse Manager/DON immediately re-educated PCA #1 to ensure all residents had ice and water served in a sanitary manner as of 4/17/2024 and hands sanitized between all residents. 3. Address what measures will be put in place or systemic changes made to ensure that deficient practice does not recur: The dietary director has re-educated all dietary staff on icing process for cold liquids and thicken liquids prior to meal service as of 5/9/2024. The dietary director has re-educated all staff on correct dish machine operating temperature and use of ice scoop when filling residents' cups with ice. The DON/Staff Development Coordinator will re-educate all certified aides and personal care aides on proper ice pace procedure per policy. The dietary director will monitor liquid temperatures during meal service and dish machine temperatures 5 times per week for 4 weeks then biweekly for 8 weeks. Director of Nursing(DON)/Nurse Managers will monitor ice pass daily for 5 residents to ensure ice is passed in a clean and sanitary manner for 4 weeks then bi-weekly for 8 weeks. 4. How the facility will monitor its performance to ensure the deficient	

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F 812	Continued From page 47 wheelchair towards PCA #1, handed a clear cup to her and asked for ice and water. PCA #1 was observed filling the clear cup with ice over the ice cooler. The ice scoop was touching the rim of the clear cup. PCA #1 scooped water with the ice scoop from the ice cooler and added it to the clear cup. The water was flowing down the side of the cup into the ice cooler. PCA #1 gave Resident #63 his cup and proceeded to fill the white disposable cup with ice. The ice scoop was touching the rim of the white disposable cup. PCA #1 went inside room #220 to deliver the ice to Resident #40. PCA #1 did not perform hand hygiene until the Unit Coordinator approached her and reminded her to perform hand hygiene. On 4/17/24 at 9:27 am, PCA #2 was observed coming out of room #218 holding a clear plastic water tumbler half-filled with water. PCA #2 filled the water tumbler with ice over the ice cooler. The ice scoop was touching the rim of the water tumbler. PCA #2 scooped water from the ice cooler with the ice scooper and filled the water tumbler. Water was observed flowing down the side of the tumbler into the ice cooler. She placed the ice scoop back into the holder and went inside room #218 to deliver the water tumbler to Resident #53. She was observed applying hand sanitizer after she came out of Resident #53's bedroom. During an interview on 4/17/24 9:49 am, PCA #1 stated she had been working in the facility for two and a half years. Refilling ice for the residents was one of her tasks. She stated it was another PCA that trained her. PCA #1 revealed she was following the same process taught to her by the PCA who trained her with passing ice. During an interview on 4/17/24, PCA #2 stated	F 812	practice does not recur: The Dietary Director/DON will report the results of the monthly audit to the Quality Assurance Performance Committee for suggestions and or recommendations until substantial compliance is obtained and maintained. 5. Completion Date: 5/16/2024	

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F 812	Continued From page 48 she was trained by a patient PCA two years ago. She stated she was supposed to perform hand hygiene in between residents when refilling ice. She explained that the cups were changed every day. Some residents preferred to refill their own cups with ice and water. During an interview on 4/17/24 at 10:07 am, the Unit Coordinator stated she was not sure who trained the PCA's. She stated the PCAs should put dates on the cups and avoid touching the rim. The Unit Coordinator revealed the PCAs were allowed to refill used cups and tumblers, but the ice scooper should not be touching the cups. The PCAs were told to refill water from the nutrition room and not scoop them out from the ice cooler. During an interview on 4/17/24 at 3:08 PM, the Director of Nursing (DON) stated she supervised the PCAs. She was not aware who the PCAs trained with, but they were trained before working in the hall. The DON stated the PCAs were supposed to use new cups daily. Night shift collected the old cups and disposed of them. The PCAs should be writing the dates on the cups. They refilled the residents' cups with ice every shift. If a resident needed water, they got water from the nourishment room. Ice scoops should never touch the cups. During an interview on 4/17/24 at 3:46 pm, the Administrator stated the PCAs, or hospitality aides got trained by nursing. He stated there was not a lot they could do but they were still expected to follow sanitary and infection control practices they were taught during orientation.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		5/8/24

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F 867	Continued From page 49 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		

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F 867	Continued From page 50 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the	F 867		

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F 867	Continued From page 51 facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor the interventions that the	F 867	F867 QAPI/QAA Improvement Activities 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 867	Continued From page 52 committee put into place in following the recertification survey of recertification surveys of 7/15/2021 and 12/8/2022, and complaint investigation survey of 10/17/2023. This was for 2 deficiencies in the areas of F584 Safe/Clean/Comfortable/Homelike Environment and F812 Food Procurement, Store/Prepare/Serve Sanitary. These deficiencies were recited on the current recertification and complaint investigation survey of 4/18/2024. The continued failure of the facility during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This tag is cross referred to: F584: Based on record review, observations, and staff interviews the facility failed to ensure the wall and window valance in a resident's rooms were clean for 1 of 3 residents (Resident # 84) observed for environmental concerns. During the recertification and complaint investigation survey of 7/15/2021, the facility failed to clean and keep furniture in good repair for 2 of 2 chairs in the front lobby, 1 of 2 overbed tables in the lobby, 8 of 8 dining room chairs, 3 of 3 cabinet drawers in the dining room, 3 of 5 chairs in the game room and 1 of 1 vinyl chair in the 100-Unit nursing station. F812: Based on observations and staff interviews the facility failed to ensure milk and thickened juice for the lunch meal observation was within safe temperature range of 41 degrees Fahrenheit (F) or below and failed to maintain the wash	F 867	As of 5/9/2024 the administrator has corrected the areas of F584 Homelike environment and F812 for Food procurement. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: No resident was named for this area of noncompliance. The Administrator will review the last 3 years of surveys and complaints for any cited area for continued compliance. 3. Address what measures will be put in place or systemic changes made to ensure that deficient practice does not recur: The Regional Director of Operations re-educated the administrator on the proper process of the Quality Assurance performance Improvement (QAPI) program regarding its process and purpose as of 5/6/2024. The Regional Director of Operations and/or the Regional Clinical Nurse will review the QAPI minutes monthly for any needed improvement for 1 year. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Administrator will report the results of the monthly audit to the Quality Assurance Performance Committee for suggestions and or recommendations until substantial compliance is obtained and maintained.	

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F 867	Continued From page 53	F 867		

temperature of the high temperature dishwasher according to manufacturer's recommendations for sanitation of dishware. The facility also failed to ensure soiled cups did not come in contact with the clean ice scoop used to refill residents' water cups. The practices had the potential to affect food served to residents.

During the recertification and complaint investigation conducted 7/15/2021 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.

During the recertification and complaint investigation conducted 12/8/2022 the facility failed to 1) wash dishes in the dish machine in water that reached at least 155 degrees Fahrenheit (F), per manufacturer recommendations, 2) store frozen foods at least 0 degrees F, and 3) store canned goods and snacks off the floor.

During the complaint investigation conducted on 10/17/2023 facility failed to remove expired food from 1 of 1 dry storage room and failed to date and label opened food in 1 of 1 walk in cooler.

The Administrator was interviewed on 4/18/2024 at 4:02 PM and he reported the QAPI committee conducted meetings monthly, and the facility physician, pharmacist, Director of Nursing, Unit Managers, Housekeeping supervisor, Dietary Manager, and therapy. The Administrator explained the QAPI committee discussed past tags, and new areas of concern, as well as

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F 867	Continued From page 54 initiating performance improvement plans. The Administrator stated the repeat tags were due to department heads were unable to maintain the corrective actions put in place.	F 867		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345183	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/18/2024

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UNIVERSAL HEALTH CARE & REHAB	**430 BROOKWOOD AVENUE NE CONCORD, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 584	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to ensure the wall and window valance in a resident's rooms were clean for 1 of 3 residents (Resident # 84) observed for environmental concerns. Findings included: During an observation of Resident #84 on 4/15/204 at 11:52 am he was lying in bed with the head of the bed raised to a sitting position. The wall beside Resident #84's bed had dry brown liquid stains that had run down the wall and there were splatters that dried over more splatters of a brown liquid substance that were also dry. Resident #84's window valance also had 4 large (4 to 5 centimeters) areas of brown liquid splattered on them. Resident #84 stated he did not know what was splattered on the wall, but it had been on the wall since he had been at the facility.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345183	A. BUILDING: _____ B. WING _____	4/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From Page 1

Resident #84's room was observed on 4/17/2024 at 8:09 am and the dark brown liquid stains on the wall beside his bed and the brown stains on his window valance remained.

On 4/17/2024 at 11:04 am Housekeeper #1 stated he did not know what caused the dark brown liquid stains on Resident #84's wall and window valance in Resident #84's room and he had not noticed the stains when he cleaned the room. The Housekeeper stated he was responsible for cleaning the walls in Resident #84's room daily.

The Housekeeping Account Manager was interviewed on 4/17/2024 at 2:40 pm and she stated Housekeeper #1 should have attempted to clean Resident #84's wall and he should have taken down the widow valance in his room to have it washed. She stated if the wall was stained, and the stains could not be removed then the wall would need to be painted by the maintenance department. The Housekeeping Account Manager stated if the widow valance stain could not removed the facility should replace the window valance.

An interview was conducted with the Administrator on 4/18/2024 at 3:01 pm and he stated Resident #84's walls and valance should have been clean, and without stains and odors. The Administrator stated Housekeeper #1 should have tried to clean the walls and valance and if the stains could not be removed the wall should have been painted and the window valance replaced.