

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Universal Health Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Brookwood Avenue NE Concord, NC 28025	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49007</p> <p>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).</p> <p>The findings included:</p> <p>Resident #37 was admitted to the facility on [DATE].</p> <p>Resident #37's electronic medical record (EMR) revealed a physician's order dated [DATE] that read code status Do Not Resuscitate (DNR).</p> <p>Resident #37's Care Plan dated [DATE] revealed Resident #37 elected to be a DNR.</p> <p>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 [DATE].</p> <p>Resident #37's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #37 was moderately cognitively impaired.</p> <p>Resident #37's EMR showed a communication banner on the top of Resident #37's opened EMR indicated DNR.</p> <p>An interview was conducted with Nurse #1 on [DATE] 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 [DATE]. Nurse #1 checked the hard chart for Resident #37 and the hard chart indicated to start CPR.</p> <p>An interview was conducted with the Director of Nursing (DON) on [DATE] 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 hard chart. Interview further revealed that DON indicated Unit Manager #1 knew correct code status for Resident #37 as she worked on that unit.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on [DATE] 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.</p> <p>An interview was conducted with Business Office Manager (BOM) on [DATE] 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.</p> <p>An interview was conducted on [DATE] 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.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904</p> <p>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).</p> <p>Findings included:</p> <p>Resident #63 was admitted to the facility on [DATE] with cumulative diagnoses of renal failure which required dialysis treatments and diabetes.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #63 was cognitively intact.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>49007</p> <p>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).</p> <p>Findings included:</p> <p>A review of the facility policy titled: Abuse Prevention, Intervention, Reporting, and Investigation dated February 2021 Revision read as follows:</p> <p>Reporting/Response</p> <p>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 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.</p> <p>Review of grievance logs revealed the following:</p> <p>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.</p> <p>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.</p> <p>There was no report filed to the State Agency for Resident #4 and Resident #86.</p> <p>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 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.</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281</p> <p>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).</p> <p>The findings included:</p> <p>a. Resident #29 was admitted to the facility 6/17/2021 with diagnoses including diabetes and respiratory failure.</p> <p>A nursing note dated 3/12/2024 documented Resident #29 was sent to the hospital for fever and a low oxygen saturation.</p> <p>The entry tracking record dated 3/21/2024 documented Resident #29 was readmitted to the facility from the hospital.</p> <p>b. Resident #145 was admitted to the facility on [DATE] with diagnoses including diabetes and hypertension.</p> <p>A nursing note dated 3/16/2024 documented Resident #145 was transferred to the hospital after a change in status.</p> <p>The discharge, return not anticipated Minimum Data Set assessment dated [DATE] documented Resident #145 was discharged to the hospital.</p> <p>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.</p> <p>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.</p> <p>The Ombudsman was interviewed on 4/11/2024 and she reported she had not received a discharge summary from the facility since December 2023.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>48945</p> <p>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).</p> <p>The findings include:</p> <p>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.</p> <p>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 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.</p> <p>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.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904</p> <p>Based on record review, observations, and staff and responsible party interviews the facility failed to ensure a resident's hair was not greasy for 1 of 4 residents (Resident #44) who were dependent on staff for personal hygiene.</p> <p>Findings included:</p> <p>Resident #44 was admitted to the facility on [DATE]. His cumulative diagnoses included stroke, hemiplegia, and aphasia.</p> <p>An annual Minimum Data Set assessment dated [DATE] 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.</p> <p>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.</p> <p>The facility's shower schedule which was undated indicated Resident #44 received his showers on Mondays and Thursdays each week.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904</p> <p>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 center three days a week, leaving before breakfast was served and returning to the facility after breakfast was served.</p> <p>Findings included:</p> <p>Resident #63 was admitted to the facility on [DATE] and his cumulative diagnoses included renal failure which required dialysis treatments and diabetes.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #63 was cognitively intact and required set up assistance with his meals.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>On 4/16/2024 at 9:02 am Resident #63 was observed and interviewed at the facility's kitchen 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>On 4/18/2024 at 10:03 am the Transportation 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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>37281</p> <p>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 was designed to address the outcome of the performance reviews (NA #4, NA #5, NA #6, and NA #7).</p> <p>The findings included:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48945</p> <p>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).</p> <p>The findings included:</p> <p>Resident #88 was admitted to the facility on [DATE] with a diagnosis of hyperlipidemia.</p> <p>Review of physician orders on 11/1/23 revealed an entry for atorvastatin 40 mg for hyperlipidemia one tablet daily at bedtime.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48945</p> <p>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).</p> <p>The findings included:</p> <p>Resident #88 was admitted to the facility on [DATE] with a diagnosis of hyperlipidemia.</p> <p>Review of physician orders on 11/1/23 revealed an entry for atorvastatin 40 mg for hyperlipidemia one tablet daily at bedtime.</p> <p>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 on 4/1/24.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>38904</p> <p>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.</p> <p>Findings included:</p> <p>1a. During an observation of the 2-hall medication cart on 4/17/2024 at 2:09 pm the following medications were found opened and were not dated:</p> <ul style="list-style-type: none"> -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. <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> -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. <p>On 4/18/2024 at 9:26 am Medication Aide #1 stated sometimes the medication aides and nurses that gave medications forgot to date the bottles when they were opened.</p> <p>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.</p> <p>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.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281</p> <p>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.</p> <p>The findings included:</p> <p>Resident #69 was admitted to the facility on [DATE] . The most recent quarterly Minimum Data Set assessment dated [DATE] noted Resident #69 had adequate vision and hearing, was able to understand and was understood by others, was cognitively intact, and without behaviors.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The Registered Dietitian (RD) was interviewed on 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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49007</p> <p>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.</p> <p>The findings included:</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>48945</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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 [ROOM NUMBER] with a white disposable cup. PCA #1 set the white cup down beside the ice cooler. Resident # 63 self-propelled his 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 [ROOM NUMBER] 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.</p> <p>On 4/17/24 at 9:27 am, PCA #2 was observed coming out of room [ROOM NUMBER] 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 [ROOM NUMBER] to deliver the water tumbler to Resident #53. She was observed applying hand sanitizer after she came out of Resident #53's bedroom.</p> <p>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.</p> <p>During an interview on 4/17/24, PCA #2 stated 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.</p> <p>During an interview on 4/17/24 at 10:07 am, the Unit Coordinator stated she was not sure who trained the PCAs. 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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281</p> <p>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 committee put into place in following the recertification survey of recertification surveys of [DATE] and [DATE], and complaint investigation survey of [DATE]. 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 [DATE]. 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.</p> <p>The findings included:</p> <p>This tag is cross referred to:</p> <p>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.</p> <p>During the recertification and complaint investigation survey of [DATE], 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.</p> <p>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 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.</p> <p>During the recertification and complaint investigation conducted [DATE] 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.</p> <p>During the recertification and complaint investigation conducted [DATE] 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.</p> <p>During the complaint investigation conducted on [DATE] 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.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Universal Health Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Brookwood Avenue NE Concord, NC 28025	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Administrator was interviewed on [DATE] 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 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.</p>