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 06/11/2018

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

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F 677 SS=D	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 observations, resident interviews, staff interviews and record reviews the facility failed to provide Activity of Daily Living (ADL) care by not providing showers for 2 out of 5 residents reviewed who required assistance with showers (Resident #6 and Resident #8) and assist 1 of 1 resident for reviewed for transfers into and out of bed (Resident #8). Findings included: 1. Resident #6 was originally admitted to the facility on 2/14/18. The resident was discharged to a hospital on 5/20/18 and was most recently readmitted on 5/28/18. The resident's admission diagnoses included: Pneumonia, Chronic Obstructive Pulmonary Disease, and cellulitis (infection) of the right lower leg. Review of the Minimum Data Set (MDS) assessments for Resident #6 revealed a quarterly assessment with an Assessment Reference Date (ARD) of 4/20/18. Review of the assessment revealed the resident was coded as having been cognitively intact. The resident was coded as having had rejection of care 1-3 days during the assessment period. The resident was coded as having required extensive assistance of 1-2 staff members for bed mobility, transfer (such as from a bed to a chair), dressing, toilet use, and personal hygiene. The resident was coded as	F 677	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correction conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident. Root Cause Analysis: Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that staff did not follow the facility policy with regards to providing showers per resident preferences. Immediate Action: On 6/13/18 Resident # 6 was given a shower and his preferences regarding shower days and times were updated. On 6/11/18 Resident #8 was given a shower and her preferences regarding shower days and times were updated.	6/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/21/2018

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F 677	Continued From page 1 having had required physical help in part of bathing activity of one person. The resident was coded as having had a stage IV pressure ulcer. Review of Resident #6's care plan revealed it had been most recently reviewed on 4/20/18. The resident had problem/need areas which included: Required assistance of ADLs related to (R/T) functional quadriplegia. A quarterly review note dated 4/20/18 documented the resident needed extensive assistance with ADLs and required total care for transfers R/T functional quadriplegia. An approach listed for the ADL problem was the resident required a mechanical lift for transfer to an electric wheelchair. There was a Problem/Need identified regarding the resident having had a diabetic ulcer to the right foot and a pressure ulcer to the right heel. A review of the Bath Report Roster for Resident #6 from 5/1/18 through 6/11/18 revealed the resident's was documented as having received two showers through the time period. One shower was documented on 5/7/18 and the other on 5/18/18. Review of the shower schedule provided by the facility on 6/11/18 revealed Resident #6's room was scheduled for a shower each Tuesday and Friday. Review of the daily assignment sheets from 5/1/18 through 5/31/18 revealed the resident had not been scheduled for a shower. Further review for the period of 6/1/18 through 6/10/18 revealed Resident #6's room number was not scheduled for a shower. Review of the departmental notes for Resident #6	F 677	Identification of others: Effective 6/18/18 interviews were conducted with all alert and oriented residents to determine preferred shower dates and times. All newly admitted or re-admitted residents will be interviewed regarding their preferences at the time of admission. Systemic Changes: Effective 6/18/18 all scheduled nursing staff were re-educated by the Assistant Director of Nursing regarding the residents right to choice including daily schedules regarding showers. Nursing staff members who did not receive the re-education will not be allowed to work until they are re-educated. All newly hired nursing staff will be educated regarding resident preferences at the time of hire. Monitoring: Effective 6/18/18 The facility interdisciplinary team, which includes the Director of Nursing, MDS Nurse #1, Unit Coordinator #2, Social Worker #1, and Activity Director # 1 will perform daily rounds and audit the shower schedule for the previous days showers to ensure that showers were given as scheduled, and to validate that the documentation is complete for showers given as well as for showers refused. This daily monitoring will continue for 4 weeks, then weekly x 4 weeks and then monthly for three months or until a pattern of compliance is	

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F 677	Continued From page 2 from 5/4/18 through 6/6/18 revealed no documentation for the resident being noncompliant, refusing showers, or refusing to be transferred into or out of his bed or chair. The resident was documented as having been discharged to the hospital on 5/20/18 and returned on 5/28/18 after having been hospitalized for pneumonia. An interview was conducted on 6/11/18 at 11:47 AM with Resident #6. The resident stated he has to be transferred into and out of bed using a sling lift. The resident explained he had been going back to bed to rest with staff assistance from 9:00 AM to 11:00 AM and from 2:00 PM to 4:00 PM. The resident stated it took two staff members to help him in and out of bed with the lift. The resident stated he had been unable to get back into bed on the day of the interview because the staff had been too busy and there was no one to help him. The resident further explained it had been about 2 weeks since he had not been able to get back into bed and rest. The resident stated there had been times when he had gotten back into bed but then it had been difficult to be able to get the help he needed from two staff members to get back out of bed. The resident stated he was usually assisted out of bed at about 5:30 or 6:00 AM by the third shift staff and returns to bed at about 9:30 or 10:00 PM with the assistance of the second shift staff. The resident further stated he felt like staying up all day without breaks to go back to bed to rest had become the new norm. The resident stated he returned from the hospital on 5/28/18 and had not received a shower since. The resident stated he did have a wound on his leg/foot but the staff had usually put a bag on his foot and he had been able to take a shower. The resident stated he did not know what day or days	F 677	achieved. Effective 6/18/18 Weekend Supervisor and/or designated nurse will review the previous days scheduled showers to ensure that the showers were given and documentation is in place for showers given as well as refused. This daily monitoring will continue for 4 weeks, then weekly x 4 weeks and then monthly for three months or until a pattern of compliance is achieved. The Director of Nursing will review these daily audits and report the findings monthly to the Quality Assurance and Performance Improvement (QAPI) committee for recommendations or modifications until a pattern of compliance is achieved. Root Cause Analysis: Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that staff did not follow the facility policy with regards to allowing residents to choose their daily schedules. This was specific to the ability to choose when to get up for the day and when to go to bed. Immediate Action: On 6/18/18 Resident # 6 was interviewed regarding his preferences and staff re-educated to assist resident out of bed and into bed per his preferences. Identification of others:	

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F 677	Continued From page 3 his shower was assigned. An interview was conducted on 6/11/18 at 2:11 PM with first shift Nursing Assistant (NA #11). The NA stated her assignment included the room in which Resident #6 resided. The NA stated she had 12 residents on her assignment for that day. The NA stated she had taken over the assignment at 1:00 PM because the other NA had left at 12:00 PM. The NA stated she was not sure if the showers which had been assigned had been completed or not. The NA stated the way the showers were scheduled had changed and she reviewed the daily assignment. The NA stated Resident #9 had been assigned to receive a shower. The NA stated she did not know how other NAs documented having gave a shower but when she completed a shower on a resident, she would put her initials next to the resident's room number on the showers portion of the assignment sheet. Review of the daily assignment sheet for the unit revealed there were no initials next to any of the room numbers on the daily assignment sheet for showers. An interview was conducted with the Director of Nursing (DON) on 6/11/18 at 6:05 PM. The DON stated there was not a mechanism in which showers which were to be given were monitored nor was there a person assigned to monitor showers given. The DON stated there was shower team up till the end of April and the first part of May but there no longer was a shower team and the NAs were responsible for the showers on their assignments. The DON stated the scheduler made the daily staffing assignment and would assign residents' showers. She further stated if the resident refused the shower, the NA was to inform the nurse and the nurse would be	F 677	On 6/18/18 interviews were conducted with all alert and oriented residents to determine preferred times to get out of bed and when to return to bed. Newly admitted residents will be asked their preference regarding daily schedules at the time of admission. Systemic Changes: Effective 6/18/18 all scheduled nursing staff were re-educated by the Assistant Director of Nursing regarding the residents right to choice including the time to get out of bed and when to go back to bed. Nursing staff members who did not receive the re-education will not be allowed to work until they are re-educated. Monitoring: Effective 6/18/18 The facility management team, which includes the Business Office Manager, MDS Nurse #1, Unit Coordinator #2, Social Worker #1, and Activity Director # 1, Maintenance Director, Admissions Coordinator will interview 5 residents per week regarding honoring of preferences with relation to daily schedules specific to the time they want to get up and the time they want to return to bed. This monitoring will continue for 4 weeks, then monthly x 3 months or until a pattern of compliance is achieved. Effective 6/18/18 Weekend Supervisor and/or designated nurse will interview two	

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F 677	Continued From page 4 responsible for documenting the resident refusal of the shower. The DON stated it was her expectation that every resident receive two showers per week. 2. Resident #8 was admitted on 7/25/17. The resident's admission diagnoses included: Kidney failure, diabetes, and lower back pain. Review of the Minimum Data Set (MDS) assessments for Resident #8 revealed a quarterly assessment with an Assessment Reference Date (ARD) of 4/23/18. Review of the assessment revealed the resident was coded as having been cognitively intact. The resident was coded as having had rejection of care 1-3 days during the assessment period. The resident was coded as having required extensive assistance of 1 staff member for bed mobility, transfer (such as from a bed to a chair), dressing, eating, toilet use, and personal hygiene. The resident was coded as having had required physical help in part of bathing activity of one person. Review of Resident #8's care plan revealed it had been most recently reviewed on 4/23/18. The resident had problem/need areas which included: Resident refused care at times. She needed extensive assistance with ADLs. An approach for ADLs included to assist the resident with bathing, grooming, washing hair, and other ADLs. Review of the shower schedule provided by the facility on 6/11/18 revealed Resident #8's room was scheduled for a shower each Monday, Wednesday, and Friday. A review of the Bath Report Roster from 6/1/18 through 6/11/18 for Resident #8 revealed the	F 677	residents per weekend with regard to preferences specific to the time to get out of bed and the time to return to bed. This monitoring will continue for 4 weeks, then monthly for 3 months or until a pattern of compliance is achieved. The Director of Nursing will review these daily audits and report the findings monthly to the Quality Assurance and Performance Improvement committee for recommendations or modifications until a pattern of compliance is achieved.	

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F 677	Continued From page 5	F 677		

resident was documented as having received a shower on 6/4/18 and 6/11/18.

Review of the daily assignment sheets for the period of 6/1/18 through 6/10/18 revealed Resident #8's room number was scheduled for a shower on the following dates: 6/1/18 and 6/4/18. At the top of the column for the assigned resident showers the column label stated, "Showers CNA initial." Neither date had initials next to resident's room to indicate a shower had been completed.

Review of the departmental notes for Resident #8 from 5/26/18 through 6/11/18 revealed no documentation for the resident being noncompliant, refusing showers, or refusing to be transferred into or out of his bed or chair.

An interview was conducted on 6/11/18 at 11:13 AM with Resident #8. The resident stated she had received a shower that morning but had not received a shower in a week. The resident stated her last shower had been on Monday, 6/4/18. The resident stated she was supposed to receive a shower on Monday, Wednesday, and Friday. The resident stated the NA had told her the shower schedule had been revised and the NA had not seen the resident's name on the shower schedule. The resident stated she went to dialysis on Tuesday, Thursday, and Saturday mornings. The resident stated when she returned from dialysis in the afternoon her bed was not made and the towels in her bathroom had not been picked up from the morning.

An interview was conducted on 6/11/18 at 2:40 PM with first shift NA #14. The NA stated she had given Resident #8 a shower and she had one more shower to give. The NA stated the shower

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F 677	Continued From page 6 schedule had been revised and she needed to find the book so she could find out who else was scheduled for a shower. The NA stated she was unable to get the second shower completed during her shift and she would give the resident a shower after her shift ended. The NA stated the showers had been divided up so the first shift was not responsible for all of the showers. The NA stated the showers were listed on the daily assignment and sometimes they were in the book. An interview was conducted with the Director of Nursing (DON) on 6/11/18 at 6:05 PM. The DON stated there was not a mechanism in which showers which were to be given were monitored nor was there a person assigned to monitor showers given. The DON stated there was shower team up till the end of April and the first part of May but there no longer was a shower team and the NAs were responsible for the showers on their assignments. The DON stated the scheduler made the daily staffing assignment and would assign residents' showers. She further stated if the resident refused the shower, the NA was to inform the nurse and the nurse would be responsible for documenting the resident refusal of the shower. The DON stated it was her expectation that every resident receive two showers per week.	F 677		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		6/18/18

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F 732	Continued From page 7 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to accurately report care hours provided by licensed and unlicensed personnel for 36 out of 36 daily staffing hours forms reviewed.	F 732	Root Cause Analysis: Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that staff did not follow the facility policy with regards to correctly posting the nurse	

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F 732	Continued From page 8 Findings included: As part of the investigation of sufficient staffing a request was made to review the daily staffing hours sheets from 5/1/18 through 6/10/18. The original daily staffing hours forms were provided for review by the facility for the period of 5/1/18 through 6/9/18. Review of the original daily staffing hours sheets provided revealed several days which had the data for registered nurse(s) (RNs), licensed practical nurse(s) (LPNs), and nursing assistants to be either missing or entered as 0.0 for the evening shift (3 PM to 11 PM and Night Shift (11 PM to 7 AM) for the period of 5/1/18 through 6/9/18. An interview was conducted with the Administrator on 6/11/18 at approximately 9:10 PM. The daily staffing sheets were reviewed from 5/1/18 through 6/10/18. The Administrator stated the census numbers on several of the daily staffing sheets were incorrect. The Administrator stated there were staff scheduled at the facility on the days where there had been no data or 0.0 entered for staffing on second and third shift. In addition the Administrator stated, she did not feel the census number on the daily staffing hours sheets was accurate for multiple days for which the daily staffing hours sheets were reviewed. The Administrator indicated the daily staffing sheets were completed and posted by the scheduler during the week (Monday through Friday) and by the charge nurse on the weekends (Saturday and Sunday). The Administrator explained the scheduler was unavailable for interview due to being on vacation. The Administrator stated her expectation was for the posted staffing to be accurate.	F 732	staffing information. Immediate Action: As of 6/12/18 The daily staffing sheet was corrected and posted to include: Facility name The current date The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: A)Registered nurses B)Licensed practical nurses C)Certified nurse aides iv) Resident census Systemic Changes: Effective 6/18/18 all administrative staff to include administrative nurses were re-educated by the Administrator regarding Posted Nurse Staffing information. All newly hired administrative staff to include administrative nursing staff will be educated regarding required Posted Nurse Staffing Information. Monitoring: Effective 6/18/18 The Assistant Director of Nursing will review the daily staffing posting to ensure that it is posted and is correct. This monitoring will continue for 4 weeks, then weekly x 4 weeks and then monthly x 3 months or until a pattern of compliance is achieved.	

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F 732	Continued From page 9 During an interview with the Corporate Consultant conducted on 6/11/18 at approximately 9:20 PM, she stated she would provide a copy of the daily staffing sheets for the dates of 5/1/18 through 6/9/18. The Corporate Consultant returned at approximately 9:40 PM and provided copies of the daily staffing hours sheets from 5/1/18 through 5/27/18 and 6/1/18 through 6/10/18, which were not the daily staffing hours sheets reviewed with the Administrator. She stated she provided copies of another set of daily staffing hours sheets which had been discovered in the scheduler's office. The Corporate Consultant stated she had not made copies of the original daily staffing sheets which had been reviewed in the presence of the Administrator. A review was completed of the daily staffing hours sheets provided by the Corporate Consultant and revealed they were dated from 5/1/18 through 5/27/18 and 6/1/18 through 6/10/18 and the corresponding daily assignment sheets from 5/1/18 through 5/27/18 and 6/1/18 through 6/9/18. The review revealed discrepancies for staffing recorded on the daily staffing hours sheets for 36 of 36 daily staffing sheets reviewed when compared to the daily staffing sheets. Discrepancies were discovered for all three shifts for LPNs and NAs.	F 732	Effective 6/18/18 Weekend Supervisor and/or designated nurse will review the Posted Nurse Staffing Information to ensure that it is posted and correct. This monitoring will continue for 4 weeks, then weekly x 4 weeks and then monthly x 3 months or until a pattern of compliance is achieved. The Director of Nursing will review these daily audits and report the findings monthly to the Quality Assurance Performance Improvement (QAPI) committee for recommendations or modifications until a pattern of compliance is achieved.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		6/18/18

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F 867	Continued From page 10 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 4/7/18 recertification survey. This was for one deficiency in the area of: ADL Care Provided for Dependent Residents which was originally cited in April, 2018. The deficiency was recited again on the current complaint investigation of 6/11/18. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program The findings included: This tag is cross referenced to: F677- Based on observations, resident interviews, staff interviews and record reviews the facility failed to provide Activity of Daily Living (ADL) care by not providing showers for 2 out of 5 residents reviewed who required assistance with showers (Resident #6 and Resident #8) and assist 1 of 1 resident for reviewed for transfers into and out of bed (Resident #8). During the recertification survey of 4/7/18 the facility was cited for failure to provide nail care to 1 of 3 residents reviewed for Activities of Daily Living (ADLs). An interview was conducted with the	F 867	Effective 6/18/18 Administrator has implemented a Quality Assurance and Performance Improvement (QAPI) monitoring tool to monitor documentation to assure that residents are receiving showers per their preferences as well as their preferences are followed regarding getting out of bed and back into bed. Root Cause Analysis: Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that staff did not follow the facility policy with regards to providing showers per resident preferences nor was facility policy followed regarding residents preferences related to getting out of bed and back into bed. Effective 6/18/18 The facility interdisciplinary team, which includes the Director of Nursing, MDS Nurse #1, Unit Coordinator #2, Social Worker #1, and Activity Director # 1 will perform daily rounds and audit the shower schedule for the previous days showers to ensure that showers were given as scheduled, and to validate that the documentation is complete for showers given as well as for showers refused. This monitoring will continue for 4 weeks, then weekly x 4 weeks and then monthly x 3 months or until a pattern of compliance is achieved.	

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 06/11/2018

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F 867	Continued From page 11 Administrator on 6/11/18 at 9:20 PM. The Administrator stated she had been the Administrator at the facility for approximately one month and was in the process of making several changes.	F 867	Effective 6/18/18 Weekend Supervisor and/or designated nurse will review the previous days scheduled showers to ensure that the showers were given and documentation is in place for showers given as well as refused. This monitoring will continue for 4 weeks, then weekly x 4 weeks and then monthly thereafter. The Director of Nursing will review these daily audits and report the findings monthly to the Quality Assurance and Performance Improvement (QAPI)committee monthly for three months or until a pattern of compliance is achieved. Root Cause Analysis: Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that staff did not follow the facility policy with regards to allowing residents to choose their daily schedules. This was specific to the ability to choose when to get up for the day and when to go to bed. Monitoring: Effective 6/18/18 The facility management team, which includes the Business Office Manager, MDS Nurse #1, Unit Coordinator #2, Social Worker #1, and Activity Director # 1, Maintenance Director, Admissions Coordinator will interview 5 residents per week regarding honoring of preferences with relation to daily schedules specific to the time they want to get up and the time they want to return to bed. This monitoring will	

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F 867	Continued From page 12	F 867	continue for 4 weeks, then monthly x 3 months or until a pattern of compliance is achieved. Effective 6/18/18 Weekend Supervisor and/or designated nurse will interview two residents per weekend with regard to preferences specific to the time to get out of bed and the time to return to bed. This monitoring will continue for 4 weeks, then monthly x 3 months or until a pattern of compliance is achieved. The Director of Nursing will review these daily audits and report the findings monthly to the Quality Assurance and Performance Improvement committee for recommendations or modifications until a pattern of compliance is achieved.	