| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| UNIVERSAL HEALTH CARE/ CONCORD | 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced complaint investigation survey was conducted from 8/28/24-8/29/24. Event ID# SDU811.<br><br>The following intakes were investigated NC00221150, NC00219883, NC00219870, NC00220835, NC00221022, NC00220709, and NC00221147.<br><br>6 of 17 complaint allegations resulted in deficiency. | F 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, staff and resident interviews and observations, the facility failed to protect 1 of 4 residents (Resident #8) the right to be free of physical abuse when Resident #7 struck Resident #8 on the left hand with a metal bar that resulted in redness, swelling and a skin | F 600 | The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s | 9/23/24 |

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

Electronically Signed | 09/10/2024

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| F 600 | Continued From page 1<br>tear to Resident #8's left hand and wrist.<br><br>Findings included:<br><br>Resident #7 was admitted to the facility 1/10/23 with diagnoses that included anxiety, depression, hallucinations, and schizoaffective disorder.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 7/17/24 indicated Resident #7 had no cognitive impairment. Resident #7 exhibited verbal behavior symptoms and rejected care 1 to 3 days of the MDS assessment review period. Resident #7 was independent for transfers and wheelchair mobility.<br><br>Review of care plans for Resident #7 included he was verbally aggressive toward other residents The care plan for Resident #7 initiated 7/18/24 included Resident #7 was verbally aggressive toward other residents and staff by yelling and cursing. Interventions included to administer behavioral medications as ordered, provide 1 resident to 1 staff (1:1) supervision for aggressive behavior toward others, refer for psychiatric services as indicated, administer medications as ordered, and redirect him from causes of aggressive behaviors. The goal was that Resident #7 would exhibit 50 % less aggressive behaviors toward other residents through the next review period.<br><br>Resident #8 was admitted to the facility on 11/1/23 with diagnoses that included traumatic brain injury, vascular dementia, anxiety ,behavioral disturbance, mood disturbance and psychotic disease.<br><br>Resident #8's quarterly Minimum Data Set (MDS) | F 600 | allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F600 Free from Abuse<br>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>On 7/17/24 Resident #7 was observed striking resident #8 on the left hand with a metal bar resulting in redness, swelling and a skin tear. X-rays were obtained with negative results. Residents were immediately separated and resident # 7 was placed on 1:1 supervision. The Facility□s administrator was made aware of the abuse immediately. The nurse manager reporting to the administrator was instructed to notify the Law enforcement and submit an initial report to the Department of Health and Human Services. Law enforcement and the County Health department were notified on 7/17/24. An investigation was initiated, and statements were obtained from staff. Resident #7 was moved to another hall. The Director of nursing completed and submitted a 5-day investigation report to the Department of Health and Human services on 7/22/24 with fax confirmation.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents have the potential to be affected by the deficient practice. The Social services Director conducted interviews with residents with BIMs of 13 | |

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| F 600 | Continued From page 2<br>assessment dated 5/8/24 revealed he had moderate cognitive impairment and exhibited physical and verbal abuse toward other residents and staff. He was independent for wheelchair mobility and transfers.<br><br>A care plan updated 7/17/24 revealed Resident #8 became physically abusive towards others by hitting, punching and kicking them. The goal was to keep Resident #8 from distressing or harming other residents through the next review period. Interventions included providing 1 staff to supervise Resident #8 at all times as directed by the physician, administer medications as ordered, mental health consults as indicated, monitor Resident #8's environment for sharp objects that could cause injury to others.<br><br>Review if the Initial Allegation Facility Report (FRI) revealed the Administrator became aware resident - to - resident abuse on 7/17/24 at 6:10 PM. The initial FRI report indicated that Resident #7 became upset when Resident #8 entered his room, and a verbal argument transpired. Resident #7 removed a small black pipe from the arm of a wheelchair and struck Resident #8 on the back of his left hand and wrist 3 times causing redness, swelling and a skin tear. Resident #8 was removed from Resident #7's room and placed on 1:1supervision. The facility filed a report with local law enforcement and the County Department of Social Services on 7/17/24 at 6:10 PM. The facility submitted an investigation report to North Carolina Department of Health and Human Services on 7/22/24 that included an interview of Resident #8 by the facility Social Worker (SW). Resident #8 revealed he entered the doorway of Resident #7's room because as he was passing the doorway, Resident #7 began | F 600 | or higher regarding care and services. Licensed nurses completed 100% body audits on all residents with a BIMs below 13 to identify any areas of injuries of unknown origin. There was no other abuse identified as the results of the interviews. Interviews and body audits were completed by 9/22/2024.<br><br>3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur:<br>The Facility□s administrator was re-educated by the Regional Director of Clinical Services on the facility□s policy on abuse and preventing abuse. Education was completed by 9/9/24.<br>100% of facility Staff and agency staff were re-educated on the facility□s abuse policy and preventing abuse by the Director of Nursing and/or the assistant Administrator. Education completed on 9/22/24. Staff will not be permitted to work until education is completed. Education will be included in new hires orientation.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>The Social Service Director will conduct interviews with residents with a BIMS of 13 and higher regarding feeling safe in the facility, who to report to if mistreated, and any care concerns? Monitoring will be conducted 5xper week for 4 weeks, 3xper week for 4 weeks: then 2xper week for 4 weeks.<br>The licensed nurses will complete body | |

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| F 600 | Continued From page 3<br>cursing at him and he did not know why he was being cursed at or why Resident #7 hit his hand with the black pole. Resident #7 was interviewed by the SW, and he stated he was in his room eating dinner and Resident #8 passed by his door and threw an adult diaper onto the floor of his room then Resident #7 asked Resident #8 not to enter his room but he came in and Resident #7 hit Resident #8 on the hand with a black pole from the arm of his wheel chair. The investigation report further revealed statements obtained from nursing staff.<br><br>On 8/28/24 at 11:23 AM an interview and observation of Resident #8 was conducted. Resident #8 was seated on the edge of his bed. He did not respond to many questions, however when asked about the altercation that was reported between him and Resident #7 the evening of 7/17/24 he stated he did not care because it really did not bother him, and he had not seen Resident #7 since then.<br><br>An interview conducted with Resident #7 at 1:36 PM on 8/28/24 revealed he thought Resident #8 was going to hit him when they were in the hallway and when Resident #7 went to his room, Resident #8 followed him so Resident #7 pulled a small black pole from the arm of another wheelchair and struck Resident #8 about 2-3 times on the hands because he feared for his life. Resident #7 reported he was happy that his room was changed to another hallway, and he had not had any more interactions with Resident #8.<br><br>The SW was interviewed on 8/28/24 at 2:03 PM and reported that Resident #7 received a mental health evaluation at the hospital on 7/18/24 he returned to the facility 7/19/24 with no changes to | F 600 | audits with residents with a BIMS below a 13 to identify bruises or injuries of unknown origin. Monitoring will be completed 5xper week for 4 weeks; 3xper week for 4 weeks; then 2xper week for 4 weeks.<br>Any areas of abuse identified will be reported immediately to the Administrator and the Director of Nursing.<br>The administrator will report the results of the audits to the monthly Quality Assurance and Performance Improvement Committee monthly for suggestion and/or recommendations x3 months or until substantial compliance is achieved and maintained.<br><br>5. Compliance date: September 23, 2024 | |

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| F 600 | Continued From page 4 | F 600 | | |

his plan of care and he was moved to a room on a different hall with no further altercations with Resident #8.

A written statement from Nursing Assistant (NA) #1 dated 7/17/24, revealed she heard yelling from Resident #7's room and observed Resident #8 with his fist raised in the doorway of Resident #7's room when she got to the room, she observed Resident #7 strike the left hand of Resident #8 with some sort of black pole. NA #1 pulled Resident #8 from the room then closed the door to Resident #7's room. She made sure Resident #8 was safe and had another staff stay with him while she reported the incident to the nurse.

An attempt to contact NA #1 by phone and text on 8/28/24 at 1:45 PM and 3:00 PM were unsuccessful.

A written statement on 7/17/24 by Personal Care Aid (PCA) #1 revealed she was passing meal trays on the evening shift and heard Resident #7 yelling at someone to get out of his room. PCA #1 then turned and observed NA #1 pulling Resident #8 from the room of Resident #7 and she stepped in the room to make sure Resident #7 did not move to approach Resident #8 and when Resident #8 was in the hall I closed to door to Resident #7's room.

On 8/29/24 at 12:00 PM an interview conducted with PCA #1 revealed she worked the evening of 7/17/24 and was making rounds and was picking up dinner trays. Resident #8 and the 1:1 staff assigned to him were near Resident #7's door and Resident #8 threw an adult brief at Resident #7. Resident #7 began to curse at Resident #8 and both NA #1 and I went to the room to

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| F 600 | Continued From page 5 | F 600 | | |

separate them, and I closed the door of Resident #7's room. Resident #8 told us his left hand hurt when he was hit by the other resident. I stayed with him while NA #1 went to report what happened to the nurse.

PCA #2's written statement on 7/17/24 revealed she was in the hall with Resident #8 because she had been assigned to provide him with 1:1 supervision that evening. She reported that Resident #8 turned his chair around quickly toward Resident #7's room because Resident #7 was yelling at him about an adult brief or something like that. PCA #2 explained that she followed Resident #8 into the doorway of Resident #7's room and saw Resident #7 with some black pole in his hand that he used to hit Resident #8's hands. NA #1 came and pulled Resident #8 out of the room and shut the door to Resident #7's room.

An interview with PCA #2 on 8/29/24 at 3:36 PM revealed that sometime in July she was assigned to supervise Resident #8 for the evening shift. She explained that the interaction between Resident #7 and Resident #8 happened so fast and Resident #8 was strong, and she was not able to pull him in his wheelchair out of Resident #7's room, but she tried to verbally get him to leave. NA #1 came and was able to pull Resident #8 out of the room.

On 8/29/24 at 4:45 PM Nurse #2 was interviewed and revealed she did not observe the altercation between Resident #8 and Resident #7 on the evening of 7/17/24. Nurse #2 reported that NA #1 reported to her what happened then she (Nurse#2) went to assess both residents. Resident #8 was in his wheelchair in his room

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| F 600 | Continued From page 6 | F 600 | | |

with PCA #2 . Nurse #2 observed some redness and slight swelling of Resident #8's left thumb but he denied pain or discomfort. Nurse #2 revealed she notified the on-call Nurse Practitioner (NP), the Director of Nursing (DON), Administrator, Social Worker (SW) and family members of both residents. She ordered an x-ray of Resident #8's left hand and wrist per the NP Nurse #2 revealed she was not certain who called the police because they did come to the facility at some point and spoke to both residents and possibly the SW or DON.

A nurse note dated 7/17/24 at 10:22 PM included the on-call Nurse Practitioner (NP) was notified of the incident between Resident #8 and Resident #7 and Resident #8 had a small skin tear, redness and swelling to his left hand and wrist. The NP ordered to obtain an x-ray of the left hand to rule out a fracture or other injury.

Review of an x ray report dated 7/18/24 at 4:11 PM the x ray report revealed Resident #8 had no fracture or dislocation of the left hand or fingers.

On 8/29/24 at 1:13 PM the facility physician was interviewed . He stated that mental health diagnoses and dementia have effects on residents that can cause them at times to be very defensive physically and verbally to themselves or others. The physician believed the facility moved Resident #7 to another hall to separate him from Resident #8 to minimize contact or interactions between them. He reported that was a very good proactive decision by the facility because there had been no other conflicts between those 2 residents. The physician reported that on 7/18/24 after he was more informed of the episode, he had Resident #7 sent to the hospital for a mental

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| F 600 | Continued From page 7<br>health evaluation and a medication review. Resident #7 returned to the facility with no medication changes and had been deemed appropriate to return as he was no danger to harm himself or others.<br><br>The Director of Nursing (DON) was interviewed on 8/29/24 at 4:53 PM. She revealed in part the incident between Resident #8 and Resident #7 on 7/17/24 was well managed by nursing staff and followed facility abuse policy. She also reported that as a precaution Resident #8 had a negative x-ray of his left hand and wrist and Resident #7 was sent to the hospital on 7/18/24 for a mental health examination and when he returned, he was placed in a different room on a different hall and there had been no further interaction between Resident #8 and Resident #7. | F 600 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) 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 | F 609 | | 9/23/24 |

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| F 609 | Continued From page 8<br>for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review, the facility failed to submit an initial report within 2 hours to the state regulatory agency for an allegation of resident- to- resident abuse for 1 of 4 residents reviewed for abuse (Resident #8).<br><br>The findings included:<br><br>Review if the Initial Allegation Facility Report (FRI) revealed the Administrator became aware resident - to - resident abuse on 7/17/24 at 6:10 PM. The initial FRI report indicated that Resident #7 became upset when Resident #8 entered his room, and a verbal argument transpired. Resident #7 removed a small black pipe from the arm of a wheelchair and struck Resident #8 on the back of his left hand and wrist 3 times causing redness, swelling and a skin tear. Resident #8 had a negative x ray for injury. The initial report was faxed to the state regulatory agency on 7/22/24 at 11:36 AM. The initial report allegation was related to resident abuse.<br><br>An interview conducted with the Administrator on 8/29/24 at 5:30 PM revealed he was made aware of the allegation of abuse on 7/17/24 at 7:15 PM | F 609 | F609 Reporting Alleged Violations<br>1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Regarding residents #7 and #8 allegation of abuse the facility□s Administrator was made aware of the incident at 6:10pm on 7/17/24. The residents were separated immediately. Law enforcement and the County Health Department were notified on 7/17/24. Resident #8 was immediately placed on 1:1 supervision. An investigation was initiated. The 5-day completed investigation report, and a copy of the initial report was submitted to the Department of Health and Human Services on 7/22/24 by the Director of Nursing with fax confirmation.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>Current residents have the potential to be affected by the deficient practice.<br>The Regional Director of Clinical Services | |

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| F 609 | Continued From page 9<br>and as he was out of town for a conference, he explained to the staff member he spoke to that all the required entities needed to be reported to within 2 hours for an allegation of abuse including the state regulatory agency. He revealed he did not confirm that the staff member reported the allegation or not to the state regulatory agency and could only prove the initial report and investigation were sent together as recorded on the fax confirmation form dated 7/22/24 at 11:36 AM.<br><br>The Director of Nursing (DON) present during the interview with the Administrator on 8/29/24 at 5:30 PM revealed that she also believed the staff member had faxed the initial report to the state regulatory agency as required and after the full investigation was completed, she attached the initial report to the investigation report and faxed them together to the state regulatory agency on 7/22/24. The DON presented the fax confirmation form for the state regulatory agency dated 7/22/24 at 11:36 AM. | F 609 | completed an audit on all Facility Reportable Incidents within the last 30 days for timely reporting. No concerns were identified. Audit was completed on 9/9/24.<br><br>3. Address what measures will be put in place or systemic changes made to ensure the deficient practice will not recur:<br>The Facility□s Administrator was re-educated on the facility□s abuse policy and timely reporting by the Regional Director of Clinical Services. Education was completed on 9/9/24.<br>100% of the facility□s staff/ including agency staff was re-educated on the facility□s policy on abuse and reporting by Director of Nursing and/or the Assistant Administrator. Education was completed on 9/22/24. Staff will not be permitted to work until education is complete.<br>Education will be included in new hires orientation.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>The Vice President of Operations and or the Regional Director will review/monitor all Facility Reportable incidents weekly x 12 weeks to verify timely reporting. The Administrator will report the results of audits monthly to the Quality Assurance Improvement Committee monthly for suggestions and/or recommendations x3 months or until substantial compliance is achieved and maintained. | |

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| F 609 | Continued From page 10 | F 609 | 5. Compliance Date: September 23, 2024 | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and Nurse Practitioner and staff interviews, the facility failed to provide care in a safe manner when a resident fell out of bed during incontinence care for 1 of 3 residents reviewed for accidents (Resident #9). Nursing Assistant (NA) #2 rolled Resident #9 away from her during incontinence care, and Resident #9 fell out of bed. Resident #9 sustained a fractured left femur (long bone of the upper leg) and required surgical repair on 8/28/24.<br><br>The findings included:<br><br>Resident #9 was admitted to the facility 9/29/2017 with diagnoses including diabetes and lung disease. The most recent quarterly Minimum Data Set assessment dated 4/20/24 assessed Resident #9 to be severely cognitively impaired and she required extensive assistance of 1 person for bed mobility and toileting. | F 689 | F689 Free from Accidents Hazards/ Supervision/ Devices<br>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>NA#2 is an agency employee and no longer works in the facility as of 8/26/24. Resident #9 returned to the facility on 9/3/24 after surgical repair of a fracture of the left femur. She is currently receiving Physical Therapy and Occupational Therapy 5 times per week. For pain management she receives Oxycodone 5mg PRN every 4 hours by mouth for pain and Tylenol 325mg 2 tabs by mouth every 4 hours for pain.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents have the potential to be | 9/23/24 |

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| UNIVERSAL HEALTH CARE/ CONCORD | 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 |

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| F 689 | Continued From page 11<br>An incident report written by Nurse #3 dated 8/26/24 documented a witnessed fall of Resident #9 from her bed to the floor during the provision of incontinence care. The report documented the nurse entered Resident #9's room and noted Resident #9 was on the right side of her bed between the bed and the window and was lying on her left side holding her head up. NA #2 was in the room with Resident #9 and reported she was providing bedtime incontinence care and Resident #9 rolled out of bed. The incident report noted that no injuries were noted, Resident #9 denied hitting her head, and Resident #9 reported her leg hurt and she wanted pain medication. The incident report documented the facility physician was notified of the fall on 8/26/24 at 9:00 PM and the resident responsible party was notified at 9:15 PM.<br><br>A phone interview was conducted with NA #2 on 8/28/24 at 4:28 PM. NA #2 confirmed she was assigned to Resident #9 on 8/26/24 and she provided bedtime incontinence care when Resident #9 rolled out of bed and fell to the floor. NA #2 explained she had Resident #9 turned on her right side, facing away from her as she provided incontinence care, and Resident #9 exclaimed, "Oh, I'm falling!" and Resident #9 grabbed the side table and rolled off the bed. NA #2 reported prior to providing care to Resident #9 she had not reviewed the Kardex to check if Resident #9 required 1- or 2-person assistance with bed mobility. NA #2 explained Resident #9 was given pain medication after she was assisted back to bed with the mechanical lift, and she did not require any additional care before NA #2 left for the night at 10:30 PM.<br><br>A nursing note written by Nurse #3 on 8/26/24 at | F 689 | affected by the deficient practice.<br>Nurse management completed a 100% audit on all current residents to identify residents requiring two person assist while performing activities of daily living. All 32 residents identified the care plans and Kardex were updated to reflex the number of staff assistance during activities of daily living care. Audit was completed on 8/28/24.<br><br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>As of 8/27/24 the Director of Nursing contacted agency providers that they must inform all staff scheduled to work at Cabarrus that before they start care they must review the resident□s care plan/Kardex for the number of assistances needed to perform activities of daily living prior starting their shift.<br>Nurse management will ensure that all agency staff are educated on the Kardex.<br>The Director of Nursing educated 100% of current staff and agency staff to review the resident□s care plan/Kardex before providing care and provide the amount of assistance needed to provide activities of daily living. Education was completed by 9/2/24. All staff including agency staff will not be permitted to work until education is completed. Education is included in new hire orientation.<br>Nurse management will review falls daily 5xper week during clinical meeting to verify if a fall occurred while activities of daily living were being provided and if staff | |

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| F 689 | Continued From page 12<br>8:30 PM documented the incident and noted Resident #9 was returned to bed by a mechanical lift and 3-person assistance. The note documented Resident #9 was neurologically intact, and no bruising, lacerations, or injuries were visible.<br><br>An order dated 8/27/24 written by Nurse #3 ordered an x-ray of the left leg related to pain.<br><br>A phone interview was conducted with Nurse #3 on 8/29/24 at 1:39 PM. Nurse #3 reported she was the nurse supervisor, and she was working on 8/26/24 when Resident #9 fell out of bed. Nurse #3 explained she had been called to Resident #9's room and found her on the floor, between her bed and the window, lying on her left side. Resident #9 denied hitting her head and did not have any obvious injury, so Resident #9 was put back into bed with a mechanical lift and 3-person assistance. Nurse #3 described Resident #9 as at her baseline neurologically. Nurse #3 reported that Resident #9 had no obvious injuries: no lacerations, no bruising, no deformity of the left leg indicating a fracture, and Resident #9 reported pain between her left lower leg and ankle. Nurse #3 reported she received an order to have an x-ray completed for Resident #9, and when she called the x-ray company, they told her it would be either later 8/26/24 or early 8/27/24 before they arrived. Nurse #3 clarified the order was not STAT (immediate) because there was no obvious indication Resident #9 had a fracture, and the pain medication was effective.<br><br>A nursing note dated 8/26/24 at 8:52 PM written by Nurse #4 documented Resident #9 received pain medication, hydrocodone/acetaminophen 5 milligrams (mg)/325 mg. | F 689 | followed the care plan/Kardex?<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Nurse management will observe staff, (including agency staff) while they are providing activities of daily living to verify that they are following the resident□s care plan/Kardex related to the amount of assistance required. Monitoring will occur 5xper week for 4 weeks; 3xper week for 4 weeks; then 2xper week for 4 weeks. The Director of Nursing will report the results of the audits to the monthly Quality Assurance Performance Improvement committee for suggestions and/or recommendations x3months or until substantial compliance is achieved and maintained.<br><br>5. Compliance Date: Completion Date 9/23/24 | |

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| F 689 | Continued From page 13 | F 689 | | |

A nursing note dated 8/27/24 at 12:04 AM written by Nurse #4 documented the pain medication was effective for Resident #9.

A nursing note dated 8/27/24 at 5:47 AM written by Nurse #4 documented that NA #3 was unable to provide incontinence care to Resident #9 because Resident #9 was screaming out in pain. The note documented Resident #9 reported her leg hurt and it felt like her leg was broken. Nurse #4 documented she called the on-call provider and reported the increase in pain and received an order to transfer Resident #9 to the hospital for evaluation. The note documented the resident responsible party was notified of the transfer to the hospital.

Nurse #4 was interviewed by phone on 8/29/24 at 9:51 AM. Nurse #4 reported she was working 7:00 PM to 7:00 AM on 8/26/2024 and she was notified by the nursing supervisor (Nurse #3) that Resident #9 had fallen. Nurse #4 reported that when she arrived at the resident's room, Nurse #3 was assessing Resident #9. Nurse #4 described Resident #9 was on the floor on her left side and was not yelling or screaming at that time, but reported her leg hurt and requested pain medication. Nurse #4 reported she provided Resident #9 with her pain medication and when she checked on her later, Resident #9 was asleep. Nurse #4 reported Resident #9 slept all night, but when she was awakened at 5:00 AM by NA #3 for incontinence care, she started to yell and scream in pain. Nurse #4 reported Nurse #5 helped prepare Resident #9 for transfer to the hospital.

Nurse #5 was interviewed by phone on 8/29/24 at

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| F 689 | Continued From page 14 | F 689 | | |

2:27 PM and she confirmed she was working 7:00 PM to 7:00 AM on 8/26/2024, but she was not assigned to Resident #9. Nurse #5 reported Resident #9 did not yell out in pain all night, until about 5:00 AM when NA #3 went in to provide incontinence care and then she reported leg pain and then had transferred her to the hospital for evaluation.

NA #3 was interviewed by phone on 8/29/24 at 9:44 AM. NA #3 reported she was assigned to Resident #9 on 11:00 PM to 7:00 AM on 8/26-27/2024 and Resident #9 had slept all night. NA #3 described waking Resident #9 for incontinence care around 5:00 AM and when she attempted to remove the covers, Resident #9 started screaming and crying. NA #3 explained she got Nurse #5 and Nurse #4 to come to Resident #9's room and she was transferred to the hospital.

The emergency department notes dated 8/27/24 were reviewed. Resident #9 presented to the hospital reporting left knee and thigh pain. The physician assessment documented Resident #9 had full range of motion of her lower extremities and no warmth, deformities or swelling was noted. An x-ray of the left leg revealed an acute intertrochanteric femur fracture with varus angulation (fracture of the upper part of the long bone of the thigh where there was a tilt of the bone inward). An orthopedic surgical consultation was conducted, and Resident #9 was found to have an externally rotated deformity of the left leg (leg was turned outward due to the fracture) and was scheduled to have a surgical fixation of the fracture on 8/28/24.

The Director of Nursing (DON) was interviewed

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| F 689 | Continued From page 15<br>on 8/29/24 at 4:51 PM. The DON explained she was notified of the fall and education of NA #2 was given by Nurse #3 on correct turning of a resident during care in bed. The DON reported on 8/27/24 a Quality Assurance Performance Improvement (QAPI) meeting was held to discuss the incident, as well as 100% audit of all resident's care needs and their Kardex's. The DON reported she and the Unit Manager identified 32 residents that required 2-person assistance with Activities of Daily Living (ADL) and the care plans and Kardex's were updated. The DON explained education was initiated for all nursing staff regarding reviewing the Kardex for care needs, as well as safe bed mobility and transfer techniques. The DON concluded by reporting that she and the Unit Manager were observing ADL care with residents that needed 1- or 2-person assistance.<br><br>The Administrator was interviewed on 8/29/24 at 5:25 PM and he reported he expected the nursing staff used the Kardex to determine the level of assistance a resident requires, and that the care plan and Kardex were current with resident needs. | F 689 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. | F 755 | | 9/23/24 |

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| F 755 | Continued From page 16<br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and Pharmacist, Nurse Practitioner, and staff interviews, the facility failed to provide routine medications ordered by the physician for 1 of 3 residents reviewed for medication pharmaceutical services (Resident #3).<br><br>The findings included:<br><br>Resident #3 was admitted to the facility 7/9/24 with diagnoses including major depression with psychotic symptoms.<br><br>Orders for Resident #3 were reviewed, and an order dated 7/9/24 ordered quetiapine fumarate | F 755 | F755 Pharmacy service/Procedures/Record<br>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident #3 was discharged from the facility on 8/14/24. Nurse #1 is an agency nurse and no longer works at the facility as of 8/29/24.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents have the potential to be | |

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| F 755 | Continued From page 17<br>(an antipsychotic medication) 50 milligrams (mg) to be administered in the morning for bipolar disorder, and quetiapine fumarate 200 mg to be administered at bedtime.<br><br>The Admission Minimum Data Set assessment dated 7/16/24 documented Resident #3 was severely cognitively impaired with verbal and physical behaviors for 1-3 days with rejection of care and wandering noted.<br><br>Review of the medication administration record revealed the morning doses of quetiapine fumarate were not administered on 8/12/24 and 8/13/24 by Nurse #1, and the bedtime time was not administered on 8/13/24 by Nurse #1.<br><br>A nursing note dated 8/13/24 at 10:22 PM written by Nurse #1 for the 8/13/24 bedtime dose of quetiapine fumarate was not administered and read: "per pharmacy, medication discontinued upon re-admission (to the facility). Need to be reentered into (order system) for delivery. Resident aware."<br><br>An observation of the automated medication dispenser was conducted on 8/29/24 at 3:38 PM with Medication Aide (MA) #1 and Nurse #2. The nurses explained the process of obtaining medications that were not on the medication cart, including calling the pharmacy to reorder, requesting the medication be sent to the facility STAT (immediately), accessing the automated medication dispenser, and requesting the medication from a local pharmacy. Nurse #2 and MA #1 explained all nurses had access to the automated medication dispenser. Quetiapine fumarate was available in 100 mg tablets in the automated medication dispenser. | F 755 | affected by deficient practice.<br>Nurse management completed a 100% audit of resident□s medication administration records of current residents to verify if any missed doses of medication administration, there were no other med errors found. Any areas of concern identified the Physician, and the Responsible party were notified. Audit was completed by 9/22/24.<br><br>3. Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur:<br>All licensed nurses are provided with an access code to the automated medication backup system before the start of a shift including agency nurses by nurse management. Director of nursing educated 100% of licensed nurses including agency nurses to obtain access to the automated medication backup system before the start of their shift, check the backup system to see if medication that is not available on the medication cart is available in the backup system, if medication is not available notify pharmacy, notify the physician to obtain an alternative or an hold order until medication arrives from pharmacy. Also notify the resident and/or the responsible party. Education was completed by 9/22/24. Staff will not be permitted to work until education is complete. Education will be included in the new hire orientation.<br>Nurse management will review medication administration records daily 5 days a week during clinical meetings to verify | |

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| F 755 | Continued From page 18<br><br>Nurse #1 was interviewed on 8/28/24 at 3:20 PM. Nurse #1 confirmed she had been assigned to Resident #3 on 8/12/24 and 8/13/24 and the quetiapine fumarate was not in the medication cart on 8/12 or 8/13/24 when she attempted to administer the medication to Resident #3. Nurse #1 explained that she did not have a code to the automated medication dispenser, and none of the nurses working on 8/12 or 8/13/24 had access to the automatic medication dispenser. Nurse #1 reported she was an agency nurse and had not received a code for the automated medication dispenser. When asked if she had contacted the pharmacy to get the medication for Resident #3, Nurse #1 reported she had called the pharmacy and was told by a technician that the quetiapine fumarate had been discontinued on their end and she needed to reenter the order for the medication, and it would be delivered to the facility. Nurse #1 did not recall she called the physician to notify him the medication was not available.<br><br>The Nurse Practitioner (NP) was interviewed on 8/28/24 at 12:55 PM and she reported that missing 3 doses of the quetiapine fumarate would not have caused an increase in behaviors for Resident #3. The NP reported she had reviewed the orders for Resident #3 and the order for quetiapine fumarate was active in the system and should have been in the medication cart. The NP further explained the medication was available in the automated medication dispenser and if it had not been, the nurse could have requested a STAT delivery from the pharmacy or used a local pharmacy to obtain the medication.<br><br>A phone interview was conducted with a | F 755 | medications are being administered as ordered.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>Nurse management will observe medication administration to verify that licensed nurses have access to the automated medication dispenser backup system and that all medications are administered as ordered. The physician is notified when a medication is not available. Monitoring will be completed 5xper week for 4 weeks; 3xper week for 4 weeks; then 2xper week for 4 weeks. The Director of nursing will report the results of the audit to the monthly Quality Assurance Performance improvement Committee for suggestions and/or recommendations until substantial compliance is achieved and maintained.<br><br>5. Compliance Date: Completion date 9/23/24 | |

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| F 755 | Continued From page 19<br>Pharmacist on 8/28/24 at 3:20 PM. The Pharmacist explained there was no record of Nurse #1 calling to report the quetiapine fumarate was not in the medication cart and reported had the pharmacy been contacted by Nurse #1, they could have given her access to the automated medication dispenser. The Pharmacist reported the facility had 100 mg tablets of quetiapine fumarate available in the automated medication dispenser.<br><br>The Unit Manager (UM) and Director of Nursing (DON) were interviewed on 8/28/24 at 4:45 PM. The UM explained that all nurses have access to the automated medication dispenser, and they were given a code as soon as they are assigned to a cart. The UM reported if Nurse #1 did not have access to the automated medication dispenser, she could have called the UM to get the code. The DON reported Nurse #1 received education during her orientation for using the automated medication dispenser, as well as obtaining medications that where not in stock and she did not know why Nurse #1 had not followed those steps to get the quetiapine fumarate for Resident #3's morning doses on 8/12 and 8/13/24, and the evening dose 8/13/24.<br><br>An interview was conducted with the Administrator on 8/28/24 at 5:25 PM. The Administrator reported he expected the nursing staff to understand how to get medications from the pharmacy and the automated medication dispenser. | F 755 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its- | F 760 | | 9/23/24 |

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| F 760 | Continued From page 20<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and Nurse Pracitioner and staff interviews, the facility failed to administer 3 of 4 doses over 2 days of quetiapine fumarate (an antipsychotic medication) as ordered by the physician for 1 of 3 residents reviewed for pharmaceutical services (Resident #3).<br><br>The findings included:<br><br>According to manufacturer's instructions: "Do not stop taking quetiapine fumarate suddenly, your condition may get worse, or you could have symptoms such as trouble sleeping, nausea, and vomiting. Ask your doctor before stopping the medication."<br><br>Resident #3 was admitted to the facility 7/9/24 with diagnoses including major depression with psychotic symptoms.<br><br>Orders for Resident #3 were reviewed, and an order dated 7/9/24 ordered quetiapine fumarate 50 milligrams (mg) to be administered in the morning for bipolar disorder, and quetiapine fumarate 200 mg to be administered at bedtime.<br><br>The Admission Minimum Data Set assessment dated 7/16/24 documented Resident #3 was severely cognitively impaired with verbal and physical behaviors for 1-3 days with rejection of care and wandering noted.<br><br>Review of the medication administration record revealed the morning doses of quetiapine | F 760 | F760 Residents are free of significant med Errors<br>1. Address how the corrective actions will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident #3 was discharged from the facility on 8/14/24. Nurse #1 is an agency nurse and no longer works in the facility as of 8/29/24.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All the residents have the potential to be affected by the deficient practice. Nurse management completed a 100% audit of resident□s medications administration records of current residents to verify that medications are being administered as ordered. No other concerns were noted during the 100% audit. Audit was completed by 9/22/24.<br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>All nurses and medication aides are provided with an access code to the automated medication backup system before the start of their shift by nurse management. The Director of nursing educated 100% of licensed nurses including agency nurses to obtain access to the automated medication backup | |

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| UNIVERSAL HEALTH CARE/ CONCORD | 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 |

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| F 760 | Continued From page 21<br>fumarate were not administered on 8/12/24 and 8/13/24 by Nurse #1, and the bedtime time was not administered on 8/13/24 by Nurse #1.<br><br>A nursing note dated 8/13/24 at 10:22 PM written by Nurse #1 for the 8/13/24 bedtime dose of quetiapine fumarate was not administered and read: "per pharmacy, medication discontinued upon re-admission (to the facility). Need to be reentered into (order system) for delivery. Resident aware."<br><br>Nurse #1 was interviewed on 8/28/24 at 3:20 PM. Nurse #1 confirmed she had been assigned to Resident #3 on 8/12/24 and 8/13/24 and the quetiapine fumarate was not in the medication cart on 8/12 or 8/13/24 when she attempted to administer the medication to Resident #3. Nurse #1 explained that she did not have a code to the automated medication dispenser, and none of the nurses working on 8/12 or 8/13/24 had access to the automatic medication dispenser. Nurse #1 reported she was an agency nurse and had not received a code for the automated medication dispenser. When asked if she had contacted the pharmacy to get the medication for Resident #3, Nurse #1 reported she had called the pharmacy and was told by a technician that the quetiapine fumarate had been discontinued on their end and she needed to reenter the order for the medication, and it would be delivered to the facility. Nurse #1 did not recall she called the physician to notify him the medication was not available. Nurse #1 reported she had entered the order into the electronic medical record.<br><br>The Nurse Practitioner (NP) was interviewed on 8/28/24 at 12:55 PM and she reported that missing 3 doses of the quetiapine fumarate would | F 760 | system before the start of their shift, check the backup system to see if medication that is not available on the medication cart is available in the backup system, if the medication is not available, notify pharmacy, notify the physician to obtain an alternative or an hold order until medication arrives from pharmacy. Also notify the resident and/or responsible party. Education was complete by 9/22/24. All nurses, including agency nurses will not be permitted to work until education is completed. Education will be included in the new hire orientation. Nurse management will review medication administration records 5 days per week during clinical meetings for 12 weeks to verify that medications are being administered as ordered.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained.<br>Nurse management will observe medication administration to verify that licensed nurses have access to the automated medication dispenser backup system and that all medications are being administered as ordered. The physician is notified when a medication is not available. Monitoring will be completed 5xper week for 4 weeks; 3xper week for 4 weeks; then 2xper week for 4 weeks. The Director of nursing will report the results of the audit monthly to the Quality Assurance Performance Improvement committee for suggestions and/or recommendations x3 months or until substantial compliance is obtained and maintained. | |

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| F 760 | Continued From page 22<br>not have caused an increase in behaviors for Resident #3.<br><br>A phone interview was conducted with a Pharmacist on 8/28/24 at 3:20 PM. The Pharmacist explained there was no record of Nurse #1 calling to report the quetiapine fumarate was not in the medication cart and reported had the pharmacy been contacted by Nurse #1, they could have given her access to the automated medication dispenser. The Pharmacist reported the facility had 100 mg tablets of quetiapine fumarate available in the automated medication dispenser and Resident #3 should have received the medication.<br><br>The Unit Manager (UM) and Director of Nursing (DON) were interviewed on 8/28/24 at 4:45 PM. The UM explained that all nurses have access to the automated medication dispenser, and they were given a code as soon as they are assigned to a cart. The UM reported if Nurse #1 did not have access to the automated medication dispenser, she could have called the UM to get the code. The DON reported Nurse #1 received education during her orientation for using the automated medication dispenser, as well as obtaining medications that where not in stock and she did not know why Nurse #1 had not followed those steps to get the quetiapine fumarate for Resident #3's morning doses on 8/12 and 8/13/24, and the evening dose 8/13/24.<br><br>An interview was conducted with the Administrator on 8/28/24 at 5:25 PM. The Administrator reported he expected the nursing staff to understand how to get medications from the pharmacy and the automated medication dispenser. | F 760 | 5. Completion Date. Completion date 9/23/24 | |

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