STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345183	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/11/2013

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review and staff interviews, the facility failed to develop a care plan for resistance to care and combativeness for one of seven residents reviewed for behaviors (Resident #83). Findings included:

Resident # 83 was admitted to the facility 8/23/11. Cumulative diagnoses included: Depression, history of psychosis and Dementia.

A Quarterly Minimum Data Set (MDS) dated 10/29/12 indicated Resident # 83 had short and long term memory impairment and modified independence with decision-making. Mood indicators noted during the assessment period included: trouble concentrating and short tempered half or most days. Behaviors were documented as the following: physical behaviors towards others noted one to three days, verbal behaviors directed towards others noted four to six days and wandering noted four to six days. Medications included: antianxiety medication--three days and antidepressant-seven days.

Physician's orders were reviewed and included, in part, the following medications: Zoloft (antidepressant) 50 milligrams (mg.) daily for depression, Remeron(antidepressant and also used as an appetite stimulant) 15 mg. 1 ½ tablets by mouth at bedtime, Ativan (antianxiety) one (1) mg. by mouth every six (6) hours as needed for anxiety and Ativan two (2) mg./ milliliter (ml.) vial injection. 0.5 ml. intramuscularly (IM.) every six (6) hours as needed for agitation.

Medication Administration records were reviewed and revealed that Resident #83 received Ativan by mouth six (6) times in November 2012, seventeen (17) times by mouth in December 2012 and two times by mouth and one time IM in January 2013.

Behavior sheets were reviewed and revealed the following: November 2012-eight episodes of anxiousness and agitation without harm to self or others; December 2012-six episodes of anxiousness and agitation

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345183	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/11/2013

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	Continued From Page 1

without harm to self or others/ one episode of wandering; January 2013-nine episodes of anxiousness and three episodes of agitation without harm to self or others.

A nursing note dated 10/26/12 stated Resident #83 had increased agitation with combative behavior and received Ativan 1 mg. IM.

A nursing note dated 12/15/12 at 12:50 PM. revealed Resident #83 refused to allow staff to provide incontinent care and refused to allow staff to assist with clothing change.

A nursing note dated 1/4/13 at 1:30 PM. stated Resident #83 refused help and refused to sit in the wheelchair. She was combative with nursing staff and hit a nursing assistant. Ativan IM was administered.

A review of Resident #83's Care plan revealed no plan of care for combative behavior and/or resistance to care.

On 1/10/13 at 9:53 AM., NA #1 stated that Resident #83 required staff assistance for all aspects of ADL (activities of daily living) care. She said that Resident #83 was resistive to care in that she would pull back from nursing staff or hit at the staff telling them she could do everything by herself. Nurse #3 stated she talked to Resident #83 when she was resistive to care and would explain what task she was going to perform. Most of the time that would not work and she would have to get another nursing staff member to come and help her complete ADL care. NA #1 stated they try to talk to her and distract her during care. She said Resident #83 was not combative or resistive to care every day-her mood and behavior fluctuated.

On 1/10/13 at 12;37 PM., Administrative staff #2 stated she completed the section of the MDS that dealt with mood and behaviors and she would be the one to initiate a care plan for mood and behaviors. She said Resident #83 had diagnoses of anxiousness and depression. Also, she wandered about the facility. Administrative staff #2 stated Resident #83 verbalized to her in May 2012 that she would be better off dead and that she wasn't going to harm herself but had those thoughts. Administrative staff #2 said she initiated a care plan for Resident #83 having thoughts of being better off dead during the 5/16/12 interdisciplinary care plan team meeting but had not written a care plan for resistance to care and combativeness.

On 1/10/13 at 4:00 PM. Administrative staff #1 stated she had reviewed Resident #83's care plan. The resident's behaviors of resisting care and combativeness should have been care planned because resident had episodes of combativeness and resistance to care that had required prn (as needed) use of Ativan by mouth and intramuscularly (IM) Ativan when Resident #83 refused to take the medication.

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 _____	01/11/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and document review the facility failed to honor a resident ' s non-verbal indication of care refusal for 1 of 1 residents (Resident #70). The findings included: Resident #70 was admitted on 9/25/12 with diagnoses including Alzheimer ' s dementia, history of schizophrenia, osteoarthrosis, anxiety, depressive disorder. Review of the contact information on the Face Sheet for Resident #70 dated 9/25/12 had a hand written note that read " call (name of second contact) when pt (patient) is combative to assist (with) care. " Review of the care plan dated 9/25/12 revealed the following approache for behavior symptoms " ask for help if res (resident) becomes abusive/resistive. " Review of the nursing notes dated 12/6/12 3-11 PM revealed Resident #70 had been paranoid	F 242	**"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."** F242 Criteria #1 Corrective action for the alleged deficient practice for resident #70 was accomplished as the resident was assessed when the incident occurred. The CNA was removed from the resident's assignment permanently.	2/25/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carol McClure	Administrator	2/15/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 242	Continued From page 1 and stated " they are trying to kill me " and refused care at 4 PM. At 7 PM Nurse #2 heard the resident yelling and when she entered the room the note indicated she saw Resident #70 slapping and scratching Nursing Assistant #1. The note also revealed NA #1 said Resident #70 attempted to throw her teeth and then threw a cup of spit at the NA. The note indicated Resident #70 was saying I will kill her if she comes in here again. The resident was given antianxiety medication and tested for a Urinary Tract Infection according to the note. Review of the Weekly skin Checks revealed: 12/6/12 - red scratches on forearms 12/7/12 - new large purplish bruises of unknown origin on bilateral arms and wrists Review of the facility investigation notes attached to the 5 day report dated 12/8/12 revealed a family member had complained about bruises on Resident #70 ' s arms. She also informed the Administrator that Resident #70 had told her " that girl with the yellow bow kissed her bottom. " The family member said she had never heard Resident #70 say anything like that or strike out at anyone before although she did get confused when she had a urinary tract infection. The investigation summary revealed that review of the medical record found episodes of agitation and combativeness with staff. Two alert and oriented residents were interviewed and denied abusive issues with staff. The allegation of abuse was unsubstantiated as it was determined there was no intent to abuse Resident #70. The Resident was diagnosed with a Urinary Tract Infection and had a history of paranoia and delusions.	F 242	Criteria #2 All residents have the potential to be affected by the alleged deficient practice, as all residents are able to have non-verbal indications of refusal of care. All facility staff, including CNAs, licensed nursing staff, therapy staff, and dietary staff (not including Environmental Services staff) will be inserviced by Admin, DON or ADON before February 25, 2013 using CMS Hand in Hand Toolkit, Module 3 (Being with a Person with Dementia: Listening and Speaking), and Module 4 (Being with a Person with Dementia: Actions and Reactions) to ensure staff are honoring residents non-verbal indications of refusal of care. DON will review audit information provided by CNAs by February 20, 2013 to determine that there were no other residents negatively affected by non-verbal indications of refusal of care.	

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F 242	Continued From page 2 Interview with NA #1 on 1/11/13 at 2:52 PM revealed that on 12/6/12 she was assigned to work with Resident #70 on second shift (3 PM - 7 AM). She stated Resident #70 refused care at around 3:45 which the NA reported to Nurse #2 and she also refused to eat stating that the food was poisoned. NA #2 said that at around 7 PM she went back in to attempt to give incontinent care. NA #1 indicated the resident was lying in bed abd did not respond when NA #1 told her what she was there for " to get you cleaned up and ready for bed. " She stated that Resident #70 cooperated at first to get the briefs off by helping to roll but that at one point she reached over Resident #70 to move her teeth off the bed so they would not fall and after putting them in the denture cup at the bedside table Resident #70 grabbed a spit cup she had and threw it at NA #1. The NA reported that she was trying to block Resident #70 from hitting her with her one arm while trying to do up the brief with the other. She stated she was later councelled that she should have left the resident immediately after ensuring Resident #70 ' s safety and asked for help or gone back later to try again. She acknowledged she should not have continued trying to give care at that point. Telephone interview with Nurse #2 on 1/11/13 at 3:34 revealed that she heard noise coming from Resident #70 ' s room when she was about to give medications. When she went in she saw Resident #70 flailing her arms at NA #1 and NA #1 was trying to block the blows from her body/face with her arm while trying to still give care. Nurse #2 stated she told NA #1 to leave the resident. Resident #70 was calmed by Nurse #2 and she saw that Resident #70 had red marks	F 242	Criteria #3 An all facility staff meeting, not including Environmental Services staff, was held on Dec 10, 14, 15,16. An inservice on dealing with combative residents was provided by Admin and DON . All facility staff, not including Environmental Services will be required to attend inservice for CMS Hand in Hand Toolkit, Module 3 (Being with a Person with Dementia: Listening and Speaking), and Module 4 (Being with a Person with Dementia: Actions and Reactions) annually. The inservice will also be required for new hires. CNAs will monitor residents for non-verbal indications of refusal of care each shift and document on monitoring tool (242B), which will be given to the charge nurse to review and will document in chart. The monitoring tools will be given to DON who will review information for 5 days, then weekly for 4 weeks, then monthly for 3 months. DON/SW will update care plans during weekly behavior management meeting for next 3 months. Criteria #4 DON will report data obtained during the audits will be analyzed for patterns/trends and reported by the DON to the QA & A Committee for a period of 3 months. The QA & A Committee will evaluate the effectiveness of the plan and will adjust the plan as needed based on trends identified to ensure continued compliance.	

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 _____	01/11/2013

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F 242	Continued From page 3 on her forearm at that time. Nurse #2 stated she did not think NA #1 was being abusive but that she could have handled the situation better and should have asked for help.	F 242		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review the facility failed to change tube feeding formula after the maximum hang time indicated by the manufacturer for 1 of 1 resident (Resident # 90). The findings included: Review of the facility policy and procedure titled ' Preparation for Medication Administration ' revised 11/1/11 revealed, in part, the following under the ' Enteral Tube Medication Administration ', " d. The manufacturer ' s written recommendation regarding suggested time period for hanging of the product are consulted when determining the schedule for enteral feeding administration. " Resident #90 was admitted on 2/23/10 with	F 322	F-322 Criteria #1 Corrective action for the alleged deficient practice accomplished for resident # 90 as first shift LPN changed the formula bottle. An order was received from the Registered Dietician on January 14, 2013 to change the feeding tube with each new bottle for tube feeding formula that is started. Criteria #2 All residents receiving continuous tube feeding have the potential to be affected by the alleged deficient practice. However no other residents were noted to be negatively affected. The Registered Dietician changed orders on January 29, 2013 to change feeding tube with each bottle of feeding formula that is started.	2/8/13

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F 322	Continued From page 4 diagnoses including hypertension and hemiparesis. The annual Minimum Data Set (MDS) assessment dated 11/7/12 revealed resident #90 had short and long term memory problems and was significantly impaired in decision making. The MDS also revealed Resident #90 had a gastrostomy tube (g-tube). An order dated 11/6/12 read Glucerna 1.5 at 35 cc (cubic centimeters) per hour) times 20 hours (on at 8 PM, off at 5 AM). On 1/8/13 at 1:23 PM Resident #90 was observed lying in bed awake with a g-tube feeding of Glucerna 1.5 infusing via a tube feeding pump at 35cc (cubic centimeters) per hour (cc/hr). The Resident did not respond to questions or appear to understand. The date, and time hung, hand written on the formula bottle was 1/7/13, 9 AM (the formula had been hanging for approximately 28 hours and 23 minutes). The manufacturer ' s instructions noted on the Glucerna 1.5 bottle read, in part, " hang product up to 48 hours after initial spike when clean technique and only one new feeding set are used. Otherwise hang no longer than 24 hours. " On 1/8/13 at 4:20 PM Resident #90 was observed lying in bed with a g-tube feeding of Glucerna 1.5 hanging but not infusing. The date, and time hung, hand written on the bottle was 1/8/13 at 4PM (the previous formula bottle had hung for 31 hours). On 1/8/13 at 4:25 PM Nurse #1 was interviewed. She stated that she was not sure how often tube feeding formula needed to be changed but that she thought it was done just before the bottle ran	F 322	Criteria #3 Licensed Nurses were inserviced on the new orders 1/30/13 and 1/31/13 by DON. Hall nurses will monitor when the tube feeding and tubing is hung and document on MAR to ensure the formula will not be hung longer than the manufacturer's recommendation. The changing of the tube and the bottle will be audited for date and time of change to ensure compliance with manufacturer's recommendation. The DON will review the monitoring tools each day for 5 days (January 29, – February 2), then weekly for 4 weeks, then monthly for 3 months. Criteria #4 Data obtained during the audits will be analyzed for patterns/trends and reported by the DON to the QA & A Committee for a period of 3 months. The QA & A Committee will evaluate the effectiveness of the plan and will adjust the plan as needed based on trends identified to ensure continued compliance.	

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F 322	Continued From page 5 out of formula. She stated she did not hang the new bottle of Glucerna 1.2 for Resident #90 that was hanging at that time and that the second shift (3 PM - 11 PM) nurse had done it. Nurse #1 added that she did not look at Resident #90 ' s tube feeding formula during her shift (7 AM - 3 PM). On 1/24/12 at 11:59 AM, telephone interview with the Administrator revealed that facility policy for changing the tube feeding tubes was to change them daily on 11 PM - 7 AM shift. She acknowledged that changing the feeding tube set daily, without changing the formula at the same time, meant that the tube feeding system was not hung with a single new feeding set and therefore, the 24 hour maximum hang time for the Glucerna 1.2 formula applied. She stated that she would check with the nursing staff to determine if they had been hanging a new feeding tube set each time they hung a new formula bottle but no new information was obtained.	F 322		

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	345183	A. BUILDING 01 - MAIN BUILDING 01 MAR 1 1 2013 B. WING _____	02/19/2013

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I - construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	**"Preparation and/or execution of this Plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."**	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include:: Medical Records door is not self closing. 42 CFR 483.70(a)	K 029	K029 On February 19, 2013 an automatic self closure door system was installed on Medical Records door. No other doors required an automatic self closure system. Maintenance Director will monitor automatic self closing door weekly for one month to ensure the door is working properly. Maintenance Director will report any findings to QA committee for one month at which time the QA committee will determine if further monitoring is needed.	2/19/13
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol McClure — TITLE: Administrator — (X6) DATE: 3/7/13

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K 038 SS=E	Continued From page 1 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: both Mini Cafe doors and staff lounge door require two motion of hand to open door. Also, bathroom door in Linen closet acroos from laundry room.	K 038	K038 On February 20, 2013, the door handles for both mini cafes, the staff lounge, and the linen closet was replaced with a single motion door handle. No other door handles needed to be replaced. Maintenance Director will monitor the replaced door handles weekly for one month to ensure the handles are working properly. Maintenance Director will report any findings to QA committee for one month at which time the QA committee will determine if further monitoring is needed.	2/20/13
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: at time of survey facility could not provide proper documentation that a 5 year obstruction investigation test has been preformed on	K 062	K062 A 5 year inspection was completed on February 27, 2013. No other inspections are required for the sprinkler system at this time. Maintenance Director will ensure all required inspections are completed timely for the sprinkler system. Maintenance Director will report any findings to QA committee for the next month at which time the QA committee will determine if further monitoring is needed.	2/27/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 2 sprinkler system. 42 CFR 483.70(a)	K 062		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: drop cords were being used in residents rooms 117 and 206 for TV' to be plugged into. 42 CFR 483.70(a)	K 147	K147 On February 19, 2013, the drop cord was removed from 206 and the double cord adapter was removed from 117. Maintenance Director audited all patient rooms on February 20, 2013 to ensure no other drop cords or plug adapters were being used. Maintenance Director will audit patient rooms weekly for one month to ensure drop cords and plug adapters are not being used. Maintenance Director will report any finding to QA committee for next month at which time the QA committee will determine if further auditing is needed.	2/19/13