PRINTED: 04/16/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	NG COM		(X3) DATE SURVEY COMPLETED
		345142	B. WING _			C 03/13/2024
	ROVIDER OR SUPPLIER  TY PLACE NURSING AI	ND REHABILITATION CENTER		STREET ADDRESS, CITY 9200 GLENWATER DR CHARLOTTE, NC 28	IVE	00/10/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BI ERENCED TO THE APPROPRIA DEFICIENCY)	DATE
E 000	Initial Comments		E	00		
F 000	investigation survey through 02/29/24. Ar conducted on 3/13/2 was changed to 3/13 compliance with the	certification and complaint was conducted on 02/26/24 n extended survey was 4. Therefore, the exit date 6/24. The facility was found in requirement CFR 483.73, dness. Event ID# 5DHV11.	F	00		
	survey was conducted 02/29/24. An extend 3/13/24. Therefore, 3/13/24. Event ID# 5 intakes were investig NC00194299, NC00 NC00198744, NC00 NC00200033, NC002 NC00206648, NC002 NC00209603, NC002 NC00211430, NC00211430, NC002	195171, NC00195816, 199456, NC00199915, 200171, NC00200564, 205487, NC00206564, 206793, NC00209280, 210218, NC00211199, 212318, NC00212339, and ne 65 complaint allegations				
		of Care was identified at:				
F 561 SS=D	of H. Self-Determination CFR(s): 483.10(f)(1)		F 5	61		4/15/24
	promote and facilitate through support of re not limited to the righ	right to and the facility must e resident self-determination esident choice, including but ats specified in paragraphs (f)				
AROPATORY I	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUE	DE	TIT	TI F	(X6) DATE

Electronically Signed 03/29/2024

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		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			C <b>3/13/2024</b>	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		3/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 561	activities, schedules waking times), health care services consist assessments, and plapplicable provisions §483.10(f)(2) The rechoices about aspect facility that are signiff §483.10(f)(3) The rewith members of the community activities facility.  §483.10(f)(8) The reparticipate in other a religious, and comminterfere with the right facility.  This REQUIREMEN by:  Based on observation and staff interviews, the resident's prefere residents reviewed for (ADL) (Resident #49).	sident has a right to choose (including sleeping and in care and providers of health tent with his or her interests, lan of care and other is of this part.  Isident has a right to make the soft his or her life in the ficant to the resident.  Isident has a right to interact community and participate in both inside and outside the inside and outside the inside the inside and outside and outside and outside the inside and outside and ou	F 5	F561 Self-Determination Resident #49 was provided a CNA on 3/01/2024. On 3/20/2024, the Social Wor conducted an interview with F to ensure bathing preferences resident. The Resident Care ( updated to reflect the resident	ker (SW) Resident #49 s for Guide will be		
	04/22/21 and readm diagnoses which inc	dmitted to the facility on itted on 06/13/22 with luded asthma, cerebral stroke, right side hemiplegia, es mellitus type II.		preference. On 3/04/2024 the SW initiated of all residents with a BIMS of greater to ensure bathing prefibeing honored. The interview completed by 3/22/2024. Res	f 13 or ferences are /s will be		

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		345142	B. WING			3/13/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
LIMIVEDOI	TV DI ACE NUDGING A	ND DELIABII ITATION CENTED		9200 GLENWATER DRIVE			
UNIVERSI	IT PLACE NURSING A	ND REHABILITATION CENTER		CHARLOTTE, NC 28262			
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F 561	Continued From pag	e 2	F 56	51			
	Review of Resident: Set (MDS) assessment also review of care behassessment, it was with to choose between a consponge bath.  An observation and on 02/27/24 at 9:25 wheelchair and dres resident's skin that will flakey. The resident her showers two times stated she preferred hot water felt good to further stated she has	#49's annual Minimum Data ent dated 02/01/24 revealed intact and required total vering and bathing. The realed Resident #49 had no aviors and according to the very important to the resident a tub bath, shower, bed bath interview with Resident #49 AM revealed her up in her sed for the day. The vas visible was dry and stated she was not getting es a week as scheduled and to take showers because the other body. Resident #49 and not refused any of her been offered showers two		BIMS of 12 and below resider representative will be contacted shower/bath preferences by 4 On 3/19/24, the Unit Manager audit of all resident shower log electronic medical records for previous week to ensure all showers/baths are being give scheduled and per resident proceeding by 3/29/2024, Director of Nurs (DON)/Assistant Director of Nurs (DON)/Unit Manager (UM) with the care plan and care guide. Will review shower logs dating week. The electronic health rereviewed to identify any misses showers/bed baths and to enspreferences are upheld. Any reshowers will be reoffered pror On 3/15/2024, Staff Developin Coordinator (SDC)/UM/ADON	ed for 1/15/2024. rs initiated an gs and the n as reference. sing lursing vill update The facility j back to one ecord will be ed sure resident missing mptly. nent I initiated an		
	meeting was held ar attendance and agai meeting that she wa times a week as sch Review of the showe which the resident re was scheduled for sl Friday on 2nd shift (3) Review of the docume lectronic medical re revealed for the mor received two shower	er schedule for the hall on esided revealed Resident #49 mowers on Tuesday and 3:00 PM to 11:00 PM).  The entation of showers in the ecord for Resident #49 with of February she had only is on 02/13/24 and 02/16/24. The was scheduled for		in-service with Nursing Staff, and Department on the activities of (ADL) for showers, including of residents the opportunity of ship bath. The nurse or CNA not an in-service by 3/29/2024 will reseducation before their next so shift.  Education will be provided to CNAs on the actions to be take resident refuses a shower. Or in-service was initiated by SD how the staff can find the bath preference in the Resident Cathe The nurse or CNA not attending in-service by 4/05/2024 will reseducation before their next so shift. The training will be provided.	of daily living offering all nower or bed ttending the eceive the cheduled nurses and sen if a n 3-21-24 C to include ning are Guide. In the eceive the eceive the eceive the cheduled		

Facility ID: 923015

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UNIVERS	ITY PLACE NURSING A	ND REHABILITATION CENTER		CHARLOTTE, NC 28262			
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F 561	Aide (NA) #4 who wa Resident #49 on 02/2 and 02/23/24 revealed provided the resident given her a partial bath. She stated the morning and someting bed early afternoon to shower so she just we further stated she had showers could be changed by the she had been told all showers on 2nd shift benefit from having the from 2nd shift to 1st.  A telephone interview who was assigned to 02/09/24 with voicent call with no response the country with the cou	partial bed bath partial bed bath partial bed bath on 1st D PM) partial bed bath on 1st shift partial bed bath on 1st shift  8/24 at 2:29 PM with Nurse as assigned to care for D2/24, 02/06/24, 02/20/24 ad on the days she had not at with a shower she had ath and documented a partial resident got up early in the mes wanted to go back to Defore it was time for her rashed her up in bed. NA #4 d not asked if Resident #49's anged to 1st shift because I B bed residents had their but said she would probably mer shower time changed shift.  W was attempted with NA #9 D care for Resident #49 on mail message left for return the from the NA.  19/24 at 2:09 PM with Nurse d to care for Resident #49 t aware of the resident d said the NAs had not she had refused showers so nted a progress note	F 5	new hires and agency nursing orientation. Beginning on 3/19/2024 the DON/ADON/UM will monitor the schedule 5 times weekly for 2 valinterdisciplinary Team (IDT) to showers are offered and/or given, preferences upheld, and nurse if resident refused. On 4/1/2024, using the Shower the DON/ADON/UM will audit 52 x's weekly x 4 weeks then 1 to month for 2 months. The audit done by interviewing the resident BIMS of 13 or higher and monit shower log and electronic record other residents. Results of audit shared with the QAPI members 2 months or until a time determing QAPI members for sustained control of the Director of Nursing is respet the Plan of Correction and the Administrator for sustained control of Compliance 4/15/2024	e shower weeks in ensure en, bed is notified r Audit tool, o residents time a will be ents with a toring the rds for all it will be s monthly x nined by the compliance. onsible for		

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		345142	B. WING_			C
NAME OF P	ROVIDER OR SUPPLIER	343142	B: WiiNO	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	13/2024
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UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER		CHARLOTTE, NC 28262		
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F 561	Manager #1 revealed Resident #49 was no scheduled and said in She stated if the 2nd working for Resident switch her to 1st shift stated the normal pro resident refused their back again a little late she/he was ready to answer was no again the nurse. She stated the resident and if the nurse, she was suppoindicating the resident despite being asked to further stated the NA timing of Resident #4 her and it could have accommodate the resident showers are were currently workin stated she expected is showers as schedule.	2/24 at 3:10 PM with Unit she was not aware treceiving her showers as o one had reported it to her. shift shower were not #49, they could certainly showers. Unit Manager #1 cess for showers was if the shower the NA had to go er and ask the resident if take their shower and if the , the NA was to report that to then the nurse was to ask eresident refused to the osed to write a progress note thad refused his/her shower three times. Unit Manager #1 should have reported the 9's shower not working for been changed to sident.	F 50	61		
F 641 SS=E	bath and for it to be d further stated if the re		F 64	11		4/15/24

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				9200 GLENWATER DRIVE			
UNIVERSI	IY PLACE NURSING AN	ID REHABILITATION CENTER		CHARLOTTE, NC 28262			
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F 641	resident's status. This REQUIREMENT by: Based on record rev facility failed to accur Data Set (MDS) asse (Resident #41, #102, Preadmission Screer (PASRR), and 1 of 3 reviewed for restraint Findings Include:  1. Resident #41 was 07/03/12 with diagno and hemiparesis follo	of Assessments. st accurately reflect the  is not met as evidenced  iew and staff interviews, the ately code the Minimum essment for 3 of 6 residents #84) reviewed for sing and Resident Review residents (Resident #110) s.  admitted to the facility on ses that included hemiplegia owing cerebral infarction,	F 6	• The Minimum Data Set (MDS modified the MDS assessments residents #41, #102 and #84 rel Pre-Admission Screening and A Resident Review (PASARR) and #110 for limb restraint usage on • An initial audit of all MDS Asse for PASARR, and restraint usage performed by the MDS/SW begi 3/12/2024 and completed by 3/2 Any areas identified will be corred/14/2024 • Re-education of how to complete	s for lated to Annual of resider 3/1/202 essments ge was sinning 22/2024. rected by	.4. s	
	from July 2021 reveal the requirements for having mental illness services required.  The annual MDS assindicated Resident #4 was not coded as har An interview with the 02/29/24 at 3:28 PM working at the facility not aware that Reside or that it had been concessident #41's MDS level II PASRR assign	evel II determination letter led Resident #41 had met a level II PASRR due to diagnosis with specialized essment dated 01/13/24 41 was cognitively intact and ving a level II PASRR.  MDS Coordinator on revealed she had begun in October 2023 and was ent #41 had a level II PASRR ded on his MDS. She stated did not reflect him having a ned and that was an uman error and a correction		assessments accurately provided Administrator and MDS Coordin Regional MDS Consultant on 3/ Social Worker received Educating PASARR process on 3/1/24 by a Administrator. New MDS nurses receive orientation upon hire on coding for PASARRs and restra Regional MDS Consultant.  • Director of Nursing, ADON or Administrator will complete audit assessments for PASARR, and residents using restraints weekl weeks, and then monthly for 1 in Results of audit will be shared with Quality Assurance Performance Improvement (QAPI) members in months or until a time determined QAPI members for sustained control of Correction and the	nator by /22/2024 on of the the s will n accurate ints by th its of MD all ly for 4 months. with the for 2 ed by the compliance	e e he OS	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		92	TREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWATER DRIVE HARLOTTE, NC 28262	1 03/	13/2024
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F 641	4:08 PM revealed sh facility on Monday 02 Resident #41 PASRF his MDS. She stated the MDS to reflect cu accurate. She felt it won human error on the Coordinator.  The Director of Nursi on 02/29/24 at 4:45 Faware of Resident #4 reflected on his MDS probably due to an of MDS Coordinator. Sh	Administrator on 02/29/24 at e had just begun at the 2/26/24 and was not aware of R level not being reflected on their process would be for irrent PASRR level and to be was just an oversight based the part of the MDS  and (DON) was interviewed PM revealed she was not and believed it was versight on the part of the the stated MDS should reflect for all residents and a	F	641	Administrator for sustained compliance • Date of Compliance: 4/15/24	<b>3.</b>	
	11/07/20 with diagnormal Review of PASRR let from May 2021 revea requirements for a let diagnosis of demention The annual MDS assindicated Resident # cognitively impaired a level II PASRR.  An interview with the 02/29/24 at 3:28 PM working at the facility not aware that Resident Resident PASR Re	a. essment dated 09/24/23					

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	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		9200	EET ADDRESS, CITY, STATE, ZIP CODE  GLENWATER DRIVE  RLOTTE, NC 28262	, 30.	
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F 641	MDS not reflecting hassigned was an overall by the previous MDS correction would need. An interview with the 4:08 PM revealed has Monday 02/26/24 an #102 PASRR level in MDS. She stated the MDS to reflect currel accurate and they fe based on human errocoordinator.  The Director of Nursion 02/29/24 at 4:45 aware of Resident # reflected on her MDS probably due to an of MDS Coordinator.	e believed Resident #102's er having a level II PASRR ersight based on human error 6 Coordinator and a ed to be made.  Administrator on 02/29/24 at ed just begun at the facility on d was not aware of Resident ot being reflected on her eir process would be for the ent PASRR level and to be It it was just an oversight or on the part of the MDS  ing (DON) was interviewed PM revealed she was not 102 PASRR level was not 6 and believed it was versight on the part of the the stated MDS should reflect for all residents and a	F	641			
	2/8/19 with diagnose schizophrenia, and a The most recent ann assessment dated 1 #84 was not currentl level II PASRR proceillness.  Review of Resident record revealed a Harman schizophrenia, and a s	nual Minimum Data Set 0/31/23 indicated Resident y considered by the state ess to have serious mental					

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F 641	Coordinator #1 indi of the MDS coordin information onto the admission and ann she initially underst be halted and there considered to have determination. How section of the MDS having a level II PA admitted with a PA health diagnoses.  The Director of Nur on 02/29/24 at 4:58 aware of Resident reflected on her MDS coordinator sexpectation was the PASRR levels for a An interview with the 5:10 PM revealed in Monday 02/26/24 as be reviewed and co	on 2/29/24 at 3:34 PM MDS cated it was the responsibility lator to enter PASRR end MDS assessment at ually. She further indicated alood Resident #84's PASRR to effore Resident #84 was not a level II PASRR ever, she realized the PASRR should have been marked as SRR, since the Resident was SRR number and mental sing (DON) was interviewed as PM revealed she was not #84's PASRR level was not #84's PASRR level was not 98. She believed it was oversight on the part of the taff changes. She stated her at MDS should reflect current II residents.	F 64	,		
	assessment dated #110 was coded for less than daily. The 9/11/23 indicated n	num Data Sheet (MDS) 12/1/23 indicated Resident r the use of a limb restraint e previous annual MDS dated o use of restraints.  t #110's current care plans				

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F 644 SS=D	restraint care plan.  An interview was con Coordinator #1 and M 2/29/24 at 3:56 PM. explained Resident # dated 12/1/23 was concordinator who was facility. The MDS Concordinator who was facility. The MDS Concordinator #2 stated and had not used one Coordinator #2 stated and they would look in During an interview of Administrator stated in MDS assessments to The Administrator fur should be checked by Coordination of PASA CFR(s): 483.20(e)(1) §483.20(e) Coordinate A facility must coordinate pre-admission screen (PASARR) program of this part to the mass avoid duplicative test includes: §483.20(e)(1)Incorporation of the PASARR level PASARR evaluation in the passage of the passa	ducted with MDS MDS Coordinator #2 on MDS Coordinator #1 110's MDS assessment Impleted by another MDS In longer employed at the In longer employed a	F6				4/15/24
	§483.20(e)(2) Referri	ng all level II residents and					

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UNIVERSI	TY PLACE NURSING AN	D REHABILITATION CENTER		CHARLOTTE, NC 28262		
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F 644	Continued From page	e 10	F 644			
⊢ 644	all residents with new serious mental disord related condition for least significant change in This REQUIREMENT by:  Based on record revifacility failed to ensure and Resident Review for resident with mentadmission and reside diagnoses for 3 of 6 resident with mentadmission and reside diagnoses for 3 of 6 resident with mentadmission and reside diagnoses for 3 of 6 resident revealed the resident completed prior to headmitted to the facility had been diagnosed to 08/31/23 and dementadisturbance as part of level II had been commedical records.  During an interview of the Social Worker (SV employed as the faciliand since that time had completing PASRR upwhen a change in coroccurred, or when the diagnosis. She reveal resident's diagnosis of seeing if they would resident would resident with the second resident's diagnosis of seeing if they would resident would resident with the second	er, intellectual disability, or a evel II resident review upon a status assessment. Is is not met as evidenced ew and staff interviews the ea a Preadmission Screening (PASRR) was completed teal health diagnosis upon ants with new mental health esidents (Resident# 141, or PASRR.  It #141's medical record had a PASRR level I and a PASRR level I are admission and was and on 08/31/23. The resident with delusional disorder on ital, severe, with psychotic for her admission. No PASRR pleted per Resident #141  In 02/29/24 at 4:05 PM with W) revealed she had been ity SW over the past year and been responsible for pon a resident admission, adition or behavior had	F 644	F644 Coordination of PASARR and Assessment  Corrective action for residents #14 #31, and resident #49 was accomplished by submitting a PASARR level 2 by the Social Worker for identified residents of 3/25/2024. The Minimum Data Set (ME will be updated to reflect Level 2 once received by the MDS Director.  Corrective action for all residents having the potential to be affected was initial audit of all MDS Assessments for Pre-Admission Screening and Annual Resident Review (PASARR), performe by the MDS Director and Social Worke 3/12/2024 on and corrections were matas needed.  Re-education of how and when to complete Level 2 PASARRs accurately provided to Social Workers and MDS Coordinators by Administrator on 3/01/2024. New MDS nurses and Social Workers will receive orientation upon hon accurate coding for PASARR coding correctly by the Regional MDS Consult Social Services will attend interdiscipling team meetings 5 times weekly with nursing where new diagnoses will be discussed.  The Director of Nursing will compleadid to fall new admission related to	ed en n DS) it is an d r de ital ire g tant. harry	
	a new diagnosis had	been added for a resident or nge in condition. The SW		PASARR documentation weekly for 4 weeks, and then monthly for 1 month.		

Facility ID: 923015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345142	B. WING _				C <b>13/2024</b>
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	•	92	TREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWATER DRIVE HARLOTTE, NC 28262	1 001	10/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 644	level of PASRR had a however based on R diagnosis of delusion severe, with psychotic preadmission PASRF PASRR level II should be completed admission for a resid diagnosis or anytime of condition or a new diagnosis. She stated admission diagnosis dementia, severe, with PASRR level II should be completed admission diagnosis dementia, severe, with PASRR level II should be completed prior to his admitted to the facility was diagnosed with a disturbance disorder level II had been commedical records.  During an interview of the Social Worker (Semployed as the facility and since that time here concurred, or when the diagnosis. She reveal resident's diagnosis of seeing if they would in the social in they would be seeing if they would in the social in the social worker (Semployed as the facility when a change in concurred, or when the diagnosis. She reveal resident's diagnosis of seeing if they would in the social would be seeing if they would in the social would be seeing if they would in the social worker (Semployed as the facility when a change in concourred, or when the diagnosis of the social would be seeing if they would in the social worker (Semployed as the facility when a change in concourred, or when the diagnosis of the would be seeing if they would in the social worker (Semployed as the facility when a change in concourred, or when the diagnosis of the worker (Semployed as the facility when a change in concourred in the worker (Semployed as the facility when a change in concourred in the worker (Semployed as the facility when a change in concourred in the worker (Semployed as the facility when a change in concourred in the worker (Semployed as the facility when a change in concourred in the worker (Semployed as the facility when a change in concourred in the worker (Semployed as the facility when a change in concourred in the worker (Semployed as the facility when a change in concourred in the worker (Semployed as the facility when a change in concourred in the worker (Semployed as the facility when a change	I admission diagnosis and simply been overlooked, esident #141 admission hal disorder and dementia, ic disturbance and the R level I, paperwork for a d have been completed.  In 02/29/24 at 4:15 PM with ealed a PASRR level II in a timely manner upon ent with a mental health a resident has had a change ly added mental health dibased on Resident #141 of delusional disorder and the psychotic disturbance a dibave been completed.  In #31's medical record thad a PASRR level I is admission and was yon 03/31/15. The resident dementia with mood on 05/05/23. No PASRR inpleted per Resident #31  In 02/29/24 at 4:05 PM with with revealed she had been lity SW over the past year ad been responsible for upon a resident admission, indition or behavior had	F	544	Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 2 months or until a time determined by the QAPI members for sustained compliant. The Director of Nursing is responsible the Plan of Correction and the Administrator for sustained compliance.  • Date of Compliance: 4/15/24	ne ice. for	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		, ,	ATE SURVEY DMPLETED
		345142	B. WING			C 03/13/2024
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	<u> </u>	03/13/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 644	there had been a ch stated she had not be #31's new mental he with mood disturban an oversight, howev diagnosis and the prepaperwork for a PAS completed.  During an interview the Administrator revisions of completed admission for a residuagnosis or anytime of condition or a new diagnosis. She state newly added diagnodisturbance disorder have been completed admitted to the facility was diagnosed with 11/28/22. No PASRI per Resident #49 mediagnosis when a change in concurred, or when the diagnosis. She rever resident's diagnosis.	al been added for a resident or ange in condition. The SW seen made aware of Resident salth diagnosis of dementia ce and felt it could have been er based on his new seadmission level I PASRR, SRR level II should have been on 02/29/24 at 4:15 PM with realed a PASRR level II d in a timely manner upon dent with a mental health dear a resident has had a change rely added mental health dear a passed on Resident #31 sis of dementia with mood a PASRR level II should d.  Int #49's medical record thad a PASRR level I ser admission and was the on 04/21/22. The resident major depressive disorder on R level II had been completed	F 64	14		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII	TIPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 644	Continued From page		F	644		
F 657 SS=D	a new diagnosis had there had been a chatted she was not having a level II PAS new diagnosis of mathe preadmission le PASRR level II should be complete admission for a residiagnosis or anytimo of condition or a new diagnosis. She state newly added diagnodisorder a PASRR lecompleted. Care Plan Timing at CFR(s): 483.21(b)(2) §483.21(b) (2) A completed with the comprehensive (ii) Developed within the comprehensive (iii) Prepared by an includes but is not lied (A) The attending plant (B) A registered nur resident. (C) A nurse aide with resident. (D) A member of for (E) To the extent prother resident and the residen	hensive Care Plans nprehensive care plan must 7 days after completion of assessment. nterdisciplinary team, that mited to	F	557		4/15/24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	and their resident renot practicable for the resident's care plant (F) Other appropriate disciplines as determined or as requested by (iii)Reviewed and reteam after each assomprehensive and assessments.  This REQUIREMENT by:  Based on record recordered observations the factor plant for Resident and care plant meetings sampled residents.  The findings included the findings	e participation of the resident epresentative is determined the development of the staff or professionals in mined by the resident's needs the resident. Evised by the interdisciplinary sessment, including both the stagnarterly review  NT is not met as evidenced eview, staff interviews, and cility failed to revise a smoking ent #75, resolve inactive care #51 and schedule quarterly (Resident #83) for 3 of 5	F	F657 Care Plan Timing and "Resident #75 care plan related to smoking on 3/20/Resident #51 inactive care resolved. Resident #83 had meeting on 3/26/2024. "On 3/22/2024, the Dire and Assistant Director of Nt Minimum Data Set (MDS) Cinitiated an audit of all resid related to smoking and infe ensure accuracy of the care Services will audit resident meeting schedules for the late to identify the residents who a quarterly care plan meetin or Responsible parties who	d Revision n was updated /2024. plan was d a care plan ector of Nursing ursing, Coordinator lent care plans ctions to e plan. Social Care Plan ast 6 months o did not have ng. Residents		
	Review of Resident assessments dated resident was an unbe supervised.  Review of Resident 03/29/23 revealed of the supervised of the super	#75's quarterly smoking 01/27/24 revealed the safe smoker and required to #75's care plan revised on on the resident's care guide ng status was an independent		invited to participate in a cameeting over the last 6 mor offered a care plan meeting and the care plan meeting documented on the sign in audit will be completed by 3 Quarterly care plan meeting scheduled for residents quarcording to the MDS sche	are plan onths will be on by 4/15/2024 oreview on sheet. The one of the sheet one of the sh		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		*			DEFICIENCY)		
F 657	Continued From page	e 15	F	657			
	smoker and may smo	oke at time of own choice			be invited to attend by social services.		
	without supervision.				" On 3/22/2024, the Staff Developm	ent	
					Coordinator (SDC) initiated an in-service	ce	
	A joint interview with	the MDS coordinator #1 and			with all nurses regarding Care Plans		
	MDS coordinator #2	on 02/29/24 at 3:30 PM			emphasizing on accuracy of the care p	lan	
	revealed Resident #7	'5 was an unsafe smoker,			relating to resident smoking status and		
	and the resident's ca	re plan should have reflected			infections. The Administrator educated	the	
	that.				social workers on care plan meetings		
					including scheduling according to the		
	An interview conduct	ed with the Director of			MDS schedule quarterly and sending a	ınd	
		2/29/24 at 4:50 PM revealed			documenting invitations to the resident		
	Resident #75 was an	unsafe smoker, and the			and responsible party in the resident		
		should have reflected that.			medical record. In-service will be		
	The DON further reve				completed by 4/15/2024. After 4/15/202		
	resident's care guide	for care areas.			any social worker who has not complet		
					the in-service will be in-serviced prior to		
		ed with the Administrator on			the next scheduled work shift. All newly		
		revealed residents who are			hired social workers and nurses will be		
		nokers should have been			in-serviced during orientation regarding	j	
		nsafe smoker. It was further			Care Plans by the SDC.		
		'5's care guide on the care			" The Administrator, Director of Nurs	sing	
		stated the resident was a			(DON), Assistant Director of Nursing		
	safe smoker.				(ADON) and the MDS Nurses will revie		
					15 resident care plans weekly x 4 week		
		admitted to the facility on			then monthly x 1 month utilizing the Ca	ire	
	_	s including neurogenic			Plan Audit Tool. This audit is to ensure		
		c autoimmune disorder that			resident care plan is accurate related to	<b>o</b>	
	affects movement, se	ensation and bodily function.			smoking, and infections. The audit will		
					include the documentation of the care		
		t51's current care plans			plan meeting review with resident and		
		evised on 4/2/23 revealed a			resident's representative, and the audit		
		sident being at risk for actual			will ensure the meeting was offered an		
		OVID 19 Virus. Will be free			documented. The Director of Nursing w		
		ns of infection through next			review the Care Plan Audit Tool weekly		
		Medications as ordered,			weeks then monthly x 1 month to ensu	re	
	treatment as ordered				all concerns are addressed.		
	T	ction, encourage resident to			" The DON will forward the results o	ıT	
		ptoms of infection to the			Care Plan Audit Tool to the Quality		
	∣ nurse, and isolation p	recautions. A care plan			Assurance Performance Improvement		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2024	
	TV DI 405 NUIDONIO AN			92	200 GLENWATER DRIVE			
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F 657	Continued From page	e 16	F 6	657				
	initiated on 3/28/22 a risk for actual infection will receive appropriate with resolution through medications as ordereducate care staff on hygiene.  Resident #51 had a complete (MDS) assessment of (MDS) assessment and be in problem is resolved. She was not aware the had not been revised the last MDS Nurse for t	and revised 4/2/23 stated at n r/t fungi candida, resident te treatment for infection th next review. Interventions ed by physician, and to performing personal  Juarterly Minimum Data Set completed on 1/17/24.  MDS Coordinator #1 on evealed that care plans and revised with each MDS made inactive when a MDS Coordinator #1 stated at some of the care plans in over a year. Stated that eft about two months ago ent #51 quarterly MDS on #1 indicated they were still update everything.  Director of Nursing (DON)  If revealed that expectations were initiated, revised, or ident condition changed.  Administrator on 2/26/24 at the expected all care plans to ed in a timely manner. For the most of the consultant was the building the following week staff with training and job both relatively new to the			Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly 2 months and review the Care Plan Au Tool to determine trends and / or issue that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Director of Nursing is responsible the Plan of Correction and the Administrator for sustained compliance."  Date of Compliance 4/15/2024	y x dit s or for		
	position.  3. Resident #83 was	admitted to the facility on noses that include dementia,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345142	B. WING				C <b>13/2024</b>	
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER		920	REET ADDRESS, CITY, STATE, ZIP CODE  O GLENWATER DRIVE  ARLOTTE, NC 28262	1 03/	13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE	
F 657	Continued From page		F	657				
	assessment dated 12 #83 had moderate con 12 #83 had moderate con 14 had been been been been been been been bee	rly Minimum Data Set (MDS) 2/01/2023 revealed Resident rignitive impairment.  33's medical record revealed care plan meeting occurred  as conducted with Resident rty (RP) on 02/26/2024 at wealed she had not attended for Resident #83 in a very r stated that she believed an meeting scheduled for rentire 2023 calendar year.  #2 was interviewed M. SW#2 confirmed thad a care plan meeting ne stated she had only been weeks and was currently re plan meetings caught up. at there were several ong overdue for care plan revealed she expected care scheduled quarterly. She e the SW's responsibility to the care plan meeting						
	stated that she realiz process was behind	ed the care plan meeting schedule and the facility was ensure care plan meetings						

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		345142	B. WING _			03/	13/2024
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 658 SS=D	Services Provided Me CFR(s): 483.21(b)(3)	eet Professional Standards (i)	F 6	658			4/15/24
SS=D	§483.21(b)(3) Compronent The services provided as outlined by the commustive of the community of the c	ehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced ns, record review, and staff failed to follow physician nds (non-pressure of left ents (Resident #128) are and failed to administer ed by the physician for 2 of d for medication errors e110).  dmitted to the facility on ted on 12/16/23 with uded congestive heart sease, dementia, and e128's quarterly Minimum ssment dated 02/06/24 ely/never understood and nds and had no speech. revealed she was severely			• On 03/01/2024 a review of the last two months of the clinical record for Residents #28 and #110 was complete by the Facility Consultant, there were nother change in condition noted and the residents' clinical status were stable. Nurse #8 was in serviced on the 6 right of medication administration by the Director of Nursing (DON)/Staff Development Coordinator (SDC) on 3/20/2024. On 3/20/2024 the wound nurse who administered wound treatment to resident #128 on 2/28/24 during observation received an in-service regarding following physician orders for wound treatments. The wound nurse removed the incorrect dressings and placed the dressings as ordered on 2/28/24. On 3/17/2024 a skin assessment on resident #128 was done to identify a with new skin concerns or wounds to ensure all concerns have been assessed.	d o s ent ent iny	
	and anticipation of he additionally revealed Il pressure ulcers and device for bed, nutrition interventions to mana	tivities of daily living (ADL) or needs. The assessment she had two unhealed stage I had pressure reducing			treatment initiated as indicated, MD/Resident Representative (RR) notified.  On 3/20/2024, The Director of Nursing completed an audit of resident medical records from 12/10/2023 to 12/27/23 which did not indicate any additional medication errors. On		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	343142	5:		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	13/2024	
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UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER			2200 GLENWATER DRIVE			
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F 658	Continued From page	e 19	F	658				
	dressings.				3/15/2024, the facility Unit Managers			
					initiated a 100% skin assessment on a	11		
	Review of Resident #	128's Treatment			residents. This audit is to identify any			
	Administration Recor	d (TAR) dated 02/01/24			resident with new skin concerns or			
		ealed the following orders for			wounds to ensure all concerns have be	en		
	wound care:				properly assessed, treatment initiated	as		
					indicated, MD/RR notified. Audit will be	;		
		ee with wound cleanser,			completed by 4/5/2024.			
		ogel AG (antimicrobial silver			On 3/21/2024, the DON initiated a	n		
		ates moist wound healing),			audit of all treatment administration			
		dry dressing every day shift			records (TAR) for all residents from			
	(7:00 AM to 7:00 PM)	) for wound healing.			3/19/24-3/20/24. This audit is to ensure			
	O Olasmas tha mimbt a	ustan and da suith succeed			treatments were completed per physic	an		
		outer ankle with wound orm (petroleum-based fine			order with documentation on the TAR.  The audit will be completed by 3/22/20	24		
		antimicrobial properties			The Staff Development Coordinate			
		ng), and cover with dry			(SDC), or another licensed nurse will	Л		
		hift (7:00 AM to 7:00 PM) for			conduct observation of treatment			
	wound healing.	(1:00 / 111 to 1:00 1 111) 101			administration for all nurses by 4/15/24			
					Any nurse not observed to do treatmer			
	An observation of wo	und care was made on			administration will be observed on thei			
	Resident #128 on 02/	/28/24 at 9:13 AM with the			next scheduled shift.			
	Treatment Nurse. Th	ne Treatment Nurse gathered			All Nurses and Med-Aides including	ıg		
	her supplies for the fo	our wounds and began with			agency nurses and Med-Aides will be			
		wound. She removed the			in-serviced regarding the 6 rights of			
	_	I the wound with wound			medication administration which include	es		
		ze and applied hydrogel			verifying the resident's identity prior to			
		d covered it with a bordered			medication administration and			
		Treatment Nurse then			administering medications as ordered	and		
		e, removed the old dressing,			documenting medications by the SDC			
		ith wound cleanser and ze to the wound bed and			beginning 3/15/2024. All nurses and Med-Aides or agency nurses and			
		lered gauze dressing. As			Med-Aides of agency nurses and Med-Aides not in-serviced by 4/05/24 v	azill		
		he left knee dressing, the			not work until the education is complet			
		d, "I think I mixed up my			by the DON/SDC. After 4/5/24, all new			
	dressings."	a, . amin i mixed up my			nurses and Med-Aides and agency nur			
					and Med-Aides will be educated on the			
	An interview on 02/29	9/24 at 9:59 PM with the			rights of medication administration before			
		ealed she realized while			working by the DON/SDC. The Unit			

Facility ID: 923015

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF D		040142	1		TREET ADDRESS CITY STATE ZID CODE	03/	13/2024	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSI	TY PLACE NURSING AN	D REHABILITATION CENTER			200 GLENWATER DRIVE			
				С	HARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From page	e 20	F6	658				
	doing the left knee tha	at she had mixed up the			Managers (UM), ADON/DON will			
		nt outer ankle and left knee			complete an initial Med Pass return			
	_	vrong treatments to the			demonstration for all nurses and			
	wounds. She stated	she was nervous about			Med-Aides including agency by 4/5/24.			
	being watched and ha	ad just mixed up the			After initial observation of all nurses, th	е		
	•	vo wounds even though she			DON/SDC/UM will observe 3 nurses			
	had labeled the treatr	nents for each wound.			and/or Med-Aides weekly for 4 weeks a	and		
		.,_, .,, _, .,.			then 3 per month for 2 months. The	_		
		9/24 at 11:51 AM with the			physician will be notified of any identified			
		OON) revealed she expected			areas of concern. The Administrator or			
		s to be done as prescribed e stated she thought the			DON will review the audits weekly x 4 weeks then monthly x 2 month to ensu	ro		
	Treatment Nurse was				all areas of concern were addressed			
		d care and just got the two			appropriately.			
	wound treatments mix				,			
		·			<ul> <li>On 3/19/24, the SDC initiated an</li> </ul>			
	2. Resident #28 was	admitted to the facility on			in-service with all nurses regarding (1)			
	11/30/2022 with a dia	gnosis of anxiety and			Wound Process with emphasis on			
	depression.				assessing, initiating treatment and			
					notification of the MD/RR for all newly			
	A quarterly Minimum				identified skin concerns or changes in			
		/12/2023 revealed Resident			wound status (2) Treatments/TAR			
		ntact. The MDS revealed			documentation with emphasis on nurse responsibility to complete treatments in			
	Resident #28 receive medication during the				the absence of treatment nurse, signing			
	medication during the	assessment period.			TAR immediately after completing	9		
	The active physician's	s orders for December 2023			treatment and notification of the physic	ian		
	for Resident #28 inclu				if treatment cannot be completed for			
		l 25 mg give 1 tablet by			further instructions. The in-service will	be		
	mouth two times a da	y for depression.			completed by 4/5/2024. After 4/5/2024,	,		
					any nurse or agency nurse who has no	it		
		tration Record (MAR) dated			worked or received the in-service will	ſ		
		aled the Seroquel 25 mg			complete it before the next scheduled	ſ		
		M was not documented as			work shift. All newly hired nurses to			
	given on 12/10/2023.				include agency nurses will be in-service	ed		
	0. Desident #440				during orientation regarding Wound	ſ		
		admitted to the facility on			Process and TAR	ſ		
	10/14/2022.				Documentation/Treatments			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			C <b>03/13/2024</b>	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		03/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	assessment dated #110 was cognitive The active physicia for Resident #110 12/04/23 for Amox mouth two times a 10 days.  A Medication Admi December 2023 rescheduled for 8:00 given on 12/10/2020.  A facility investigate revealed the facility reviewing the Med report for the previmedication errors. Resident #47, Resident #47, Resident #79, Resident #79, Resident #79, Resident #7:00 Phinvestigation was to Director was notific completed by the lidentified the caus nurse not reporting shift.  An interview conductive with the Director of 12/10/23 around 60 Manager #1 that No. 7:00 PM to 11:00 PM Manager #1 told hourse #5 were ins	Im Data Set (MDS) 12/01/2023 revealed Resident ely intact.  an's orders for December 2023 included an order dated icillin 500 mg give 1 tablet by day for a bacterial infection for inistration Record (MAR) dated evealed the Amoxicillin 500 mg PM was not documented as	F 6	The UM/ADON/DON wound observations week then monthly x1 month.  The DON will present the Medication Administration observations and the treat observations to the Quality Performance Improvement committee 1 time monthly. The QAPI Committee will for 2 months and review to determine trends and/or in need further interventions and to determine the need frequency of monitoring. Nursing is responsible for Correction and the Administration of Compliance.  Date of Compliance.	kly x4 weeks, at the findings of ation atment ty Assurance nt (QAPI) y for 2 months. I meet monthly the audits to issues that may is put into place ad for further The Director of the Plan of histrator for		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E SURVEY PLETED	
		345142	B. WING		l l	C /13/2024	
	ROVIDER OR SUPPLIER  TY PLACE NURSING AI	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	03	13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 658	residents had not recinterview revealed reference #28 and Resident #1 scheduled medication her she had complet thought someone else the rest of the reside stated it was a commurses. She stated noccurred from the increased medical treatheir medication.  On 02/29/24 at 11:20 conducted with the Nointerview he stated he that the residents had 12/10/23. The intervince Practitioner's incident and that nur monitoring the resident condition. He stated symptoms from not round the sy	next morning that some relived their medication. The sidents including Resident 10 did not receive any in. She stated Nurse #5 told red her assigned half and relive was going to administer rents' medication. The DON relivence of adverse outcomes had relident and no residents the timent due to not receiving and a management of the relivence was notified by the facility of missed their medication on rew revealed he notified the reliant were in the facility of the rese on the unit were reliant for any changes of the residents were having receiving their medication. The reliant reliant is an analysis of the residents were having receiving their medication. The reliant relia	F 6			4/15/24	
SS=D	CFR(s): 483.24(a)(2) §483.24(a)(2) A residence out activities of daily	dent who is unable to carry living receives the necessary good nutrition, grooming, and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345142	B. WING _			03/	13/2024	
NAME OF P	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE			
LIMIN/EDGI	TV DI ACE NUDCINO AN	ID DELIADII ITATION CENTED		,	9200 GLENWATER DRIVE			
UNIVERSI	IT PLACE NURSING AN	ID REHABILITATION CENTER		(	CHARLOTTE, NC 28262			
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F 677	Continued From page	e 23	F	677	7			
	This REQUIREMENT by:	is not met as evidenced						
		ns, record reviews, resident, he facility failed to provide			F677 ADL Care Provided for Dependence Residents	∍nt		
		shing to 1 of 10 residents			Resident #94 was provided a sho	wer		
		ailed to provide incontinence			and hair wash on 3/1/24 CNA. Reside			
		of 10 residents (Resident			#51 was provided incontinent care on			
	#51). These failures of	•			2/28/24 by a different CNA.			
		r activities of daily living			Showers/baths were offered to any			
	(ADL).				resident who had not received a			
					shower/bath per preference. On 3/19/2			
	The findings included	:			the Unit Managers initiated an audit of	all		
					resident shower logs and electronic			
		admitted to the facility on			medical records for the previous week			
	_	ses which included diabetes in deficiency, dementia, and			ensure all showers/baths are being given as scheduled and per resident prefere			
	anorexia.	in deliciency, dementia, and			CNA #1 provided one on one	nce.		
	апогола.				education by Director of Nursing on			
	Review of Resident #	94's quarterly Minimum			2/28/24 on proper cleaning for a reside	ent		
		essment dated 02/21/24			that has had a bowel movement. On			
	, ,	erely cognitively impaired			3/19/24, the Unit Managers initiated ar	า		
		sistance with showering and			audit of all resident shower logs and			
	bathing. The assessn	nent also revealed Resident			electronic medical records for the			
	#94 had no rejection	of care behaviors.			previous week to ensure all			
					showers/baths are being given as			
		94's care plan revealed a			scheduled and per resident preference			
		es of daily living/personal			On 3/20/24, the social workers initiated			
		dementia. The interventions			Resident Preference Questionnaire wi			
	included personal hyg	-			all residents with a BIMS of 13 or great			
	substantial/maximal a				regarding resident preferences to inclu	ide		
	showering/bathing de	pendent on stail.			but not limited to preferences for showers/baths and morning/evening.			
	An observation and in	nterview with Resident #94			Residents with a BIMS of 12 and below	W		
		AM revealed the resident			resident representative will be contact			
		air in her room, dressed for			for shower/bath preferences by	<i>-</i> 4		
	_	's hair appeared greasy and			4/15/2024. The Unit Managers/Assista	ınt		
		tated she was not getting			Director of Nursing (ADON) will update			
		duled two times per week.			the care plan for all newly identified or			
	Resident #94 further				changes in resident preferences.			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	· /	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER						
UNIVERSI	TY PLACE NURSING AN	ND REHABILITATION CENTER		9200 GLENWATER DRIVE			
				CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 677	Continued From page	e 24	F 67	7			
	showers because the showers because showers because the showers be	_		Questionnaires will be completed by 4/5/24.	'		
				On 3/20/24, Staff Development			
	Review of the showe	r schedule for the hall on		Coordinator (SDC) initiated a 100%			
		sided revealed Resident #94		education and return demonstration	for all		
	was scheduled for sh	lowers on Tuesday and		nurse aids that provide incontinence	care		
	Friday on 1st shift (7:	00 AM to 3:00 PM).		to ensure proper technique. The SI			
				initiated 100% education of the show			
		entation of showers in the		schedules, and the expectation that			
		cord for Resident #94		times weekly all residents are offere			
		th of February she had only		shower per their preference. Any Cl			
		on 02/27/24. On the other		attending the in-service by 4/15/202			
	days she was schedu following was docum						
	lollowing was docum	silleu.		scheduled shift. The training will be provided to all new hires and agence	v CNA		
	Tuesday 02/06/24 documentation	no indication or		staff during orientation.	, 0.0.1		
	Tuesday, 02/13/24	no indication or		On 3/19/24, the Director of Nurs	sina		
	documentation			(DON) /Administrator will monitor the			
	Tuesday, 02/20/24	no shower or bed bath given		shower schedules 5 times weekly in			
	Friday, 02/23/24	partial bed bath (not a		to ensure showers are given, bed ba	aths		
	complete bed bath)			offered, preferences upheld, and nu	rse		
				notified if resident refused. Beginning			
	•	v on 02/29/24 at 10:46 AM		3/25/24, Staff Development Coordin			
	with NA #8 who was			will audit incontinence care of 3 resi			
		06/24 and 02/13/24 stated if		on various shifts and residents weel	dy x 4		
		a resident and did not have		weeks then 1 time a month.			
		hower, she would wash		On 2/25/24 using the Shower A	\dit		
		locument it as a partial bath complete bed bath. NA #8		<ul> <li>On 3/25/24, using the Shower A tool, the Unit Managers/DON will au</li> </ul>			
		recall why she had not given		residents 2 x's weekly x 4 weeks the			
		er on 02/06/24 or 02/13/24		time a month. The audit will be done			
		ikely due to staffing issues.		interviewing the residents with a BIN	-		
		,		13 or higher and monitoring the sho			
	An interview on 02/28	3/24 at 10:34 AM with NA		log and electronic records for reside			
		ed to care for Resident #94		with a BIMS of 12 or less. DON/AD			
		l if she was assigned to the		will review all audits for incontinence			
	resident and had give	en her a complete bed bath		2x's weekly x 4 weeks, then 1 time i	nonth.		
	instead of a shower in	t was due to not having time		Results of the audits will be shared	with		

Facility ID: 923015

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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NAME OF T	TOVIDER OR SOLT EIER						
UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER			2200 GLENWATER DRIVE		
					CHARLOTTE, NC 28262		
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F 677	Continued From page	e 25	F	677			
F 6//	to shower the resident short of help sometime time-consuming to give shower.  An interview on 02/29 who was assigned to 02/23/24 revealed shhad not given the resident a shear one of those days where gives the resident a shear of the stated worked short of help some of those days where gives the resident a shear of the stated when stried to cut their nails but did not always has staffing issues.  An interview on 02/29 Manager #1 revealed Resident #94 was not scheduled and said in She stated the normat the resident refused to go back again a little.	at. She stated they were thes and it was less we residents a bed bath than all 2/24 at 1:45 PM with NA #7 care for Resident #94 on the could not recall why she ident a shower as at there were days they and that could have been then she did not have time to hower and just bathed her in it as a partial bath. NA #7 the showered residents, she and shave them as needed we time to do so due to	F	677	the Quality Assurance Performance Improvement (QAPI) members monthl 2 months or until a time determined by QAPI members for sustained compliar The Director of Nursing is responsible the Plan of Correction and the Administrator for sustained compliance.  • Date of compliance is 4/15/24	the ice. for	
	the nurse. Unit Mana nurse was to ask the refused the nurse, sh	, the NA was to report that to ger #1 further stated that the resident and if the resident e was supposed to write a					
	her/his shower despit She indicated if the N completing their show reported that to her so them with additional s	ing the resident had refused the being asked three times. As were having difficulty wers, they should have to she could have provided staff to assist with showers.					
	An interview on 02/29	9/24 at 4:53 PM with the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED		
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OVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	•			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE		
Director of Nursing (struggled with gettin document showers as were currently working stated she expected showers as schedul receive their shower receive a complete lead bath and for it to be further stated if their she expected the number of the receive a complete lead to be further stated if their she expected the number of the receive a complete lead to be further stated if their she expected the number of the receive a complete lead to be further stated if their she expected the number of the receive a complete lead to be further stated if their she expected the number of the receive a complete lead to be further stated if their she expected the number of the receive a complete lead to a chromatic state of their she will be further of the receive she and their she will be further of the receive showers as the receive she will be further of the receive showers as the receive she will be further of the receive showers as the receive showers are the receive showers as t	(DON) revealed they had g the NAs to give and and said it was a process they ing on with the NAs. She it residents to have their ed and said if they did not as, she expected them to be be be bath not a partial bed documented. The DON resident refused their shower, are to document the refusal es.  Is admitted to the facility on es including neurogenic ic autoimmune disorder that tensation and bodily  plan initiated 1/17/24 ea for the resident having an ang (ADL) self-care deficit due une disorder that affects and bodily functions] and The interventions included ies of daily living (ADL), toileting, promote dignity, and provide positive activities.  #51's quarterly Minimum ressment dated 1/17/24 and ence for toilet and bathing. The resident was coded as of bowel and for the presence	F 6	77				
	OVIDER OR SUPPLIER  TY PLACE NURSING A  SUMMARY S (EACH DEFICIEN REGULATORY OF  Continued From page Director of Nursing (struggled with gettin document showers awere currently working stated she expected showers as schedul receive their shower receive a complete both and for it to be further stated if the right shower receive a complete both and for it to be further stated if the right shower receive a complete both and for it to be further stated if the right shower receive a complete both and for it to be further stated if the right shower receive a complete both and for it to be further stated if the right shower receive a complete both and for it to be further stated if the right shower served the right shower receive a complete both and a chronic allower extremities of daily livit to [chronic autoimm movement, sensation for autoimm movement, sen	OVIDER OR SUPPLIER  TY PLACE NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26  Director of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said it was a process they were currently working on with the NAs. She stated she expected residents to have their showers as scheduled and said if they did not receive their showers, she expected them to receive a complete bed bath not a partial bed bath and for it to be documented. The DON further stated if the resident refused their shower, she expected the nurse to document the refusal in their progress notes.  2. Resident # 51 was admitted to the facility on 2/2/21 with diagnoses including neurogenic bladder and a chronic autoimmune disorder that affects movement, sensation and bodily	OVIDER OR SUPPLIER  TY PLACE NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26  Director of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said it was a process they were currently working on with the NAs. 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Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated 1/17/24 revealed total dependence for toilet and bathing. Impaired range of motion was noted to bilateral lower extremities. The resident was coded as always incontinent of bowel and for the presence	OVIDER OR SUPPLIER  345142  STREET ADDRESS, CITY, STATE, ZIP CODE  9200 GLEWATER DRIVE  CHARLOTTE, NC 28262  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26  Director of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said if was a process they were currently working on with the NAs. She stated she expected residents to have their showers, she cacheduled and said if they did not receive their showers, she expected them to receive a complete bed bath not a partial bed bath and for it to be document the refusal in their progress notes.  2. Resident #51 was admitted to the facility on 2/2/21 with diagnoses including neurogenic bladder and a chronic autoimmune disorder that affects movement, sensation and bodily functions.  Resident #51's care plan initiated 1/17/24 revealed to a facily living (ADL), dressing, grooming, toileting, promote independence and dignity, and provide positive reinforcement for all activities.  Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated 1/17/22 revealed total dependence for toilet and bathing, Impaired range of motion was noted to bilateral lower extremities. The resident was cooded as always incontinent of bowel and for the presence	OVIDER OR SUPPLIER  345142  SUMMARY STATEMENT OF DESDIGNOISS  DP PRICTIX  REGULATORY OR LSC. IDENTIFYING INFORMATION)  F677  Continued From page 26  Drivetor of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said it was a process they were currently working on with the NAs. She stated she expected residents to have their showers as scheduled and said if they did not receive their showers, she expected them to receive their showers, she expected them to receive their showers, she expected their book of the stated if the resident refused their shower, she expected the nurse to document the refusal in their progress notes.  2. Resident #51's care plan initiated 1/17/24 revealed a focus area for the resident having an activities of daily living (ADL), self-care deficit due to [chronic autoimmune disorder that affects movement, sensation and bodily functions] and neurogenic bladder and a chronic autoimmune disorder that affects movement, sensation and bodily functions and neurogenic bladder. The interventions included assisting with activities of daily living (ADL), dressing, grooming, toileting, promote independence and dignity, and provide positive reinforcement for all activities.  Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated 1/17/24 revealed total dependence for toilet and bathing, Impaired range of motion was noted to bilateral lower extremities. The resident was cod		

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		345142	B. WING			C <b>03/13/2024</b>
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F 677	care from NA #1. Will care NA #1 was obsestarting under the scribis penis with wash on it. NA#1 continue from under the scrotula abdomen while using washcloth. When the there was visible boweright buttocks and an with the same washowith downward motion bowel movement from scrotum. The NA follower from the result in the same washow with downward motion bowel movement from scrotum. The NA follower from the result in the process continued under the process continued under the perineal region to up was nervous and munitary in the penis and wiped down from the anal area to further stated the shoupper perineal area as scrotal area, and from buttocks. NA #1 state how to provide incontinuence in the penis and wiped down from the anal area to further stated he shoupper perineal area as scrotal area, and from buttocks. NA #1 state how to provide incontinuence in the penis and wiped incontinuence in the penis and wiped down from the anal area to further stated he shoupper perineal area, and from buttocks. NA #1 state how to provide incontinuence in the penis and state in the	#51 receiving incontinence carved wiping the resident rotum and wiping up towards cloth that had soap and water and wiping several more times are up towards the resident's at the same surface of the eresident turned on his side wel movement on his left and all area. NA #1 continued cloth and continued to wipe an and was observed wiping an anal area towards the ded the washcloth to change ing the resident. This notil all bowel movement was sident's skin.  4 at 1:50 PM with NA #1 he had done a good job be care on Resident #51 and do been wiping from lower per perineal area. Stated he st not have been thinking, should have started at the rotoward the anal area, and the upper buttocks. NA #1 and wiped down towards the mand area to the upper ed he had been trained in tinence care.  4 at 4:46 PM with the DON) revealed she would of follow the care plans and	F	577		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 679 SS=H	Continued From pacare and the approbe followed. Activities Meet Interest CFR(s): 483.24(c)(1) The the comprehensive and the preference program to support activities, both facilindividual activities designed to meet the physical, mental, a each resident, encound interaction in the This REQUIREME by: Based on record mand resident and sit to ensure group activities outside of the faciliar residents who expendent to attend group facility for 4 of 5 resident #17, 31, expressed not being the control of the faciliar to the control of the faciliar testidents who expendents who	age 28 priate process was to always prest/Needs Each Resident 1)  es. facility must provide, based on assessment and care plan as of each resident, an ongoing a residents in their choice of ity-sponsored group and and independent activities, the interests of and support the nd psychosocial well-being of ouraging both independence the community. NT is not met as evidenced eview, facility activity calendar, taff interviews, the facility failed tivities were planned for ty to meet the needs of ressed that it was important to up activities outside of the sidents reviewed for activities 35, and 110). The residents ug able to leave the facility for	F 679	1. Transportation arrangements hat been made and an outside activity has been scheduled by the Activities Dire for a resident shopping trip and lunch on 3/21/24. Residents #17,31,35, an were invited to this outing by the Acti Director and attended. On 3/19/2024 facility van was taken to be repaired the vendor by the Transportation	4/15/24  4/15/24  as ector h trip d 110 ivity 4, the by
	less social, sad, and the group to shop a The findings included A review of the February revealed activities the week and on the			Specialist. This repair with an anticip date of completion for 3/26/24 2. On 3/14/2024 a resident council meeting was held by the operation's consultant specific to resident activiti and the following requests were madoutside activities during good weather seasons, a basketball goal and new games. On 3/14/2024 the Operations consultant ordered new board games a basketball goal. The Activities Dire	ies de, er board s s and

345142				(X3) DATE SURVEY COMPLETED	
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OF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE	
	F 6	79			
nutes from February revealed grievances outside of facility luring meetings and revious facility vans was transportation for van was only president medical  30 AM revealed the usiness and ined sidewalks, as within walking and commercial independent of the facility on  (MDS) dated 5/3/23 at it was very at included going g things in a group er indicated intact.  th Resident #17 on ident council of been a scheduled acility in over a year equested one each met with the transport and the facility on the facility in over a year equested one each met with the transport and the facility in obscause the facility was provided to because the facility was provided to because the facility was provided to the facility was provided to because the facility was provided to be a scheduled to be a schedu	F 6	will schedule an outside activity during mild weather months indict the activity calendar.  3. The Administrator in-service Activities Director on developing calendars to meet the residents include outside activities at least monthly during good weather se 3/13/2024. The Activities Director review the monthly activity Caler the next month with resident courincorporate any resident feedback activities and document that in the resident council meeting minutes All new Activities staff will receive in-service during orientation.  4. The Activities Director will sumonthly activity calendar prior to beginning of the month, and resicouncil meeting minutes monthly Administrator to ensure all areas concern are addressed. The Administrator to the Quality As Performance Improvement (QAF committee monthly for 3 months compliance. The Administrator is responsible for the Plan of Correfor sustained compliance.	cated on ed the needs to once ason on or will ndar for incil and ck into the ne s monthly. e the ubmit the dent of to the s of ministrator sident ssurance PI) to ensure s cction and		
	DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)  That the street of the	PRECEDED BY FULL PREFIX TAG  TO DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)  For the strome February revealed grievances outside of facility uring meetings and revious facility vans was transportation for rown was only to resident medical  30 AM revealed the usiness and ined sidewalks, as within walking and commercial indicommercial indicated indicated intact.  The Resident #17 on ident council on been a scheduled indicitive in over a year equested one each met with the tand each time was build do because the In no other way to	SILITATION CENTER  SILITATION CENTER  DEFICIENCIES PRECEDED BY PULL PRECEDED BY PULL FYING INFORMATION)  TAG  DEFICIENCIES PRECEDED BY PULL PRECEDED BY PULL FYING INFORMATION)  TAG  DEFICIENCY  Will schedule an outside activity. during mild weather months individe activity calendar. 3. The Administrator in-service activities Director on developing calendars to meet the residents include outside activities at least monthly during good weather se and ined sidewalks, is within walking dommercial and commercial indicommercial indicommercial indicommercial and commercial indicommercial ind	STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262  PRECEDED BY FULL FYING INFORMATION)  F 679  INUTES from February revealed grievances outside of facility uring meetings and revious acility vans was transportation for van was only or esident medical  30 AM revealed the usiness and ined sidewalks, us within walking id commercial ti-down restaurants.  (MDS) dated 5/3/23 at it was very at included going g things in a group er indicated intact.  h Resident #17 on ident council ot been a scheduled cility in over a year equested on no each met with the tand each time was full do because the In oo other way to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	•	0/10/2024		
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F 679	important to the reand participate be lasting independe and outside world and physical heal that they weren't j #17 stated not be year and participate facility had somet she had lost some was having to rely personal shopping revealed personal shopping and socoutside of the facil Resident #17 ask resident council matheir concerns with able to schedule a over the past year was to all of them.  b. Resident #31 was 3/31/15.  An Admission Mir 10/28/23 indicated very important to going outside of the group setting. The Resident #31 was 2/28/24 at 2:00 Pl meeting revealed year that they we group activities outside world and participated year that they we group activities outside world and participated year that they we group activities outside world and participated year that they we group activities outside world and participated year that they we group activities outside year that they we group activities year.	attside of the facility were esidents that were able to go cause it allowed them some nce, socialization with the group, and helped with their mental th, it made them feel normal and ust stuck in a facility. Resident ing able to leave the facility in a atte in group activities outside the imes made her feel as though the of her own independence and to on someone else to do her og instead of on her own. She ally being able to do her own ializing with other people lity was very important to her. The ed surveyor at the end of the end if she promised to share the administration about not being activities outside of the facility or and how important this matter	F 6	79				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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F 679	Continued From pa	ge 31 en. He stated he asked about	F 6	79		
	pay for if they wante to insurance reasor past year they have facility for any outin appointment and af looking at the inside began shaking his be towards the floor ar eat at a restaurant a going into a store a own personal belon independent and no being able to do the had made him less on staff and not as would just like the of things again.	tion that the residents could ed to and was also told no due as. He also stated that for the enot been able to leave the gs other than to a doctor's ter a while they get tired of e of the facility. Resident #31 nead and looking down and revealed that going out to and talking with the group or and being able to shop for your gings made you feel formal, and he felt that not use things over the past year independent and more reliant social as he used to be and he apportunity to have those				
	5/2/16.  An Annual Minimum 6/11/23 indicated R very important to ha going outside of the group setting. The a Resident #35 was considered at 2:00 PM meeting revealed stresident council had to the Administrator schedule group actiand each time was because the van was	n Data Set (MDS) dated esident #35 felt that it was ave activities that included efacility and doing things in a assessment further indicated cognitively intact.  Inducted with Resident #35 on during resident council the knew for a fact that d made numerous grievances about not being able to vities outside of the facility told that was not possible as broken, and they had no sidents. She revealed they				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	ZIP CODE	03/13/2024
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F 679	activities inside of the of the facility and the of finding a different of transportation. Resid go outside of the faci important to her because with her friends, and health and allowed health and allowed health and allowed health and intervented in the facility and miss what the wealth in the facility and interview was correctly on the facility of the facility of the facility in the facility of	rould have to continue with a building or on the grounds are was never any discussion way to help with ent #35 stated being able to lity for group activities was ause she enjoyed interaction it helped with her mental er some independence. She cole to have group activities had made her sad at times corld outside the facility was admitted to the facility on Data Set (MDS) dated sident #110 felt that it was a cativities that included facility and doing things in a desessment further indicated	F 6	579		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		COMP	B) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	DDE	1 03/	13/2024	
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F 679	and gave her a brea building all the time	munity in a different setting k from being inside the and made her feel good.	F 6	79				
	Director (AD) on 02/she had been working the past 2 years and was scheduling and activities inside and month. She stated powould schedule more to attend outside of the eat at a restaurant, so the past year she schedule any reside the facility due to transportation for over a year and substantial administrator the other for over a year and substantial administrator the other for over a year and substantial administrator the other for over a year and substantial administrator the other for over a year and substantial administrator the other for over a year and substantial administrator the other for over a year and substantial administrator the other for over a year and substantial administrator the other for over a year and substantial administrator the other facility or on fa	nducted with the Activity 28/24 at 2:30 PM revealed ag as the AD at the facility for a part of her responsibilities implementing resident outside of the facility for each rior to this past year, she athly outings for the residents the facility such as going to shopping, or the movies, but a had not been able to not group activities outside of asportation issues. She facility vans had been broken she was told by the previous per facility van could only be cointments and residents articipate in activities inside of lity grounds. The AD stated issue to Administration ents requesting to schedule the facility and each time was an sportation and alternate are residents was never aled she had been doing for residents so they could their preferences but not the same as the to leave the facility and shop at a meal together at a a movie outside of the facility. Ke activities outside of the dents who could participate						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	03/13/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 679	Continued From page		F 679	9	
	•	eir overall mental and and allowed them some			
F 686 SS=D	facility and she was uneeding repair and reparticipate in activitie the past year. She stathe issue and see whomethods were availal assist with the reside in activities outside owith the vans could be	29/24 at 5:15 PM she r first week of work at the unaware of the facility vans esidents not having been to s outside of the facility over ated she would investigate at alternative transportation ble that could be used to nts being able to participate of the facility until the situation e resolved. event/Heal Pressure Ulcer	F 68	6	4/15/24
	§483.25(b) Skin Integ §483.25(b)(1) Pressults Based on the compressional, the facility in (i) A resident received professional standard pressure ulcers and dulcers unless the individemonstrates that the (ii) A resident with pronecessary treatment with professional star promote healing, present ulcers from devertibles and the compressional star promote healing, present ulcers from devertibles. Based on observation interviews, the facility	grity lire ulcers. The hensive assessment of a must ensure that- s care, consistent with the discontinuous develop pressure vidual's clinical condition the ey were unavoidable; and the essure ulcers receives and services, consistent and ards of practice, to went infection and prevent		F686 Treatment/Services to Prevent/F Pressure Ulcer	<del>-l</del> eal

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
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	10115211 011 001 1 2.2.1			9200 GLENWATER DRIVE	. 0052	
UNIVERSI	TY PLACE NURSING AN	ND REHABILITATION CENTER		CHARLOTTE, NC 28262		
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F 686	Continued From page	e 35	F 6	86		
	outer ankle) on 1 of 3 reviewed for wound of	3 residents (Resident #128) care.		1.On 2/22/24, the fa ordered a wound treatment of the control	ent to "cleanse	
	The findings included			Dermasyn hydrogel aligi wound bed, cover with g	nate (AG) to gauze, and dry	
		dmitted to the facility on		dressing" for resident #1		
	11/24/22 and readmit			the facility physician ord		
		uded congestive heart isease, dementia, and		treatment to "Cleanse R with wound cleanser, ap		
	osteoarthritis.	isease, dementia, and		cover with dry dressing"  On 3/15/2024 The U	for resident #128.	
	Review of Resident #	t128's quarterly Minimum		Managers/Director of Nu		
		essment dated 02/06/24		(DON)/Assistant Directo	•	
		ely/never understood and		(ADON) initiated skin ch		
	rarely/never understa	ands and had no speech.		residents. This was done	e to identify any	
		revealed she was severely		resident with new skin co		
	impaired and was de	₹`		wounds. All concerns wi		
		ctivities of daily living (ADL)		assessed, treatment initi		
	-	er needs. The assessment		Medical Director (MD)/R		
	-	she had two unhealed stage		Representative (RR) we		
	device for bed, nutriti	d had pressure reducing on, and hydration		documentation complete Ulcer Flowsheet or Non-		
		age skin problems, pressure		incident report complete	d for any newly	
		cation of medications and		identified wounds and ca	are plan updated.	
	dressings.			All areas of concern will	•	
				addressed by the DON t		
	Review of Resident #			assessment of resident,	•	
		d (TAR) dated 02/01/24		incident report, notification		
		ealed the following orders for		initiating treatment per M		
	wound care:			documentation in Wound		
	1 Cleaned the right of	outer ankle with wound		or Non-Ulcer Flowsheet	and updading	
	_	outer ankle with wound orm (petroleum-based fine		care plan.		
		antimicrobial properties		• On 3/20/2024 the w	ound nurse who	
		ng), and cover with dry		administered wound trea		
		hift (7:00 AM to 7:00 PM) for		#128 on 2/28/24 during		
	wound healing.	( 1221 12 1, 121		received an in-service re		
	3			Wound Process with em		
	2. Cleanse the left kn	ee with wound cleanser,		assessing, initiating trea	-	

OLIVIEI	OT OIT MEDIO, TILE OF	WEDIO/ ND CEITTIGEC				<del></del>	<del>7. 0000 000 1</del>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDII	NG		,	c
		345142	B. WING _				13/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER			200 GLENWATER DRIVE		
				С	HARLOTTE, NC 28262		
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F 686	Continued From page	26		200			
F 000	Continued From page		F (	686			
		ogel AG (antimicrobial silver			notification of the physician/resident		
		ates moist wound healing),			representative for all newly identified s		
		I dry dressing every day shift			concerns or changes in wound status ( Treatments/Treatment Administration	2)	
	(7:00 AM to 7:00 PM)	) for wound nealing.			Record (TAR) documentation with		
	An observation of we	und care was made on			emphasis on nurse responsibility to		
		/28/24 at 9:13 AM with the			complete treatments in the absence of		
		ne Treatment Nurse gathered			treatment nurse, signing TAR immedia		
		our wounds and began with			after completing treatment and notifica	-	
	the right outer ankle			of the physician if treatment cannot be			
		I the wound with wound			completed for further instructions.		
	J .	ze and applied hydrogel			<ul> <li>On 3/15/2024, the facility Unit</li> </ul>		
	_	d covered it with a bordered			Managers initiated a 100% skin check	on	
		Treatment Nurse then			all residents. This audit is to identify an		
	moved to the left kne	e, removed the old dressing,			resident with new skin concerns or		
	cleaned the wound w	rith wound cleanser and			wounds. All concerns will be properly		
	applied xeroform gau	ze to the wound bed and			assessed, treatment initiated as indica	ed,	
		lered gauze dressing. As			MD/RR notified, documentation		
		he left knee dressing, the			completed in the Wound Ulcer Flowshe		
		d, "I think I mixed up my			or Non-Ulcer Flowsheet, incident repor		
	dressings."				completed for any newly identified wou and care plan updated. All areas of	nds	
	An interview on 02/29	9/24 at 9:59 PM with the			concern will be immediately addressed	by	
	Treatment Nurse reve	ealed she realized while			the DON to include assessment of	-	
	doing the left knee the	at she had mixed up the			resident, completion of incident report,		
	_	ht outer ankle and left knee			notification of MD/RR, initiating treatme		
		wrong treatments to the			per MD orders, documentation in Woul		
		she was nervous about			Ulcer Flowsheet or Non-Ulcer Flowshe	et	
	being watched and ha				and updating care plan. Audit will be		
	_	wo wounds even though she			completed by 4/5/2024		
	had labeled the treatr	ments for each wound.					
		2/04   44 54 484   ''' ''			On 3/21/2024, the DON initiated a	n	
		9/24 at 11:51 AM with the			audit of all treatment administration		
		OON) revealed she expected			records (TAR) for all residents from		
		s to be done as prescribed			3/19/24-3/20/24. This audit is to ensure		
		e stated she thought the			treatments were completed per physici	an	
		s nervous about being			order with documentation on the TAR.		
	_	nd care and just got the two			The DON will address all concerns		
	wound treatments mi	xeu up.			identified during the audit to include		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	ULTIPLE CONSTRUCTION  LDING		(X3) DATE SURVEY COMPLETED		
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UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER		HARLOTTE, NC 28262			
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					DEFICIENCY)		
F 686 Continued From page 37		e 37	F	686			
				assessment of the resident, initiating treatment per physician order, notification of the physician of treatment omission/wound status for further recommendations and education of states.	ff.		
					<ul> <li>The audit will be completed by 4/5/202</li> <li>On 3/19/24, the SDC initiated an</li> </ul>	4.	
					in-service with all nurses regarding (1) Wound Process with emphasis on		
					assessing, initiating treatment and notification of the physician/resident		
					representative for all newly identified sl concerns or changes in wound status (		
					Treatments/TAR documentation with emphasis on nurse responsibility to		
					complete treatments in the absence of treatment nurse, signing TAR immedia	telv	
					after completing treatment and notification of the physician if treatment cannot be	•	
					completed for further instructions. The	4	
					in-service will be completed by 4/5/202 After 4/5/2024, any nurse including	4.	
					agency nurse who has not worked or received the in-service will complete		
					in-service before next scheduled work shift. All newly hired nurses will be		
					in-serviced during orientation regarding	1	
					Wound Process and TAR Documentation/Treatments		
					The IDT team to include Minimum  Data Set Nurse Nurse Supervisor, and	ı	
					Data Set Nurse, Nurse Supervisor, and Administrator will review Treatment		
					Administration Report 5 times a week a weeks then monthly x 1 month and 1 times a SDC/DON will absorbe 3		
					weekly the SDC/DON will observe 2 resident treatments being performed; the state of		
					audit will ensure the correct treatment	per	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE C		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAIVIE OF PI	ROVIDER OR SUPPLIER						
UNIVERSI	TY PLACE NURSING AN	D REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	6 Continued From page 38		F 68		Physician order is being done. This audis to ensure treatments were completed per physician order and that the nurse documented on TAR following treatment. The DON will address all concerns identified during the audit to include completing treatment per physician order assessment of the resident, notification the physician for any missed treatment and re-training of staff. The DON will review the Treatment Administration Report 5 times a week x 4 weeks then monthly x 1 month to ensure all concertare addressed.  • The DON will present the findings the Treatment Administration Report to the Quality Assurance Performance Improvement (QAPI) committee month for 2 months. The QAPI Committee will meet monthly for 2 months and review Treatment Administration Report to determine trends and/or issues that maneed further interventions put into place and to determine the need for further frequency of monitoring. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance.	d nt. ler, n of s of ly the ay e	
F 689 SS=D	Free of Accident Haza CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F	689	Date of Compliance 4/15/2024		4/15/24
	§483.25(d) Accidents The facility must ensu §483.25(d)(1) The res						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2024
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UNIVERSI	TY PLACE NURSING AN	D REHABILITATION CENTER			CHARLOTTE, NC 28262		
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F 689	Continued From page 39		F6	389			
	as free of accident ha	zards as is possible; and					
	supervision and assis accidents.	esident receives adequate stance devices to prevent					
	Based on record revi facility failed to compl	iew and staff interviews the lete a quarterly smoking			F689 Free of Accidents, Hazards, Supervision, Devices and Devices		
	assessment 1 of 3 res (Resident #75).	sidents reviewd for smoking			<ul> <li>Resident #75 is no longer a smoke per resident choice and does not need smoking assessment. Progress note</li> </ul>		
	The findings included:				completed with resident desire to no longer smoke; care plan updated to be	а	
	Resident #75 was ad	mitted to the facility on			non-smoker.		
	02/13/20 with hyperte	ension.			<ul> <li>On 3/25/24, the Regional Nurse Consultant audited all resident smoker</li> </ul>	s	
		75s quarterly Minimum Dat			for smoking assessments. All residents	;	
	,	4/23 revealed the resident			have current Smoking Assessments.		
		red and was independent for			On 3/22/24, Staff Development		
	most activities of daily	y living (ADL).			Coordinator (SDC) initiated education the nurses to include agency nurses or		
		75's care plan revised on			completing all assessments for Reside	nt	
		e resident had problematic			Smoking Assessment, supervised		
		resident acts characterized			smoking residents' assessments are		
		ne goal was for resident #75			completed quarterly. The quarterly		
	to smoke safely in de	-			assessments are automatically genera	ted	
		he next review. Interventions			by the Point Click Care (PCC) system		
		esidents ' ability to smoke			quarterly, based on the admission		
	safely on a consisten	t and regular basis.			Smoking assessment results. The nurs and agency nurses not attending the	es	
	Review of Resident #	75's quarterly smoking			in-service on 3/22/24 will receive the		
	assessments reveale	d the resident did not			training before their next scheduled shi	ft,	
	receive a quarterly sn	noking assessment from			to be completed by 4/15/24. The training	ıg	
	09/27/23 until 01/27/2	24.			will be provided to all new nurse hires agency nurses during orientation.	and	
	A joint interview was	conducted with the MDS			<ul> <li>On 3/25/24, Minimum Data Set (M</li> </ul>	IDS)	
		DS coordinator #2 on			/Director of Nursing (DON) /Assistant	,	
		revealed Resident #75 was			Director of Nursing (ADON) will audit 3	,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l \ '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345142	B. WING			C / <b>13/2024</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2024
				9200 GLENWATER DRIVE		
UNIVERSI	TY PLACE NURSING AN	D REHABILITATION CENTER		CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689 F 725 SS=E	have been completed revealed Resident #7 smoking assessment 01/27/24 and could not updated in the quarter. An interview conducter Nursing (DON) on 02 Resident #75 should smoking assessment unsafe smoker. It was DON she was not aware completed assessment completed prior to 01. An interview conducter 02/29/24 at 5:15 PM is considered unsafe smoking assessment Administrator stated at the be completed in a sufficient Nursing State CFR(s): 483.35(a) Sufficient	and an assessment should a quarterly. It was further 5 did not receive a quarterly from 09/27/23 until of recall why it was not recall when are Resident and a quarterly completed due to being an a further revealed by the are Resident #75 had a late not and it should have been 1/27/24.  The with the Administrator on revealed residents who are nokers should have a completed quarterly. The she expected assessments timely manner.	F 68	resident smokers weekly to review pr week's documentation to ensure no change in condition that would warran new assessment or change in resider smoking preference. DON/ADON/UM audit 3 resident smokers monthly x 2 months. The DON will submit the find of the audit to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to er compliance. The Director of Nursing i responsible for the Plan of Correction the Administrator for sustained compliance.  • Date of Compliance 4/15/24.	nt a nts will ings nsure s	4/15/24
	the appropriate comp provide nursing and r resident safety and at practicable physical, I well-being of each res resident assessments and considering the n diagnoses of the facil	etencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345142	B. WING _		03	C 3/13/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
I INIVEDSI	TV DI ACE NUIDRING AN	ND REHABILITATION CENTER		9200 GLENWATER DRIVE			
UNIVERSI	IT PLACE NORSING A	NO REHABILITATION CENTER		CHARLOTTE, NC 28262			
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F 725	725 Continued From page 41		F 7	25			
	§483.35(a)(1) The fa by sufficient numbers types of personnel or nursing care to all re- resident care plans: (i) Except when waiv this section, licensed (ii) Other nursing per limited to nurse aides §483.35(a)(2) Excep- paragraph (e) of this	cility must provide services sof each of the following in a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not so.					
	nurse on each tour o This REQUIREMEN by:	f duty. Γ is not met as evidenced		Madienties			
	and staff interviews, sufficient nursing star administered medica orders for 8 of 16 res significant medication #47, #51, #73, #79, #	n errors (Residents #7, #28, #88, and #110) and provide vers and hair washing for 1 of d for assistance with		<ul> <li>Medication error reports of completed, and the Medical Dinotified for Resident #7, #28, #73, #79, #88 and #110 by the Nurse (RN) on 12/10/2023. Viswere collected, and no adversional related to the medication error found on 12/15/2023 for the arresidents. Resident #94 receives shower on 2/27/24 and on 3/1 thereafter, as to follow the shortest in the shortest resident.</li> </ul>	virector was #47. #51, e Registered ital signs se outcomes rs were ffected ved a /24		
		d: admitted to the facility on agnosis of diabetes mellitus.		schedule of the resident. Skin assessments completed on re 2/20/24, 3/5/24 and 3/19/24 re new skin integrity issues.	esident #94		
	was severely cognitive was coded as received assessment period.	Data Set (MDS) 1/20/23 revealed Resident #7 vely impaired. Resident #7 ed insulin 7 times during the s orders for December 2023		• On 3/20/2024, The Direct Nursing (DON) completed an resident medical records from and 12/27/2023 which did not additional medication errors. (3/18/2024, a full facility audit skin, using the skin assessme	audit of 12/10/2023 indicate any On of resident		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	1 1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2024
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725 Continued From page 42		e 42	F 7	25			
	for Insulin Detemir so (ml), inject 13 units a an order dated 11/06	ded an order dated 08/07/23 slution 100 units per milliliter t bedtime for diabetes and /2023 for Novolog flex pen 100 units/ml sliding scale ay for diabetes.			<ul> <li>initiated to identify other residents who could be impacted by inconsistency in completing showers. This audit will be completed by 4/5/24.</li> <li>On 3/20/2024 Director of Nursing</li> </ul>		
	A Medication Administration December 2023 reversions 13 units, soft documented as given Novolog flex pen slid for 8:30 PM was not 12/10/2023.	stration Record (MAR) dated aled the Insulin Detemir neduled for 8:00 PM, was not n on 12/10/2023 and the ing scale insulin scheduled documented as given on			(DON) and Staff Development Coordinator (SDC) initiated an in-service to all nurses and medication aide regarding proper notification to Director Nursing in any case of an absence or tardy that will cause the medication can not to be attended, so a nurse or medication aide can be scheduled to cover the absence or tardiness. On	r of	
	11/30/2022 with a dia anxiety, diabetes me	admitted to the facility on gnosis of hypertension, litus and heart failure.			3/20/2024 DON and SDC initiated an in-service to all Nurses, medication aid including agency nurses and medication aides regarding the 6 rights of medication administration which includes verifying	on ion	
	#28 was cognitively intended to have received assessment period.	/12/2023 revealed Resident ntact. Resident #28 was ed insulin 5 times during the The MDS revealed Resident osychotic medication during			administration which includes verifying resident's identity prior to medication administration and administering medications as ordered and document medications by the nurse. Nurses, medication aides, agency nurses and medication aides not in-serviced by 4/14/24 will not be allowed to work until	ing	
	for Resident #28 incli 11/10/23 for Lantus S units/ml, inject 10 uni an order dated 11/09 tablet 6.25 mg 1 table for heart failure and a Seroquel 25 mg give a day for depression.	Solostar pen-injector 100 ts at bedtime for diabetes, /2023 for Carvedilol oral et by mouth two times a day an order dated 11/09/23 for 1 tablet by mouth two times			the education is completed by the DON/SDC. After 4/14/24, all new nurse medication aides and agency nurses a medication aides will be educated on the rights of medication administration before working by the DON/SDC. On 3/19/2024 Administrator met with staffing scheduler to begin implementation of a shower team each day Monday-Saturd to ensure resident showers are given process.	es, nd ne ng lay per	
	A Medication Administration Record (MAR) dated December 2023 revealed the Lantus Solostar				schedule and preference. On 3/20/202  DON and SDC initiated an in-service to		

PREFIX (EACH DEFICIENCY TAG REGULATORY OR LE	345142  D REHABILITATION CENTER  ITEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD 9200 GLENWATER DRIVE CHARLOTTE, NC 28262  PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	<b>03</b>	C /13/2024
UNIVERSITY PLACE NURSING ANI  (X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LE	D REHABILITATION CENTER  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	9200 GLENWATER DRIVE CHARLOTTE, NC 28262 PROVIDER'S PLAN OF CC	DE .	113/2024
UNIVERSITY PLACE NURSING ANI  (X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LE	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	PREFIX	9200 GLENWATER DRIVE CHARLOTTE, NC 28262 PROVIDER'S PLAN OF CC		
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LE	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	PREFIX	CHARLOTTE, NC 28262  PROVIDER'S PLAN OF CO		
PREFIX (EACH DEFICIENCY TAG REGULATORY OR LE	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO		
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F 705 0 1: 15			CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 725 Continued From page	43	F 7	25		
pen-injector 100 units/tablet 6.25 mg and Se 8:00 PM, were not doc 12/10/2023.  c. Resident #47 was a 10/13/2019 with a diag schizophrenia and and A quarterly Minimum E assessment dated 10/ #47 was severely cog #47 was coded as recomedication, antianxiet antidepressant medication. The active physician's for Resident #47 inclu 02/19/22 for Seroquel mouth at bedtime for r 03/10/22 for Lorazepa a day for agitation, an Trazodone 125 mg by insomnia and an order Percocet oral tablet 10 mouth three times a diagram A Medication Administ December 2023 reveating Trazodone 125 mg, Lo Percocet oral tablet 10 PM were not documer 12/10/2023.	In 10 units, Carvedilol oral proquel 25 mg scheduled for cumented as given on admitted to the facility on gnosis of depression and xiety.  Data Set (MDS)  Out/2023 revealed Resident eleving antipsychotic ymedication, ation and opioids.  Forders for December 2023 ded an order dated 200 mg give 1 tablet by mood, an order dated im 1 mg by mouth two times order dated 08/25/22 for mouth at bedtime for a dated 04/07/23 for 0-325mg give 1 tablet by ay for severe pain.	F 7:	Certified Nursing Assistant (Cregarding protocol for giving scommunication with their Nur Manager (UM) or DON/ADON showers cannot be given. An Nursing Assistant (C.N.A.) no by 4/14/24 will not be allowed the training is completed by a All new and agency C.N.A. w same training upon hire.  The Administrator will me staffing scheduler daily to rev x5 days per week and ongoin a shower team is in place, an carts are covered. Shower sh secondary piece of document point of care will be brought to Interdisciplinary Team (IDT) to Manager (UM) for review and against shower schedule dail week x4 weeks and then week months. The Director of Nurs responsible for the Plan of Cothe Administrator for sustaine compliance.  Date of compliance 4/15/	showers and see, Unit N when y Certified of in-serviced of to work until an SDC/DON. Fill receive the seet with the riew staffing and to ensure and all nursing seets (as a station to to o The by Unit I confirmed by 5 days per sekly x2 ing is orrection and sed	
	gnosis of diabetes mellitus				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			C 03/13/2024	
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER		9200	EET ADDRESS, CITY, STATE, ZIP CODE O GLENWATER DRIVE ARLOTTE, NC 28262	1 00	10/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 725	#51 was moderately of Resident #51 was condays during the asset revealed Resident #5 anticoagulant during. The active physician's for Resident #51 included 11/15/22 Insulin Glarginject 12 units at bedded dated 11/15/22 for Elitwo times a day for all order dated 7/16/23 for tablet by mouth two times a day for all order dated 7/16/23 for tablet by mouth two times a day for all order dated 7/16/23 for tablet by mouth two times and Medication Administrates December 2023 reversolution 100 units/ml and Metformin 500 m were not documented e. Resident #73 was 06/19/2023 with a diameter of the Medication Minimum I dated 10/30/2023 reversidated 10/30/2023	a/30/2023 revealed Resident cognitively impaired. ded as receiving insulin on 7 issment period. The MDS is 1 had received an the assessment period. It is orders for December 2023 anded an order dated gine solution 100 units/ml time for diabetes, an order iquis tablet 5 mg by mouth inticoagulant therapy and an or Metformin 500 mg 1 imes a day for diabetes. It is a day for diabetes. It is a day for diabetes and a diabetes. It is a day for diabetes and a	F	725			
	for Resident #73 inclu	ne 50 mg 1 tablet by mouth					
	December 2023 reve	stration Record (MAR) dated aled the Trazodone 50 mg M was not documented as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE  200 GLENWATER DRIVE	<u>  US/</u>	13/2024	
UNIVERSI	TY PLACE NURSING AN	D REHABILITATION CENTER			CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 725	Continued From page	<del>2</del> 45	F 7	725				
	given on 12/10/2023.							
		dmitted to the facility on gnosis of diabetes mellitus.						
	#79 was moderately of	/16/2023 revealed Resident cognitively impaired. ded as received insulin on 7						
	for Resident #79 inclu	largine solution 100 units/ml						
	December 2023 reveal solution 100 unit/ml 2	tration Record (MAR) dated aled the Insulin Glargine units scheduled for 9:00 ited as given on 12/10/2023.						
	10/02/2020 with a dia	admitted to the facility on gnosis of hypertension, nary artery disease (CAD).						
	A quarterly Minimum assessment dated 10 #88 was severely cog	/15/2023 revealed Resident						
	for Resident #88 inclu 03/31/22 for Metoprol	s orders for December 2023 ided an order dated ol Tartrate 25 mg give 0.5 mes a day for heart failure.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			C <b>03/13/2024</b>
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	° CODE	00,10,202
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F 725	Continued From page	e 46	F7	725		
	I .	s admitted to the facility on agnosis of hypertension and				
	A quarterly Minimum assessment dated 12 #110 was cognitively	2/01/2023 revealed Resident				
	for Resident #110 inc 1/10/23 for Carvedilo two times a day for h dated 12/04/23 for Ar	s orders for December 2023 cluded an order dated I 3.125mg 1 tablet by mouth ypertension and an order moxicillin 500 mg give 1 imes a day for a bacterial				
	December 2023 reve and Carvedilol 3.125	stration Record (MAR) dated aled the Amoxicillin 500 mg mg scheduled for 8:00 PM d as given on 12/10/2023.				
	PM with Nurse #1. SI was working the 7:00 assigned to Resident #47, Resident #51, R Resident #88, and Rerevealed Nurse #2 has PM stating she would the 7:00 PM to 11:00 resident assignment. #2 she would need to let them know. The ir told Unit Manager #1 #2 would be coming assigned shift. She s was given to Nurse #	ducted on 02/28/24 at 4:00 ne stated on 12/10/23 she AM to 7:00 PM shift #7, Resident #28, Resident esident #73, Resident #79, esident #110. The interview ad contacted her after 12:00 I not be coming into work for PM shift to take over the She stated she told Nurse o contact management and aterview revealed she then that she did not think Nurse into the facility for her tated report on the residents 3, Nurse #4 and Nurse #5 Unit Manager #1 to split the				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345142	B. WING			C	
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		03/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO T  DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 725	medication cart. The offered to stay over to PM to 11:00 PM but with escheduler. She stay 7:00 PM.  An interview conduct with Unit Manager #1 was notified later in the Nurse #2 was not go scheduled 7:00 PM to she called the scheduled the facility and Direct them know they were The interview reveale get in touch with Nurse #1 they would need to stay they would need to stay they would look at the medical too many resider then left the facility at until 12/12/23 that the received their schedule evening of 12/10/23.  An interview was atted 20/28/24 and on 02/2 call received.  An interview was atted 44 and Nurse #5 on 0 phone call received.  An interview conduct with the Director of Nurse with t	interview revealed she had a cover the shift from 7:00 was told it was necessary by ated she left the facility at ed on 02/28/24 at 3:36 PM revealed on 12/10/23 she he day by Nurse #1 that ng to come in for the of 11:00 PM shift. She stated aller who no longer works in for of Nursing (DON) to let e going to be a nurse short. Ed the scheduler could not see #2 so Unit Manger #1 as, Nurse #4 and Nurse #5 polit the medication cart for PM shift. She stated Nurse ed to get some food and dication cart when she #5 stated the medication cart ints to split. She stated she in 7:00 PM and did not know	F	725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			03/	13/2024	
	ROVIDER OR SUPPLIER  TY PLACE NURSING AI	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD BE		(X5) COMPLETION DATE	
F 725	7:00 PM to 11:00 PM Manager #1 told her Nurse #5 were instrucant and had taken restated she heard the residents had not recinterview revealed the the assigned resident other 8 residents Resident #47, Resident #79, Resident #79, Resident #79, Resident #79, Resident #79, Resident #79, Resident #10 assigned half and the going to administer the medication. The DON communication error interview revealed the obtained on 12/11/23 levels for the diabetic adverse outcomes had no residents need to not receiving their.  2. Resident #94 was 08/21/23 with diagnomellitus type II, vitamanorexia.  Review of Resident #10 Data Set (MDS) asservealed she was seand required total as bathing. The assessified #94 had no rejection.	se #2 had called out for the I shift. She stated Unit that Nurse #3, Nurse #4 and cted to split the medication eport on the residents. She next morning that some revived their medication, but the sident #7, Resident #28, ent #51, Resident #73, ent #88 and Resident #110 cheduled medication. She her she had completed her ought someone else was ne rest of the residents' N stated it was a between the nurses. The e residents vital signs were a along with blood glucose or residents. She stated no ad occurred from the incident reded medical treatment due medication.  admitted to the facility on ses which included diabetes ain deficiency, dementia, and essment dated 02/21/24 verely cognitively impaired sistance with showering and ment also revealed Resident	F	725				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345142	B. WING _		,	C 03/13/2024	
	ROVIDER OR SUPPLIER  TY PLACE NURSING A	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	· · · · · · · · · · · · · · · · · · ·		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 725	included personal h substantial/maximal showering/bathing of An observation and on 02/26/24 at 11:4 sitting in her wheeld the day. The resided disheveled, and she her showers as sch Resident #94 further showers because so washed when she which the resident rowas scheduled for seriday on 1st shift (*)  Review of the documentation revealed for the more received one showed days she was scheduled for the more ceived one showed days she was scheduled for the more received one showed days she was scheduled for the more received one showed days she was scheduled for the more received one showed days she was scheduled for the more received one showed days she was scheduled for the more received one showed days she was scheduled for the more received one showed days and the following was documentation Tuesday, 02/13/24 documentation Tuesday, 02/20/24 Friday, 02/23/24 complete bed bath)  A telephone interview with Nurse Aide (National States) and the following was documentation Tuesday, 02/23/24 complete bed bath)	o dementia. The interventions ygiene with assistance and dependent on staff.  interview with Resident #94 2 AM revealed the resident chair in her room, dressed for not's hair appeared greasy and estated she was not getting eduled two times per week. It is taken to get her hair was bathed.  er schedule for the hall on esided revealed Resident #94 showers on Tuesday and 7:00 AM to 3:00 PM).  mentation of showers in the eccord for Resident #94 onth of February she had only er on 02/27/24. On the other duled for showers the mented:  no indication or  no shower or bed bath given partial bed bath (not a	F 7:	25			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			C 03/13/2024	
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262			10/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	·			(X5) COMPLETION DATE
F 725	25   Continued From page 50		F	725			
	wash them up in bed bath but said it was n #8 stated she could r given Resident #94 a	them a shower, she would and document it as a partial ot a complete bed bath. NA not recall why she had not shower on 02/06/24 or vas most likely due to staffing					
	#12 who was assigned on 02/09/24 revealed resident and had give instead of a shower it to shower the resider short of help sometime.	8/24 at 10:34 AM with NA ed to care for Resident #94 if she was assigned to the en her a complete bed bath it was due to not having time nt. She stated they were nes and it was less we residents a bed bath than					
	who was assigned to 02/23/24 revealed sh had not given the res scheduled. She state worked short of help one of those days wh give the resident a sh bed and documented further stated when s tried to cut their nails	care for Resident #94 on e could not recall why she ident a shower as d there were days they and that could have been hen she did not have time to nower and just bathed her in it as a partial bath. NA #7 he showered residents, she and shave them as needed ve time to do so due to					
	Manager #1 revealed Resident #94 was no scheduled and said r She indicated if the N completing their show	9/24 at 3:10 PM with Unit I she was not aware It receiving her showers as to one had reported it to her. IAs were having difficulty wers, they should have to she could have					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N NI IMBED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, a Boile			(	2
		345142	B. WING			l	13/2024
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		92	REET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWATER DRIVE HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	An interview on 2/29 Nursing Scheduler v for the last two monthat all call ins by nu of Nursing (DON) who be filled. The Nurfilled out the schedupick up extra hours a picking open shifts. was the call ins and the opening. The sowas not on call and Friday 8:00 AM to 50 the weekends, it fall open positions. The not aware of a situal nurse for a cart whe and take care of the indicated the following she was expected to went on to say that it levels of staffing in the toget positions filled that it happens at time can be done about in the can be	staff to assist with showers.  2/23 at 12:30 PM with the who has been in her position ths. The Scheduler revealed arsing staff go to the Director the then tells her what needs using Scheduler stated she les in advance, so staff can and staff were good about She explained the problem trying to find someone to fill cheduler further stated she worked Monday through 100 PM so after hours and on 100 son nurse management to fill excheduler stated she was atton where there was not a 100 nother nurses did not step up 100 cart. The Nursing Scheduler 100 maintain. The Scheduler 100 two shard to keep those 100 maintain. The Scheduler 100 two staff were not short, but 100 nes and there is nothing that 100 the shift 100 ness and 2 nurses 100 maintain. The Scheduler 100 staff were not short, but 100 ness and there is nothing that 100 ness and 2 nurses 100 ness	F	725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			C 03/13/2024
	ROVIDER OR SUPPLIER  TY PLACE NURSING A	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE
F 725	Director of Nursing expect nursing staff manner when they so that the facility h position. They have on their website and staffing agency to a An interview on 02/Director of Nursing struggled with gettin document showers were currently work stated she expected showers as schedureceive their shower receive a complete bath and for it to be	ge 52  24 at 4:46 PM with the (DON) revealed she would to communicate in a timely are not going to report to work as time to try and fill the open be been posting open positions did have recently started using a ssist with staffing levels.  29/24 at 4:53 PM with the (DON) revealed they had and said it was a process they ing on with the NAs. She did residents to have their led and said if they did not res, she expected them to bed bath not a partial bed documented. The DON resident refused their shower,	F 7	25		
F 726 SS=D	in their progress no Competent Nursing CFR(s): 483.35(a)(3) §483.35 Nursing Set The facility must hat the appropriate comprovide nursing and resident safety and practicable physical well-being of each resident assessment and considering the diagnoses of the factors.	Staff 3)(4)(c)	F 7	26		4/15/24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
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F 726	Continued From pag	ge 53	F 7	726		
	licensed nurses have and skill sets necess needs, as identified assessments, and dispenses systems, and dispenses systems of the facility must ensure to demonstrate complements, and dispenses systems of the facility must ensure the facility of the faci	ding care includes but is not evaluating, planning and ent care plans and responding and ent care plans and responding acy of nurse aides.  Sure that nurse aides are able petency in skills and ry to care for residents' through resident escribed in the plan of care.  T is not met as evidenced a rewidenced wiews, family member and facility failed to provide to a new nurse when Nurse e Nurse #9 during medication ing in a resident receiving the This deficient practice ent reviewed for medication ident #83).  d:  dmitted to the facility on gnoses including cerebral acVA), high blood pressure, etes mellitus (DM).		1. On 12/27/2023 Resident #8 assessed by the nurse and had vital signs and no health-related were noted related to the medicerror. The physician and resporwere notified by the nurse of the medication error. The Nurse Pravisited Resident #83 on 12/27/2 found the resident to be in no di Nurse #8 was in serviced on the of medication administration by Director of Nursing (DON) and Development Coordinator (SDC 4/5/2024. Nurse #9 is no longer employed.  2. The Director of Nursing coraudit of resident medical record 12/10/23 to 12/27/2023 which dindicate any additional medication.	stable d concerns cation nsible party e actitioner 2023 and istress. e 6 rights the Staff c)  mpleted an ds from lid not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF D	ROVIDER OR SUPPLIER	343142	D. WING	CT	REET ADDRESS, CITY, STATE, ZIP CODE	03/	13/2024
		ID REHABILITATION CENTER		9200 GLENWATER DRIVE CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	tablet by mouth one tablet by mouth one tablet by mouth one tablet or vimpat Oral Solution mouth two times a darabic provention.  Amouth two times a day for deprevention.  Amlodipine Besylated daily for high blood por time a day for deprevention.  Amlodipine Besylated daily for high blood por high blood por the physical portion of the physical portion of the physical portion.  A review of the physical portion o	issant) 150 milligrams (mg) 1 ime a day for depression. In (anti-seizure) 250mg by ay for seizures. In (anti-seizure) delayed Ilets by mouth twice a day for Int) 20 mg 1 tablet by mouth Interpretent thrombosis Into mg 1 tablet by mouth one time Interpretent thrombosis Interpretent throm	F	726	3. All Facility Nurses and med-aides including agency nurses and med-aides will be in-serviced regarding the 6 rights medication administration which include verifying the resident's identity prior to medication administration by the Staff Development Coordinator (SDC) beginning 3/15/2024. Facility nurses, med-aides or agency nurses, med-aide not in-service by 4/5/2024 will not be allowed to work until the education is completed by the SDC/DON. After 4/5/2024, all new nurses, med-aides a agency nurses will be educated on the five rights of medication administration before working by the SDC/DON. The Unit Managers, Assistant Director of Nursing (ADON) or DON will complete Med Pass Check Off tool for all nurses and med-aides including agency nurses and med-aides by 4/5/2024 and on 3 nurses, med-aides per week on varying shifts and days of the week using the N Pass Check Off tool to validate nurse skills for 4 weeks and then 3 per month for 3 months.  4. The DON will review the Med Pass Check Off tools weekly for 4 weeks and submit them to the Administrator for compliance. The Administrator will subit the findings of the Med Pass Check Off audits with Quality Assurance Performance Improvement (QAPI) monthly for 3 months to ensure compliance.  5. Date of Compliance 4/15/24	s of es nd a s Med	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345142	B. WING _			C <b>03/13/2024</b>		
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	IP CODE	33/13/2021		
(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 APPROPRIATI DEFICIENCY)				
F 726	had occurred. She funurse who was still be #83's the wrong medithat the nurse in train allowed to administer another staff member.  Multiple unsuccessful contact Nurse #8, and training) for interview.  An interview was contact Nurse #8, and training) for interview.  An interview was contact Nurse #8 was given medications. Nurse #8 medications. Nurse #8 medication cart and Note administer the medication cart and Note administer the medication cart and Note administer the medication will be staff should have #8 longer employed by the stated Nurse #8 should have prototo the correct residen Nurse #8 and Nurse in nursing orientation will "Six Rights of Medical".	cher that a medication error arther stated that a new eing oriented gave Resident cations. She also stated ing should not have been medications without being present.  I attempts were made to d Nurse #9 (nurse in ducted on 02/28/2024 at ector of Nursing (DON). at during a medication pass, ren the incorrect #9 was being oriented by was standing at the Nurse #9 went into the room dications. Nurse #9 got boom numbers and got bed A Nurse #8 went into the Nurse #9 at Resident #83's ad already given Resident Resident #83. The DON and Nurse #9 were no the facility. She further all have stayed with Nurse tire medication pass ally administering the edicide. She stated nursing wided the correct medication to the tion Administration" (a medication administration to	F7	726				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED	
		345142	B. WING		C 03/13/20	124	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00:10:20		
HMIVEDSI	TV DI ACE NUDSING AN	ID REHABILITATION CENTER		9200 GLENWATER DRIVE			
UNIVERSI	IT PLACE NORSING AN	D REHABILITATION CENTER		CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COM	(X5) IPLETION DATE	
F 760 SS=E	Residents are Free of CFR(s): 483.45(f)(2)	f Significant Med Errors	F 70	60	4/15/	/24	
	medication errors. This REQUIREMENT by: Based on record revistaff, and Medical Dirfailed to prevent signiwhen Nurse #9 admir Resident #83 prescribincluded Lasix (fluid pused to treat anxiety, Celexa (an antidepresto treat cardiac disord to prevent significant medications were not the physician. This de 16 residents reviewed errors (Resident #83 #79, #88, and #110.) The findings:  1. Resident #83 was a 09/26/2022 with diagrous vascular accident (CV dementia, and diabeted Review of the quarter assessment dated 12 #83 had moderate composition of the December of Resident #83 reversible to the composition of the December of Resident #83 reversible to the composition of the December	is not met as evidenced  lews, and family member, ector interviews, the facility ficant medication errors histered medications to led for Resident #30 which hoill), Ativan (a medication Seroquel (an antipsychotic), lessant), and Diltiazem (used lers). The facility also failed medication errors when leadministered as ordered by efficient practice affected 9 of left for significant medication left, #7, #28, #47, #51, #73, leadmitted to the facility on hoses including cerebral left/A), high blood pressure, less mellitus (DM).  In Minimum Data Set (MDS) left/01/2023 revealed Resident legnitive impairment. The lent #83 was not receiving left, or anti-psychotics.  In the series of any significant left and series of a color		1. On 12/27/2023 Resident #83 was assessed by the nurse and had stable vital signs and no health-related conce were noted related to the medication error. The physician and responsible pwere notified by the nurse of the medication error. The Nurse Practition visited Resident #83 on 12/27/2023 ar found the resident to be in no distress. Nurse #8 was in serviced on the 6 righ of medication administration by the Sta Development Coordinator (SDC)/Director of Nursing (DON) on 3/20/2024. Nurse is no longer employed. Medication error reports were completed, and the Medi Director was notified for Resident #83, #28, #47. #51, #73, #79, #88 and #110 the RN on 12/10/2023. Vital signs we collected, and no adverse outcomes related to the medication errors were found by 12/15/2023 for the affected residents.  2. On 3/20/2024, The Director of Nursing completed an audit of resident medical records from 12/10/2023 and 12/27/2023 which did not indicate any additional medication errors.  3. All nurses and med-aides including agency nurses and med-aides will be serviced regarding the 6 rights of medication administration which includes	erns arty er d ts aff etor e #9 or cal #7, 0 by ere		
	medications:			verifying the resident's identity prior to			

PRINTED: 04/16/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
			7 50.25			С	
		345142	B. WING _		03	/13/2024	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				9200 GLENWATER DRIVE			
UNIVERSI	TY PLACE NURSING	AND REHABILITATION CENTER		CHARLOTTE, NC 28262			
(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	(X5)		
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE	
F 760	Continued From p	age 57	F7	760			
	-Sertraline (antide	pressant) 150 milligrams (mg) 1		medication administration and			
	tablet by mouth or	ne time a day for depression.		administering medications as o	ordered and		
		tion (anti-seizure) 250 mg by		documenting medications by the	ne RN		
	mouth two times a			beginning 3/15/2024. Any Lice			
		m (anti-seizure) delayed		registered nurses or agency nu			
		tablets by mouth twice a day for		serviced by 4/5/24 will not be a			
	neurological disor			work until the education is com			
		ulant) 20 mg 1 tablet by mouth		the RN. After 4/5/24, all new a	• .		
		deep vein thrombosis		nurses will be educated on the	•		
	prevention.	late 10 mg 1 tablet by mouth		of medication administration be			
	daily for high bloo	late 10 mg 1 tablet by mouth		working by the RN. The RN an Managers, ADON or DON will			
	daily for flight bloo	u pressure.		med pass check off for all nurs	•		
	Resident #30 was	admitted to the facility on		including agency by 4/5/24 and			
	11/03/2022.	auminou to uno nuomi, on		nurses per week on varying sh			
				days of the week using the Me			
	A review of the ph	ysician orders dated December		Check Off tool to validate nurs			
	2023 revealed Re	sident #30 had orders for:		weeks and then 3 per month for	or 3		
	-Diltiazem (cardia	c medication) 120 mg extended		months. The Director of Nursir	ig or		
	release 1 capsule	by mouth one time a day for		Assistant Director of Nursing w	∕ill audit		
	atrial fibrillation.			10% of all Medication Administ			
		bbromide 10 mg one tablet by		records weekly x 4 weeks ther			
	mouth daily for de			1 month to ensure medications	•		
	,	id pill) 20 mg by mouth one time		administered per physician ord	•		
	day for fluid.			a Medication Administration re			
		ychotic) 25 mg by mouth three		audit tool. The physician will be			
		hizoaffective disorder ety) 0.5 mg by mouth twice a		any identified areas of concerr  Administrator or DON will revie			
	day for anxiety.	ety) 0.5 mg by mouth twice a		initial the audits weekly x 4 we			
	day for arrivery.			monthly x 1 month to ensure a			
	An incident report	dated 12/27/2023 written by		concern were addressed appro			
		d Resident #83 had received			i		
		edication which included: Lasix		4. The DON will review the n	ned pass		
	20 mg, Ativan 0.5	mg, Seroquel 25 mg, Celexa		check off tools and medication	•		
		em 120 mg at 10:00 AM in		administration Audit tool weekl	y for 4		
	addition to her ow	n morning medications. The		weeks and submit to the NHA	for		
		rted to the on-call provider at		compliance. The NHA will sub	mit the		
		se #8 realized Resident #83		findings of the med pass check			
	had been given R	esident #30's medications.		with QAPI monthly for 3 month	s to ensure		

Facility ID: 923015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING _				C <b>13/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2024	
				9:	200 GLENWATER DRIVE			
UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER		С	HARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE				
F 760	760 Continued From page 58		F 7	760				
	Resident #83 was no distress and at her ba responsible party (RF	ted to be in no acute aseline.  Resident #83's			compliance. The Director of Nursing is responsible for the Plan of Correction a the Administrator for sustained compliance.  5. Date of compliance 4/15/2024	and		
	12/27/2023 at 1:35 P blood pressure123/74 number) less than 12 number) less than 80 range 97 to 99), pulse (normal range 60-100 per minute (normal range)	mented vital signs dated M revealed the following: 4 (normal range systolic (top 0 and diastolic (bottom ), temperature 97.2 (normal e 55 beats per minute 0), respirations 14 breaths ange 12-20), oxygen nal range 92% or greater) on						
	note dated 12/27/202 was being seen due to Resident #83 receive Celexa, and Diltiazen further revealed Residente with stable wand alert and offered note also indicated R distress and no adverted to the provider ordered.	d Lasix, Ativan, Seroquel, in in error. The NP visit note dent #83 appeared at her vital signs and was awake no complaints. The NP's esident #83 was in no acute reactions were noted. vital signs to be checked rs and to closely monitor						
	13:20 PM with Reside the facility reported to had occurred. She fu nurse who was still be #83's the wrong medi	ducted on 02/26/2024 at ent #83's RP. The RP stated of her that a medication error arther stated that a new eing oriented gave Resident ications. She also stated ing should not have been medications without						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345142	B. WING			C 03/13/2024		
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		1 001	10/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			(X5) COMPLETION DATE	
F 760	60   Continued From page 59		F	760				
		r being present. She also contacted the pharmacy and r.						
		I attempts were made to I Nurse #9 (the nurse in						
	9:03 AM. The pharm medication error report of 12/27/2023. She with the Amlodipine a for hypotension. She	ducted on 03/05/2024 at acist stated there was no out on file for Resident #83 further stated the concernant the Diltiazem would be also stated hypotension aday of administration due to the drugs.						
	09:36 with the Nurse evaluated Resident # notified of the medica 12/27/2023 and she what time she evalua stated it was before 1 indicated she was mo cardiac medications: Diltiazem and the pot further added Reside evaluation and that s monitor Resident #83	ost concerned with the Amlodipine and the tential for hypotension. She nt #83 was stable during her he asked the nursing staff to						
	11:40 AM with the Dir The DON revealed th Resident #83 was giv medications. Nurse	ducted on 02/28/2024 at rector of Nursing (DON). eat during a medication pass, even the incorrect #9 (nurse in training) was rse #8. Nurse #8 was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345142	B. WING _			C <b>03/13/20</b> 2	24	
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	ŽIP CODE	00/10/20/	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		COMP	X5) PLETION ATE	
F 760	went into the room to Nurse #9 got confuse and got bed A and be went into the room w Resident #83's bedsi given Resident #30's #83. The DON also s #9 were no longer en DON further revealed notified the physician notified the RP follow stated the staff did exafter the incident occ Nurse #8 should have training throughout the especially when actu medications at the bestaff should have proto the correct resident 2a. Resident #7 was 10/05/2020 with a dia A quarterly Minimum assessment dated 11 was severely cognitive was coded as receive assessment period.  The active physician' for Resident #7 inclusion for Resident #7 inclusion for Resident #7 inclusion for Resident #7 inclusion pen-injector insulin four times a diamond of the solution pen-injector insulin for times a diamond of the solution pen-injector insulin four times a diamond of the solution pen-injector insulin four times a diamond of the solution pen-injector insulin for tim	administer the medications. ad about the room numbers ad B mixed up. Nurse #8 then she saw Nurse #9 at de. Nurse #9 had already medications to Resident stated Nurse #8 and Nurse apployed by the facility. The I Nurse #8 had immediately assessed the resident, and ing the incident. The DON terything they should have turred. She further stated the stayed with the nurse in the entire medication pass ally administering the tedside. She stated nursing wided the correct medication t.  Data Set (MDS) //20/23 revealed Resident #7 the impaired. Resident #7 the impaired. Resident #7 the insulin 7 times during the the sorders for December 2023 and an order dated 08/07/23 and the incident sand for December 2023 and the insulin of diabetes and for December 2023 and the incident sand for December 2023 and the i	F7	760				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345142	B. WING _			1	C <b>13/2024</b>
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262			10/2027
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 760	December 2023 reversions of the active physician for Resident #28 inc 11/10/23 for Lantus units/ml, inject 10 ur an order dated 11/08	ealed the Insulin Detemir heduled for 8:00 PM, was not n on 12/10/2023 and the ding scale insulin scheduled documented as given on agnosis of hypertension, ellitus and heart failure.	F	760	DEFICIENCY)		
	December 2023 reverse pen-injector 100 unit tablet 6.25 mg and \$8:00 PM, were not december 12/10/2023.  c. Resident #47 was 10/13/2019 with a dischizophrenia, anxietymphedema with low A quarterly Minimum						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345142	B. WING		,	C 3/13/2024		
	ROVIDER OR SUPPLIER  TY PLACE NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		5/13/2024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 760	Continued From pa	•	F 70	60				
	#47 was coded as r medication, antianxi antidepressant med The active physician for Resident #47 inc							
	03/10/22 for Loraze a day for agitation, a Trazodone 125 mg insomnia and an ord Percocet oral tablet	r mood, an order dated pam 1 mg by mouth two times an order dated 08/25/22 for by mouth at bedtime for der dated 04/07/23 for 10-325mg give 1 tablet by day for severe pain.						
	December 2023 rev Trazodone 125 mg, Percocet oral tablet	A Medication Administration Record (MAR) dated December 2023 revealed the Seroquel 200 mg, Frazodone 125 mg, Lorazepam 1 mg and Percocet oral tablet 10-325mg scheduled for 8:00 PM were not documented as given on 12/10/2023.						
		s admitted to the facility on agnosis of diabetes mellitus						
	#51 was moderately Resident #51 was c days during the ass revealed Resident # anticoagulant during The active physiciar for Resident #51 ind 11/15/22 Insulin Gla	19/30/2023 revealed Resident or cognitively impaired. oded as receiving insulin on 7 essment period. The MDS						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345142	B. WING _			C 03/13/2024	
	ROVIDER OR SUPPLIER  TY PLACE NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	<b>,</b>	30.10.202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	two times a day for a order dated 7/16/23 tablet by mouth two A Medication Admin December 2023 rev solution 100 units/m and Metformin 500 were not documented. Resident #73 was 06/19/2023 with a dated 10/30/2023 recognitively intact. Received an antidep assessment period. The active physiciar for Resident #73 inc 06/20/23 for Trazodat bedtime for insorn A Medication Admin December 2023 rev scheduled for 8:00 figiven on 12/10/2023 f. Resident #79 was 11/10/2023 with a diameter and massessment dated 1479 was moderately	Eliquis tablet 5 mg by mouth anticoagulant therapy and an for Metformin 500 mg 1 times a day for diabetes.  istration Record (MAR) dated ealed the Insulin Glargine of 12 units, Eliquis tablet 5 mg mg scheduled for 9:00 PM end as given on 12/10/2023.  Is admitted to the facility on its indicated ealed Resident #73 was easident #73 was easident #73 was coded as ressant during the  It's orders for December 2023 eliuded an order dated one 50 mg 1 tablet by mouth innia.  Instration Record (MAR) dated ealed the Trazodone 50 mg PM was not documented as 3.  In admitted to the facility on its indicated ealed the Trazodone 50 mg PM was not documented as 3.  In admitted to the facility on its indicated ealed the Trazodone 50 mg PM was not documented as 3.  In admitted to the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its indicated ealed Resident end in the facility on its interface end in the facility on its in	F 7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONST	RUCTION	(X3) DATE SURVEY COMPLETED		
		345142	B. WING				C <b>13/2024</b>	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262				
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIENC REGULATORY OR		ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE		
F 760	The active physician for Resident #79 incl 11/14/23 for Insulin Cinject 2 units at bedti A Medication Administ December 2023 revessolution 100 unit/ml 2 PM was not docume g. Resident #88 was 10/02/2020 with a diaheart failure and corona A quarterly Minimum assessment dated 10 #88 was severely co	de da norder dated de d	F	760				
	03/31/22 for Metopro tablet by mouth two for tablet by mouth and seem to table	olol Tartrate 25 mg give 0.5 imes a day for heart failure.  Stration Record (MAR) dated ealed the Metoprolol Tartrate or 9:00 PM was not n on 12/10/2023.  Is admitted to the facility on agnosis of hypertension and  Data Set (MDS)  2/01/2023 revealed Resident						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER:  A. BU			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345142	B. WING _			1	C <b>13/2024</b>	
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER	,	920	REET ADDRESS, CITY, STATE, ZIP CODE  OO GLENWATER DRIVE  HARLOTTE, NC 28262	1 00	10/2027	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 760	Continued From page	e 65	F	760				
	two times a day for h dated 12/04/23.	ypertension and an order						
	December 2023 reversion and Carvedilol 3.125 were not documented. A facility investigation revealed the facility in reviewing the Medical report for the previous medication errors and Resident #47, Resident #47, Resident #79, Resident #79, Resident #79, Resident #79, Resident #700 PM to investigation was the Director was notified. completed by the Residentified the cause of	stration Record (MAR) dated aled the Amoxicillin 500 mg mg scheduled for 8:00 PM d as given on 12/10/2023.  In summary dated 12/12/23 atterdisciplinary team was attion Administration Audit as 48 hours and noted the d Resident #7, Resident #28, and #51, Resident #73, and #88 and Resident #110 attered their medication of 11:00 PM shift. An an initiated, and the Medical The investigation was agional Nurse Consultant who of the incident was due to a for the 7:00 PM to 11:00 PM						
	PM with Nurse #1. SI was working the 7:00 assigned to Resident #47, Resident #51, R Resident #88 and Rerevealed Nurse #2 ha PM stating she would the 7:00 PM to 11:00 resident assignment. #2 she would need to let them know. The ir told Unit Manager #1 #2 would be coming it.	ducted on 02/28/24 at 4:00 ne stated on 12/10/23 she AM to 7:00 PM shift #7, Resident #28, Resident esident #73, Resident #79, sident #110. The interview ad contacted her after 12:00 I not be coming into work for PM shift to take over the She stated she told Nurse o contact management and atterview revealed she then that she did not think Nurse into the facility for her tated report on the residents						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345142	B. WING _			03/	) 13/2024
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	ODE	1 00/	10/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 760	who were told by the medication cart. The offered to stay over to PM to 11:00 PM but to the scheduler. She significant was notified later in the Nurse #2 was not go scheduled 7:00 PM to she called the scheduled 7:00 PM to 11:00 PM to	e 66  #3, Nurse #4 and Nurse #5 Unit Manager #1 to split the interview revealed she had to cover the shift from 7:00 was told it was necessary by tated she left the facility at ed on 02/28/24 at 3:36 PM I revealed on 12/10/23 she he day by Nurse #1 that ing to come in for the to 11:00 PM shift. She stated uler who no longer works in for of Nursing (DON) to let e going to be a nurse short. Ed the scheduler could not se #2 so Unit Manger #1 3, Nurse #4 and Nurse #5 plit the medication cart for PM shift. She stated Nurse ed to get some food and dication cart when she #5 stated the medication cart into to split. She stated she to 7:00 PM and did not know the residents had never uled medication on the empted with Nurse #2 on 29/24 with no return phone empted with Nurse #3, Nurse ed on 02/28/24 at 4:30 PM	F7	760			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	· ,	TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		3/13/2024
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F 760	12/10/23 around of Manager #1 that I 7:00 PM to 11:00 Manager #1 told in Nurse #5 were instructed and had take stated she heard residents had not interview revealed the assigned residents Resident #47, Re Resident #47, Re Resident #79, Re did not receive an stated Nurse #5 to assigned half and going to administed medication. The Ecommunication erinterview revealed obtained on 12/11 levels for the diab adverse outcomes and no residents to not receiving the On 02/29/24 at 11 conducted with the interview he state that the residents 12/10/23. The interview Practitioner	of Nursing (DON) revealed on 6:30 PM she was told by Unit Nurse #2 had called out for the PM shift. She stated Unit her that Nurse #3, Nurse #4 and structed to split the medication in report on the residents. She the next morning that some received their medication. The did that Nurse #5 had given half of dents their medication, but the Resident #7, Resident #28, sident #51, Resident #73, sident #88 and Resident #110 by scheduled medication. She had completed her thought someone else was been the residents' DON stated it was a morn between the nurses. The did the residents' vital signs were 1/23 along with blood glucose etic residents. She stated no shad occurred from the incident needed medical treatment due	F 7			
	monitoring the rescondition. He stat symptoms from norther MD stated all	sidents for any changes of ed no residents were having or receiving their medication. Though medication such as pioids, antipsychotics and insulin				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION		
F 760	residents to miss one revealed none of the missed their medicati or experienced a char	uld not be harmful to the dose. The interview residents identified to have on were sent to the hospital nge of condition.	F 76		4/45/04		
F 761 SS=E	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the capplicable.  §483.45(h) Storage of §483.45(h)(1) In accordance several laws, the faci biologicals in locked of temperature controls, personnel to have accessor storage of controlled of the Comprehensive Experience of the comprehensive Expe	of Drugs and Biologicals are used in the facility must be with currently accepted as, and include the yand cautionary expiration date when are districted by and Biologicals are dance with State and lity must store all drugs and compartments under proper and permit only authorized	F 76	On 2/28/24, Director of Nursing (DON) removed and discarded the	4/15/24		
		sulin pens, failed to discard		Glargine insulin pen and Novolin insu	lin		

PRINTED: 04/16/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSI	TY PLACE NURSING AN	D REHABILITATION CENTER		9	200 GLENWATER DRIVE		
				C	CHARLOTTE, NC 28262		
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F 761	1 Continued From page 69		F 7	761			
	an expired insulin per unopened insulin pen 4 medication carts (G Arboretum Cart #2) w medication storage. The findings: Review of the manufa Glargine stated to sto insulin pens in a refrig	n and failed to store s in the refrigerator for 2 of arden City Cart #1 and rhich were reviewed for acturer's package insert for are unopened Glargine gerator and in-use (opened)			pen that were not labeled with an open/expired date from the medication cart #1 on Garden City. On 2/28/24, the DON removed and discarded the 2 unopened insulin pens and Glargine insulin pen on Arboretum medication ca #2.  • On 2/29/24 the Unit Managers (UM)/DON/Assistant Director of Nursin (ADON) initiated an audit of all medical carts and medication storage rooms. T	e art g tion	
	insulin pens at room temperature for 28 days.  1a. An observation of the Garden City medication cart #1 was conducted on 02/28/2024 at 11:11 AM with Nurse #6 and the Director of Nursing. The observation revealed an opened Glargine insulin pen and an opened Novolin insulin pen that were not dated. The medication cart observation also revealed an opened insulin pen with an open date of 12/08/2023 which had passed the 28-day expiration date of 01/05/2024.  An interview was conducted with Nurse #6 on 02/28/2024 at 11:26 AM who stated she thought				audit is to ensure medication is labeled with an "open" date or "use by" date who pened if indicated and if medications require refrigeration.  On 2/28/24, the Staff Developmen Coordinator (SDC) initiated an in-service with all nurses and medication aides to agency include nurses and medication aides regarding the Medication Storage with emphasis on (1) checking medications before administration for expired dates (2) appropriately discard expired medications per pharmacy poli	t ce ing cy,	
	responsible for check expired medications a insulin pens were not expired.  1b. An observation of conducted on 02/28/2 #7 and the Director of revealed 2 unopened the medication cart at "refrigerate until open	ed" and one Glargine insulin e that was illegible. The ink			(3) labeling medications with an "open" date or "use" by date when indicated, a (4) if medications require refrigeration, they are in the refrigerator. In-service we be completed by 4/5/24. After 4/5/24 A nurse or medication aide who has not worked or received the in-service will complete it upon the next scheduled we shift. All newly hired nurses and medication aides to include agency nurses and medication aides, will be educated in medication storage and labeling during orientation.  • The unit managers will audit all	ind vill ny	

Facility ID: 923015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	N	(X3) DATE SURVEY COMPLETED	
		345142	B. WING _				C <b>13/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE	1 00/	
UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER		9200 GLENWATE	R DRIVE		
UNIVERSI	TT FEACE NORSING AN	ID REHABILITATION CENTER		CHARLOTTE, N	IC 28262		
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F 761	Continued From page	e 70	F 7	61			
F 761	unidentifiable.  An interview was con 02/28/2024 at 12:24 realize there was no pens, and she though open date on the insushe did not know the required refrigeration the insulin pens had she also added she copen date was not ledid not know who was the medication carts.  An interview was con Nursing (DON) on 02 DON revealed all insulabled when opened expiration date sticker all nurses were response opening on the insuling medications in the medications in the medications in the medication opening. She also stapens should be store ready for use and the should be available for carts.  Food Procurement, S	ducted with Nurse #7 on PM who stated she did not open date on the insulin at the pharmacy placed the alin pens. She also stated unopen insulin pens and she did know how long open in the medication cart. did not realize the insulin pen gible. She further stated she is responsible for checking  ducted with the Director of 1/28/2024 at 1:12 PM. The alin pens should have been a for use with a 28-day r. She also indicated that insible for putting the date of in pens and checking all edication carts. She further steed all insulin pens to be and discarded 28 days after ated that all unopened insulin in the refrigerator until it no expired medications or use in the medication to tore/Prepare/Serve-Sanitary 2)	F 7	medication rooms weel months utili Biological A medications date or "use indicated ar refrigeration Director of I Storage of I weekly x 4 months.  • The Director of I Storage of I weekly x 4 months.  • The Director of I Storage of I weekly x 4 months.	carts and medication storage kly x 4 weeks then monthly izing the Storage of Drugs a Audit. The audit is to ensure is are labeled with an "open" by date when opened if and all medications that require are in the refrigerator. The Nursing (DON) will review to Drugs and Biological Audit is weeks, then monthly x 2 rector of Nursing will forware of the Storage of Drugs and the Storage of Drugs and the Elmprovement (QAPI) monthly x 2 months. The mittee will meet monthly x 2 dreview the Storage of Drug cal Audit to determine trend ues that may need further ans put into place and to the need for further and / or of monitoring. The Director of responsible for the Plan of and the Administrator for compliance.	x 2 and  iire e he tool d ce gs	4/15/24
	§483.60(i)(1) - Procu approved or consider	re food from sources ed satisfactory by federal,					

NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE NURSING AND REHABILITATION CENTER  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  9200 GLENWATER DRIVE  CHARLOTTE, NC 28262	AME OF PROVIDER OR SUPPLIER		IDENTIFICA	A. BUILDIN	NG		(X3) DATE SURVEY COMPLETED	
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UNIVERSITY PLACE NURSING AND REHABILITATION CENTER			₹	<u>'</u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
I CHARLOTTE NC 28262	NIVERSITY PLACE NURSING A	ENTER	G AND REHABILITA					
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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	PREFIX (EACH DEFICIEN	FULL	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 812 Continued From page 71 state or local authorities (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not proclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to remove expired food items and unlabeled items which belonged to staff for 1 of 3 resident's nourishment rooms. These practices had the potential to affect food served to residents.  Findings included:  An observation and interview was conducted with Nurse Aide (NA) #5 on 02/26/24 at 10:15 AM revealed an 8 oz, fat free milk with the best by date of 02/24/24 and three separate lunch bags not tabeled in the memory care unit nourishment room. NA #5 indicated nursing staff on the memory care unit had stored their personal items in the nourishment room because the nursing staff break room was on the other side of the facility. NA #5 stated nursing staff had been educated to not store personal items in the nourishment room and to discard any expired items.  F 812 Food Procurement, Store/Prepare/Serve-Sanitary  On 2/26/24, the 8-ounce fat free milk was discarded by the Dietary Manager, and all employee lunch bags were being stored.  **A 100/9 audit of all nourishment rooms were inspected to ensure no other milks were outdated, and no employee lunch bags were being stored.  **A 100/9 audit of all nourishment rooms in the facility was conducted by the Dietary Manager/Supervisor on 3/20/24 to ensure all milk that was undated or expired, and all employee lunch bags were removed immediately.  **Education was conducted by the Di	state or local author (i) This may include from local producer: and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and fo (iii) This provision d from consuming for §483.60(i)(2) - Store serve food in accord standards for food s This REQUIREMEN by: Based on observat facility failed to remunlabeled items whi resident's nourishm had the potential to residents.  Findings included:  An observation and Nurse Aide (NA) #5 revealed an 8 oz. fa date of 02/24/24 an not labeled in the m room. NA #5 indicat memory care unit h in the nourishment is staff break room wa facility. NA #5 state educated to not stor nourishment room a	e State vent ity cable ents e facility.  nd al nced s, the s and or 1 of 3 ctices  ted with AM st by bags shment e al items sing the en ee	cers, subject to appropriate to appropriate to compliance with a does not prohibit ing produce grown to compliance with a does not preclud foods not procured tore, prepare, districted and staff interview and staff interview expired foo which belonged to hament rooms. The late after the and interview was of the and three separate and interview was of the and three separate and three separates and three separa	F8	312	<ul> <li>Store/Prepare/Serve-Sanitary</li> <li>On 2/26/24, the 8-ounce fat free many discarded by the Dietary Manager and all employee lunch bags were relocated to the appropriate break area. The refrigerator for all units (SPARC, Arboretum, and Garden City) nourishmore rooms were inspected to ensure no oth milks were outdated, and no employee lunch bags were being stored.</li> <li>A 100% audit of all nourishment rooms in the facility was conducted by Dietary Manager/Supervisor on 3/20/24 ensure all milk that was undated or expired, and all employee lunch bags were removed immediately.</li> <li>Education was conducted by the Dietary Manager/Supervisor and the Stopevelopment Coordinator for 100% of dietary staff on the guidelines for check and clearing all outdated milk and</li> </ul>	the taff all	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
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UNIVERSI	IY PLACE NURSING A	ND REHABILITATION CENTER		CHARLOTTE, NC 28262		
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F 812	Continued From pag	ge 72	F 8	12		
	(DM) on 02/06/24 at aides check nourishmot recall if any staff weekend. It was furt had been educated the nourishment roo throw away any expiration of the control of the nourishment roomal of the control of the contr	ted with the Dietary Manager 10:30 AM revealed dietary ment rooms daily but could had checked them over the her revealed nursing staff not to store personal items in ms refrigerators and to also ired items that were found.  ted with the Director of 2/29/24 at 4:55 PM revealed ducated not to store personal urishment rooms because eak room available with a N further stated she was cored items in the memory om refrigerator. The DON es were responsible for nt rooms, but nursing staff e for throwing out items if to be discarded.		the product for a date to discard as nursing staff on personal iter stored in the resident's nourishr refrigerators. The staff were instituted in the staff breakroom and not the staff breakroom and not the nourishment rooms. The education 3/15/24 and will be completed 4/15/2024. Any dietary personnursing personnel who have not or received the in-service will conservice prior to their next schwork shift. Any newly hired staff educated by the Staff Developm Coordinator or Dietary Manager/Supervisor during ories and before their first shift starts.  The Dietary Manager/Aide/Administrator impanaudit tool on 3/20/24 that will daily x4 weeks and then monthly months to monitor the nourishmes.	ns being ment room tructed to food items he tion began ed on el or t worked omplete eduled f will be nent  ntation  blemented I be used y x2	
F 867 SS=E	02/29/24 at 5:10 PM to check nourishmer any expired or unlab further revealed it was		F 80	to include checking that outdate and staff items are not being sto audits will be taken to Quality All Improvement (QAPI) team. The be reviewed monthly x2 months discussed with the Interdisciplin (IDT) members. IDT team will dat that time the need for continu monitoring. The Dietary Manageresponsible for the Plan of Correthe Administrator for sustained compliance.  • Date of Compliance: 4/15/2	ed products bred. All ssurance audit will and ary team etermine led er is ection and	4/15/24
30 2	2. 1.(3). 100.10(0)(u	,,-,, <del>-</del> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING			C <b>03/13/2024</b>	
	ROVIDER OR SUPPLIER	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	ZIP CODE	03/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATI CIENCY)	(X5) COMPLETION DATE	
F 867	§483.75(c) Program is monitoring. A facility must establic policies and procedure collections systems, and adverse event monitor procedures must inclificate following:  §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representative information will be used are high risk, high volop opportunities for impression for the systems to identify, conformation from all differences.	reedback, data systems and sh and implement written res for feedback, data and monitoring, including bring. The policies and ude, at a minimum, the remaintenance of effective duse of feedback and input other staff, residents, and res, including how such ed to identify problems that lume, or problem-prone, and	F	367			
	will be used to develor indicators.  §483.75(c)(3) Facility and evaluation of per including the method development, monitor §483.75(c)(4) Facility including the method systematically identify analyze and use data adverse events in the	ology and frequency for such ring, and evaluation.  adverse event monitoring, s by which the facility will y, report, track, investigate, a and information relating to a facility, including how the ta to develop activities to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			1	C <b>13/2024</b>
	ROVIDER OR SUPPLIER	ID REHABILITATION CENTER		9200	EET ADDRESS, CITY, STATE, ZIP CODE  O GLENWATER DRIVE  ARLOTTE, NC 28262	1 03/	13/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	§483.75(d) Program systemic action.  §483.75(d)(1) The far aimed at performance implementing those and track performance improvements are resulting the second of problems in those outcomes, resident events, analimplement provents, analimplement provents, analimplement provents, and (iii) How they will devel to prevent quality afety problems; and (iii) How the facility wor its performance improvents are that improvents are that improvents are improvents and (iii) How the facility wor its performance improvents are that improvents are improvents and implement preventive implement preventive implement preventive implement preventive in the second implement preventive in the second implement preventive improventive implement preventive im	cility must take actions e improvement and, after actions, measure its success, the to ensure that alized and sustained.  cility will develop and ddressing: a systematic approach to causes of problems ems; elop corrective actions that ifect change at the systems ty of care, quality of life, or  ill monitor the effectiveness provement activities to nents are sustained.  activities.  cility must set priorities for its ement activities that focus on e, or problem-prone areas; ee, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care.	F	367			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345142	B. WING		C 03/13/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	1 00/10/2024
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 867	improvement activities distinct performance number and frequence conducted by the far and complexity of the available resources assessment required Improvement project annually a project the problem-prone are collection and analunal (c) and (d) of this section with the assurance committing governing body, or functioning as a goactivities, including program required to (e) of this section.	art of their performance ties, the facility must conduct the improvement projects. The ency of improvement projects acility must reflect the scope the facility's services and to, as reflected in the facility the dat §483.70(e). The cust include at least that focuses on high risk or the as identified through the data typic described in paragraphs the encycle of the facility's the designated person(s) the facility's the designated person(s) the committee must:	F 86	,	
	action to correct ide (iii) Regularly revie data collected underesulting from drug available data to m This REQUIREME by: Based on observatinterviews, the facil Assurance (QAA) of implemented procestinterventions the collection.	plement appropriate plans of centified quality deficiencies; w and analyze data, including er the QAPI program and data regimen reviews, and act on ake improvements.  NT is not met as evidenced tions, record reviews, and staff lity's Quality Assessment and committee failed to maintain edures and monitor or mmittee put into place ed infection control survey that		On 3/28/2024, The Facility Nu Consultant initiated an audit of precitations and action plans within the year to include accuracy of assess food procurement, store/prepare/s food under sanitary conditions, and	vious e past sments, erve

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		345142	B. WING _		03/13/2024
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	TV DI 405 MUDONIO			9200 GLENWATER DRIVE	
UNIVERSI	ITY PLACE NURSING	S AND REHABILITATION CENTER		CHARLOTTE, NC 28262	
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				DEFICIEN	CY)
F 867	Continued From p	page 76	F 8	367	
	occurred on 02/13	3/21, the recertification and		infection control and preven	ention to ensure
	complaint investig	gation surveys that occurred on		the Quality Assurance Per	
	06/24/21 and 08/2	25/22. This failure was for three		Improvement (QAPI) com	mittee has
	deficiencies that v	vere originally cited in the areas		maintained and monitored	interventions
	of Accuracy of Ass	sessments (F641), Food		that were put into place. A	ction plans were
	Procurement, Sto	re/Prepare/Serve Food Under		revised, updated and pres	ented to the
		ns (F812) and Infection		QAPI Committee by the Q	
		ontrol (F880) and were		Assurance (QA) Nurse for	-
		ted on the current recertification		identified. The Facility Nur	
	•	estigation survey of 02/29/24.		will address all concerns in	<u> </u>
		encies during multiple surveys of		the audit, including staff tr	aining. Audit will
		ttern of the facility's inability to		be completed by 4/5/24.	
	sustain an effectiv	ve QA program.			
	T. C. I			• On 3/21/2024, the Fa	-
	The findings inclu	aea:		Consultant initiated an in-	
	This tow is sween w			Administrator, Director of	
	This tag is cross r	eleffed to.		and Quality Assurance (Q	*
	E6/1: Basad on r	ecord review and staff		regarding the Quality Assu Performance Improvemen	
	_	cility failed to accurately code		process to include implem	
		a Set (MDS) assessment for 3		Action Plans, Monitoring T	
		esident #41, #102, #84)		Evaluation of the QA proc	
	,	dmission Screening and		modification and correctio	
		(PASRR), and 1 of 3 residents		prevent the reoccurrence	
		eviewed for restraints.		practice to include profess	
	,			In-service also included id	
	During the recertif	fication and complaint		that warrant development	
	_	ey conducted 08/25/22 the		a system to monitor the co	_
	facility failed to ac	curately code the Minimum		implement changes when	the expected
	Data Set (MDS) a	ssessment related to tobacco		outcome is not achieved a	nd sustaining
	use for residents	reviewed for smoking.		an effective QA process. I	
				completed by 3/21/2024.	-
		bservation and staff interviews,		Administrator, DON and G	A nurse will be
		o remove expired food items		educated during orientation	n regarding the
		ms which belonged to staff for 1		QAPI Process.	
		urishment rooms. These			
	· .	potential to affect food served		All data collected for i	
	to residents.			of concerns to include acc	- I
				assessments, food procur	ement,

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345142	B. WING _			1	C <b>13/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2024
					200 GLENWATER DRIVE		
UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER			HARLOTTE, NC 28262		
(VA) ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	e 77	F 8	367			
	During the recertificat	tion and complaint			store/prepare/serve food under sanitar	y	
		conducted 06/24/21, the			conditions, and infection prevention an	d	
	facility failed to remove	ve expired food items in the			control will be taken to the QAPI		
	refrigerator in 1 of 4 r	nourishments rooms and			committee for review monthly x 3 mont	hs	
	failed to label and da	te opened food items stored			by the Director of Nursing. The QAPI		
	for use in 3 of 4 nouri	shment rooms.			committee will review the data and		
					determine if a plan of corrections is bei	•	
	During the recertificat				followed, if changes in plans of action a		
		conducted 08/25/22, the			required to improve outcomes, if furthe		
	_	rd produce with signs of			staff education is needed, and if increa	sed	
		pired food items and date			monitoring is required. Minutes of the		
		eady for use in the walk-in			Quality Assurance Committee will be		
	cooler.				documented monthly at each meeting the QA Nurse.	ЭУ	
		ervations, record reviews,					
		the facility failed to ensure			The Facility Nurse Consultant will		
	-	eir handwashing/hygiene			ensure the facility is maintaining an		
		infection control policy when			effective QAPI program by reviewing a		
	the Treatment Nurse	an gloves after cleaning two			initialing the Quarterly meeting minutes and ensuring implemented procedures		
		cleanser and one wound with			and monitoring practices to address		
		fore applying treatment to			interventions, to include accuracy of		
		esidents (Resident #128 and			assessments, food procurement, infect	ion	
		d not doff gloves, sanitize			control and all current citations and QA		
	,	gloves after wound care			plans are followed and maintained		
		the resident's (Resident			monthly x2. The Facility Nurse Consult	ant	
		dding. The Treatment Nurse			will immediately retrain the Administrat		
	/ ·	uring wound care on another			and DON for any identified areas of		
	resident (Resident #1	_			concern. The Administrator is responsi	ble	
	`	Staphylococcus Aureus			for the Plan of Correction and for		
	(MRSA) and Carbape				sustained compliance.		
		RE) in the wound and she			<ul> <li>Date of compliance 4/15/2024.</li> </ul>	ſ	
	did not doff gloves, s	anitize hands and don clean				ĺ	
	gloves after cleaning	the wound which had brown				ĺ	
	colored drainage and	before applying the				ĺ	
	treatment to the wour	nd and with the same gloves				ĺ	
	on the Treatment Nur	se used to clean the				ĺ	
	drainage from the wo	und was observed touching				ĺ	
	the bed controls to lo	wer the resident's bed and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONST	RUCTION	(X3) DATE COMP	SURVEY PLETED
		345142	B. WING _			1	C <b>13/2024</b>
	ROVIDER OR SUPPLIER  TY PLACE NURSING AN	ID REHABILITATION CENTER		9200 GLE	ADDRESS, CITY, STATE, ZIP CODE ENWATER DRIVE DTTE, NC 28262	1 00/	10/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	addition, another staf #1) was observed pro bowel movement to a and with the same glo the resident with touc door, bedside drawer failures occurred for 3 wound care and 1 of incontinence care.  During the focused in conducted 02/13/21 t dietary staff impleme control measures who wear a facemask cov while working in the k  During an interview of the Administrator she committee meets mo heads, administrative and at least quarterly	g on the resident's bed. In f member (Nurse Aide (NA) poiding incontinence care of a resident (Resident #51), byes on that he had cleaned thing the resident's closet and over bed table. These 3 of 3 residents reviewed for 3 residents reviewed for 3 residents reviewed for 4 fection control survey the facility failed to ensure the facility's infection en 2 staff members failed to the ring their mouth and nose sitchen.  In 02/29/24 at 5:19 PM with revealed the QAPI inthly with department e staff, the Medical Director,	F	367			
F 880 SS=E	Improvement Plans ( the issues she and the identified at the facilit currently being addre care plan meetings, r physician visits. She putting PIPs into place concerns addressed recertification and con Administrator stated to and monitored to ensicompliance.	ssed included grievances, esident weights, and also reported they would be e to address the current during the current mplaint survey. The the PIPs would be ongoing ure ongoing and future	F	880			4/15/24

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
		345142	B. WING _			C <b>03/13/2024</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 9200 GLENWATER DRIVE CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	infection prevention designed to provide comfortable environdevelopment and tradiseases and infection program.  The facility must estand control program a minimum, the followard for the facility investigates and communicable staff, volunteers, visproviding services used arrangement based conducted accordinaccepted national services for the followard for the followard for the facility in the faci	ontrol tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions.  In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements:  Stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment g to §483.70(e) and following tandards;  en standards, policies, and program, which must include, oce eillance designed to identify able diseases or ey can spread to other	F	880		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345142	B. WING		C 03/43/2024
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	03/13/2024
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F 880	depending upon the involved, and (B) A requirement the least restrictive possicircumstances.  (v) The circumstance must prohibit employ disease or infected secontact with resident contact will transmit (vi) The hand hygient by staff involved in disease of infected secontact will transmit (vi) The hand hygient by staff involved in disease or infected secontact will transmit (vi) The hand hygient by staff involved in disease staff involved in disease or infected secontact will transmit (vi) The hand hygient by staff involved in disease staff involved interviews, the facility implemented their happart of their infection.  Treatment Nurse disease staff involved involved in disease staff in	ration of the isolation, infectious agent or organism at the isolation should be the lible for the resident under the lible for the resident under the less under which the facility wees with a communicable skin lesions from direct the disease; and less procedures to be followed irect resident contact.  The for recording incidents facility's IPCP and the library incidents facility with the facility.  The formula of the library incidents facility is IPCP and the library incidents facility	F 88	F 880 Infection Control  On 2/28/2024 the nurse respondent for treatments for resident #128 was serviced by the Director of Nursing (DON)/Staff Development Coordinate (SDC) on Infection Control for Wou Care including proper handwashing Certified Nursing Assistant (CNA)	as in l ator und g. The

OLIVILIV	O I OIL MEDIO/IILE A	MEDIO/ ND CEITHIOLO				OIVID ITC	7. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345142	B. WING				13/2024
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	T/ D/ 405 1111D01110 41			92	200 GLENWATER DRIVE		
UNIVERSI	IY PLACE NURSING AN	ND REHABILITATION CENTER		С	HARLOTTE, NC 28262		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 880	Continued From page	e 81	F	880			
		gloves after wound care			responsible for catheter care for Reside	≥nt	
		the resident's (Resident			#51 was educated on proper	J110	
		dding. The Treatment Nurse			handwashing technique and Infection		
		uring wound care on another			control related to catheter care by the		
	resident (Resident #1	_			Director of Nursing DON/Staff		
	Methicillin-Resistant	Staphylococcus Aureus			Development Coordinator (SDC) on		
	(MRSA) and Carbape	enem-Resistant			2/28/24.		
		RE) in the wound and she			<ul> <li>A complete return demonstration</li> </ul>		
	_	anitize hands and don clean			observation audit will be performed for		
	_	the wound which had brown			nursing staff on hand washing, cathete	r	
	colored drainage and				care and wound care beginning on		
		nd and with the same gloves			3/19/24 to be completed by 4/15/24.		
	on the Treatment Nu				On 3/15/2024 the Staff Developme  Coordinator (SDC) initiated on in continuous		
	_	ound was observed touching			Coordinator (SDC) initiated an in-service	ce	
		ower the resident's bed and ag on the resident's bed. In			regarding handwashing with all staff including the agency staff. Any staff		
	_	ff member (Nurse Aide (NA)			member not in serviced by 4/15/2024 v	vill	
		viding incontinence care of			not be allowed to work until they are	V 1111	
		a resident (Resident #51),			in-service for handwashing by the SDC	<b>;</b>	
		nis gloves and perform hand			Newly hired staff and nursing agency s		
		ing the resident's closet			will be in-service on handwashing by the		
		Irawer and other surfaces.			SDC in orientation before beginning wo		
	These failures occurr	red for 3 of 3 residents			On 3/20/2024 the Staff Development	ent	
	reviewed for wound of	care ( Resident #128, #43,			Nurse initiated an in-service including t	he	
	/	residents reviewed for			wound care (nurses) and catheter care		
	incontinence care (R	esident #51).			skills check off with all nursing staff		
					including agency by 4/5/2024, after wh		
	The findings included	1:			staff or agency will not be allowed to w		
	The feetility to the little	estitle d III le reduce de la companio della companio della companio della companio de la companio della compan			until they are in serviced for handwash	ing	
		ntitled "Handwashing Policy"			by the SDC. Newly hired staff and the		
		nfection Control Policies and sed on 04/2023 read in part:			agency staff will be in service on	a hv	
		ed to wash their hands after			handwashing, catheter and wound care	-	
		ed to wash their hands after et resident contact for which			the SDC in orientation before beginning work.	J	
	handwashing is indic				Beginning 4/5/2024, the RN		
	_	e. An alcohol-based hand			supervisors will observe 3 staff, to inclu	ıde	
		d for handwashing unless			C.N.A. #1 providing direct resident wou		
	-	soiled. The hands should be			and catheter care using the Wound Ca		
	-	ic material when using an			and Catheter Care Audit Tool weekly o		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
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		345142	B. WING			3/13/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
IIMIVEDOI	TV DI ACE NUIDSING AN	ND REHABILITATION CENTER		9200 GLENWATER DRIVE			
UNIVERSI	IT PLACE NORSING AI	NO REHABILITATION CENTER		CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From page	e 82	F 88	30			
F 880	alcohol hand sanitized washed with soap and blood or body fluids. Personnel should wan "After contact with secretions, excretions contaminated by ther "After removing gorocedures in which body is entered. "Before and after "After situations of contamination of han "After touching in likely to be contaminated procedures in when otherwise microorganisms to otherwise	sh their hands:  th blood, body fluids, s and equipment or articles m.  sloves and before performing a normally sterile part of the  touching wounds. during which microbial ds is likely to occur. animate sources that are ated with virulent or inficant microorganisms. Int contacts. indicated to avoid transfer of	F 8	varying shifts for 2 months. A be presented by the Administ Director of Nursing to the Quates Assurance and Performance Improvement team (QAPI), for recommendations for 2 month needed. The Director of Nursing responsible for the Plan of Cothe Administrator for sustaine compliance.  • Date of Compliance 4/15	rator or ality or review and hs and as sing is orrection and		
	removing the dressin donned clean gloves with wound cleanser- Treatment Nurse the	g, sanitized her hands, , and cleansed the wound					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		345142	B. WING			C 03/13/2024
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		00/10/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	The state of the s	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	ankle dressing and a Treatment Nurse the left knee and doffed hands, donned new clean the left knee we gauze and without of her hands and donn xeroform gauze to the border gauze dressisthen moved to the wearm and removed the wound with normal segloves, sanitizing her gloves applied xerof covered with a border same gloves on the the resident's bed we her in bed with pillow her trash, doffed her sanitized her hands the trash.  b. A wound observation of the sanitized her hands the trash.  b. A wound observation of the sanitized her hands the trash.	pe 83  oplied the hydrogel gauze and reapplied her boot. The en moved to the wound on the her gloves, sanitized her gloves, and proceeded to with wound cleanser-soaked offing her gloves applied the knee and covered with a lang. The Treatment Nurse round (a skin tear) on the left e dressing and cleansed the saline and without doffing her or hands, and donning new form gauze to the wound and the gauze dressing. With the Treatment Nurse adjusted in the controls, positioned to between her legs, gathered or gloves, left the room, and in the hallway after discarding the tinn was made on 02/29/24 at the treatment of the treatment hallway after discarding the treatment of the treatment hallway after dean of the treatment hallway after dean of the treatment hallway cleaned	F	880		
	the wound with anas wound cleaner)-soa her gloves, sanitizing new gloves she app hydrocolloid dressin same gloves on, she brief and adjusted the controls, repositione The Treatment Nurs washed her hands w	sept (antimicrobial skin and ked gauze and without doffing g her hands, and donning				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345142	B. WING			C <b>3/13/2024</b>	
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	•	35/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	Treatment Nurse rechad not doffed her gwounds, sanitized higloves before apply to the wounds. She about someone wat correct procedure.  An interview on 02/2 Infection Prevention done several in-service donning, and doffing equipment (PPE) but one-on-one education. The IP stated any timprocedure (cleaning procedure (applying should doff their glo don clean gloves are touching objects in the resident may later to the control of the control	29/24 at 9:59 AM with the vealed she did not realize she gloves after cleaning the er hands and donned clean ing treatment and dressings stated she was just nervous ching her and forgot to do the 29/24 at 11:51 AM with the list (IP) revealed they had vices on handwashing, g personal protective at said she would do on with the Treatment Nurse. The nurses went from a dirty a wound bed) to a clean at treatment to wounds) they wes, sanitize their hands, and and especially if they are the resident's room that the buch.  The Director of Nursing (DON) O PM revealed the Treatment vith them her errors during dent's #128 and #43. The ught the Treatment Nurse is someone watching her and did re-educate her on proper	F 88	30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345142	B. WING _		_	C 3/13/2024	
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 9200 GLENWATER DRIVE CHARLOTTE, NC 28262					
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F 880	Methicillin-Resista (MRSA) and Carb Enterobacterales Treatment Nurse and water and do the resident's dreshad a small amoud dressing. She dof the dressing, sani gloves, and clean cleanser-soaked at the doffed her gloves, and clean gloves are gloves. The Trevithout doffing he and donning clear dermacol collager silver and covered same gloves on the tresident's bed her in bed with pill her trash, doffed her in bed with pill her trash.  An interview on 02 Infection Prevention done several in-section Prevention done several in-section Prevention done deduction from the trash.	ier precautions due to ant Staphylococcus Aureus apenem-Resistant (CRE) in the wound. The washed her hands with soap aned clean gloves to remove using from her right ankle which ant of drainage on the old fed her gloves after removing tized her hands, donned clean sed the wound with wound gauze. The Treatment Nurse oves, sanitized her hands and ves. She then lifted Resident do began cleaning the wound colored drainage observed on eatment Nurse then proceeded ar gloves, and applied the finance and calcium alginate with the the Treatment Nurse adjusted with the controls, positioned low between her legs, gathered are gloves, left the room, and dis in the hallway after discarding are presonal protective but said she would do ation with the Treatment Nurse. It ime nurses went from a dirty and a wound bed) to a clean and treatment to wounds) they loves, sanitize their hands, and and especially if they are	FE	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING				C / <b>13/2024</b>	
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE NURSING AND REHABILITATION CENTER				9200	EET ADDRESS, CITY, STATE, ZIP CODE  GLENWATER DRIVE  ARLOTTE, NC 28262	1 03/	13/2024	
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 880	touching objects in the resident may later to  An interview with the on 02/29/24 at 12:00  Nurse had shared wite treatments for Resideshe thought the Treatments for Resideshe thought the Treatments for Resideshe thought the Treatments of the procedures and would re-educate he procedures and a chroniaffects movement, so functions.  Resident #51's care revealed a focus are activities of daily living to [chronic autoimmute.]	ne resident's room that the uch.  Director of Nursing (DON) PM revealed the Treatment th them her errors during ent #126. The DON stated tment Nurse was nervous thing her and she and the IP or on proper hand hygiene ld be monitoring her during ints.  Se admitted to the facility on se including neurogenic cautoimmune disorder that	F	380	DEFICIENCY)			
	assisting with activitic dressing, grooming, independence and dreinforcement for all Review of Resident and Data Set (MDS) asserve aled total dependence of management of the suprapulse cather of a suprapulse cather dressing and suprapulse cather dressing and suprapulse and dressing assistance	ignity, and provide positive activities.  #51's quarterly Minimum essment dated 1/17/24 dence for toilet and bathing. otion was noted to bilateral the resident was coded as f bowel and for the presence						

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		345142	B. WING			C <b>03/13/2024</b>	
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP C 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	•	33/13/2024		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	care. NA #1 was and applied gloves cleaning bowel moright and left butto soap. After the bothe NA went to the without removing bedside and open table to retrieve the applied the cream NA#1 proceeded to change bed linens gloves. NA #1 was uniform. After NA incontinence care removed his glove washing his hands up the barrier creatube and putting the beside table. The and dirty linen bag and continued down trash and soiled lines antitized his hand. Interview on 02/28 revealed he believ providing incontined did not realize he perform hand hygicompleted and be room. NA #1 state were not visibly dicare but stated he and after care.	age 87 ent #51 receiving incontinence observed washing his hands is. NA #1 was observed overment from Resident #51's ocks using a wet washcloth and owel movement was cleaned up a closet to get a clean adult briefinis dirty gloves. He returned to ed the drawer of the bedside to barrier cream, opened it, and to the resident's buttocks. To apply the adult brief and to and was still wearing dirty is also observed touching his #1 had completed the and changed the bed linens, he are sand washed his hands. After is NA #1 was observed picking and, placing the cap back on the ne barrier cream back into the ne hallway and placed the nens into barrels. NA#1 then is using hand sanitizer.  8/24 at 1:50 PM with NA #1 and the had done a good job bence care on Resident #51 and the had to remove dirty gloves and the ene immediately after care was fore touching surfaces in the end he thought since his gloves rety that he was okay to continue had washed his hands before	F	380			

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	345142 B. WING				C 03/13/2024		
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	<b>_</b> _	03/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	expect nursing staff to hygiene and glove po DON stated that all el in hand hygiene and g	e 88 o follow the policy for hand licy and procedures. The mployees had been trained glove policy and procedures rocess was to always be	F8				