DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. BUILDING _____ B. WING _____	C 02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately assess falls for two (2) of six (6) sampled residents (Resident #4 and #3) and failed to accurately assess one (1) of three (3) sampled residents with a urinary catheter	F 278	University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. University Place Nursing and Rehabilitation Centers response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, University Place Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	February 22, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Allen Kuffel QR

TITLE: Administrator

(X6) DATE: 2-17-12

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.

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BY:

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F 278	Continued From page 1 (Resident #10). The findings are: 1. Resident #4 was admitted to the facility on 1/31/11 with diagnoses that included Alzheimer's disease, and difficulty walking. The most recent Minimum Data Set (MDS) dated 12/26/11 specified the resident had no falls since the prior assessment. Review of Resident #4's medical record revealed nurses' entries that specified the resident had fallen on 10/16/11, 11/17/11 and 12/1/11. On 2/2/12 at 4:25 p.m. the MDS Coordinator was interviewed and reported she completed the assessment on Resident #4. She stated she used the facility's "Risk Management Report" to review resident falls. She reviewed Resident #4's fall history and confirmed the resident had three (3) falls during the assessment period that were not documented on the MDS assessment. She stated it was an oversight. On 2/2/12 at 6:30 p.m. the Administrator was interviewed and confirmed he expected the MDS assessments to be accurate. 2. Resident # 3 was admitted to the faclity with diagnoses that included Alzheimer's disease, cerebrovascular accident, seizure disorder and chronic obstructive pulmonary disease. The most recent Minimum Data Set (MDS), a quarterly assessment, dated 1/02/12 specified the resident had no falls since the prior assessment. Review of Resident #3's medical record revealed nurse's notes on 11/26/11 and 11/30/11 that specified the resident had fallen.	F 278	**F278** **Criteria One:** For Resident # 3 and 4 the care plan was updated by the Minimum Data Set Nurse on 02/02/2012 regarding the falls. For Resident # 10 the care plan was updated by the Minimum Data Set Nurse on 02/02/2012 regarding the urinary catheter by the Minimum Date Set Nurse. **Criteria Two:** A 100% audit was completed on the residents that have falls or urinary catheters and the care plans were updated by 02/03/2012. **Criteria Three:** The Minimum Data Set Nurses were re-educated by the Administrator and Director of Nursing on 02/03/2012 to ensure the Falls and urinary catheters were coded on the MDS and addressed on the care plan.	February 22, 2012

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F 278	Continued From page 2 On 2/2/12 at 4:25 p.m. the MDS Coordinator was interviewed and reported she completed the assessment on Resident #3. She stated she used the facility's "Risk Management Report" to review resident falls. She reviewed Resident #3's fall history and confirmed the resident had two (2) falls during the assessment period that were not documented on the MDS assessment. She stated it was an oversight. On 2/2/12 at 6:30 p.m. the Administrator was interviewed and confirmed he expected the MDS assessments to be accurate. 3. Resident #10 was admitted to the facility with diagnoses that included sepsis, dementia, end stage renal disease and metabolic encephalopathy. The most recent MDS, a significant change assessment, dated 1/09/12 specified the resident did not have a urinary catheter. Review of Resident #10's medical record revealed a physician's order dated 1/05/12 for "16 French 10cc (cubic centimeter) balloon foley." On 2/2/12 at 4:25 p.m. the MDS Coordinator was interviewed and reported she completed the assessment on Resident #10. She stated not indicating Resident #10 had an indwelling urinary catheter was an oversight. On 2/2/12 at 6:30 p.m. the Administrator was interviewed and confirmed he expected the MDS assessments to be accurate.	F 278	The Director of Nursing or licensed nurse designee will complete a 10% sample audit of the MDS and Care plans to ensure the falls and urinary catheters were coded on the MDS and updated on the care plan bi-monthly for three months. **Criteria Four:** The Director of Nursing or Nurse Designee will review the completed audits with the Quality Assurance and Assessment Team monthly for three months for further follow up and recommendations or continuation as indicated.	February 22, 2012
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 3 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview facility staff failed to administer sliding scale insulin as ordered for one (1) of three (3) sampled residents. (Resident #8). The findings are: Resident #8 was admitted with diagnoses including Diabetes Mellitus Type II, Alzheimer ' s disease, Hypertension and Peripheral Vascular Disease. A review of the January and February 2012 monthly recapitulation of physician orders included an order for fingerstick blood sugars to be done every day at 6:30 AM and 4:30 PM with Novolog sliding scale insulin to be given as follows: for blood sugars of 151 - 200: 2 units; 201 - 250: 4 units; 251 - 300: 6 units; 301 - 350: 8 units; 351 - 400: 10 units; above 400: 12 units and re-check in two (2) hours. If still above 400, give 6 additional units Humalog insulin; otherwise no treatment According to the January and February 2012 Medication Administration Record (MAR) Resident #8's blood sugar was scheduled to be	F 309	**F309** **Criteria One:** A Registered Nurse reviewed Resident # 8 on 02/02/2012 to ensure their blood sugars were monitored, medication administered per the physician order, was assessed for signs and symptoms of hyper/hypo glycemia and the physician was notified as indicated. **Criteria Two:** A 100% audit of all diabetic residents was completed on 02/02/2012 by the Director of Nursing, Quality Indicator Nurse, Laboratory Nurse, MDS Nurses and Treatment Nurse. The audits checked for the following: 1. MD Order for diabetic medication matched the Medication Administration Record (MAR) 2. The correct diabetic medication was available on the medication cart. 3. MAR was reviewed for accuracy of sliding scale insulin dosage as compared to what was documented as being given per the MD order.	February 22, 2012

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F 309	Continued From page 4 checked at 6:30 AM and 4:30 PM every day. Further review of the January 2012 MAR revealed there were four (4) instances when the correct dosage of sliding scale insulin was not given: a) 1/3/12 - 6:30 AM: Blood sugar - 167 - 2 units of insulin was ordered - " 0 " documented as given b) 1/11/12 - 4:30 PM: Blood sugar - 462 - 12 units of insulin was ordered - " 10 " documented as given c) 1/12/12 - 4:30 PM: Blood sugar - 450 - 12 units of insulin was ordered - " 10 " documented as given d) 1/14/12 - 6:30 AM: Blood sugar - 155 - 2 units of insulin was ordered - " 0 " documented as given Review of the February 2012 MAR revealed one (1) instance when the correct dosage of sliding scale insulin was not given: 2/1/12 - 4:30 PM: Blood sugar - 229 - 4 units of insulin was ordered - " 2 " documented as given A telephone interview with Licensed Nurse (LN) # 1, who was at the facility, on 2/3/12 at 7:50 AM about the sliding scale insulin that was documented as not given to Resident #8 on 1/3/12 and 1/14/12 at 6:30 AM revealed she thought she might not have given it because sliding scale insulin coverage was usually not ordered unless a resident's blood sugar was over 200. A telephone interview with LN #4 on 2/3/12 at 10:37 AM about administering the incorrect dosage of sliding scale insulin at 4:30 PM on 1/11/12, 1/12/12 and 2/1/12 revealed that LN #4	F 309	4. Blood Sugars were reviewed to ensure the correct amount of sliding scale insulin was given. Immediate correction of missing documentation was completed upon identification by the Registered Nurses completing the audits. No other issues were identified during this audit. The consulting pharmacists completed a 100% medical record reviewed by 02/04/2012 for the maintenance of glucose control. **Criteria Three:** Beginning on 02/02/2012 the RN-Staff Development Director began re-educating the Licensed nurses on obtaining, transcribing, delivering the insulin per the physicians order, when to call the physician if the Blood Sugar indicates hyper/hypo glycemia, and the protocol for standing orders for the treatment of hypo glycemia. The 100% retraining was completed Monday 02/06/2012.	February 22, 2012

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F 309	Continued From page 5 could not recall any details about those dates. LN #4 stated she usually gave whatever was ordered.	F 309	The New Hire orientation was updated on 02/06/2012 to include how to monitor blood sugars, medication administration per the physician order, assessing for signs and symptoms of hyper/hypo glycemia, physician notification as indicated and the standing orders for hypo glycemia. Medication Pass audits began on 02/03/2012 to observe the correct dose of sliding scale insulin, complete documentation, and appropriate interventions were taken for hypo/hyper glycemic blood sugars The consulting pharmacists completed random medication pass audits by 02/04/2012 for the maintenance of glucose control. The Director of Nursing and Registered Nurse Supervisors reviewed the MAR of the residents that are receiving insulin medication daily for seven days, weekly	February 22, 2012
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview facility staff failed to document that sliding scale insulin was given as ordered and failed to document fingerstick blood sugars were checked as ordered for two (2) of two (2) sampled residents. (Residents #8 and #9). The findings are: 1. Resident #9 was admitted with diagnoses including acute cerebrovascular accident, diabetes mellitus Type II, hypertension and hyperlipidemia. Resident #9 received all nutrition and medications through a gastrostomy tube inserted directly into her stomach.	F 514		

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F 514	Continued From page 6 A review of the January 2012 monthly recapitulation of physician orders included an order for fingerstick blood sugars to be done at 12:00 PM and 6:00 PM every day with Novolog sliding scale insulin to be given as follows: for blood sugars of 0 - 200: none; 201 - 250: 2 units; 251 - 300: 4 units; 301 - 350: 6 units; 351 - 400: 8 units; above 400: 10 units; and above 600: call physician. For blood sugars of less than 70, administer Glucagon Hydrochloride 1 mg (milligram) IM (intramuscularly). Resident #9 also had orders for Levemir 32 units every day at 8:30 AM and Levemir 14 units every day at 8:30 PM. Levemir is a man-made long-acting insulin. According to the January 2012 Medication Administration Record (MAR) Resident #9's blood sugar was to be checked at 12:00 PM and 6:00 PM every day and insulin or glucagon administered according to the above parameters. The January MAR listed Levemir 32 units scheduled for 8:30 AM daily and Levemir 14 units scheduled for 8:30 PM daily. Further review of the January 2012 MAR revealed the Levemir scheduled for 8:30 AM was not documented as given on 1/1/12, 1/20/12, 1/28/12 or 1/29/12. The Levemir scheduled for 8:30 PM was not documented as given on 1/31/12. Further review of the January 2012 MAR revealed four (4) instances when there was no documentation to indicate Glucagon was given according to the prescribed parameters for administration: a) 1/8/12 - 12:00 PM: Blood sugar - 37 - Glucagon ordered - no documentation that it was	F 514	for four weeks and monthly for three months . The Director of Nursing or Nurse designee will review the completed audits with the Quality Assurance and Assessment Team monthly for further follow up and recommendations as indicated. **F514** **Criteria One:** Resident # 8 and # 9 had their blood sugars documented, medication administered per the physician order and documented. The residents were assessed for signs and symptoms of hyper/hypo glycemia and the physician was notified if indicated and documented per the protocol by the Registered Nurse **Criteria Two:** A 100% audit of all diabetic residents was completed on 02/02/2012 by the Director of Nursing, Quality Indicator Nurse, Laboratory Nurse, MDS Nurses and Treatment Nurse. The audits	February 22, 2012

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F 514	Continued From page 7 given b) 1/10/12 - 12:00 PM: Blood sugar - 64 - Glucagon ordered - no documentation that it was given c) 1/13/12 - 12:00 PM: Blood sugar - 65 - Glucagon ordered - no documentation that it was given d) 1/17/12 - 12:00 PM : Blood sugar - 41 - Glucagon ordered - no documentation that it was given An interview with LN #5 on 2/3/12 at 9:58 AM about the scheduled dosage of Levemir insulin that was not documented as given at 8:30 AM on 1/1/12, 1/28/12 and 1/29/12 and the Glucagon that was not documented as given on 1/8/12 at 12:00 PM to Resident #9. LN #5 stated she knows she gave the insulin scheduled for administration at 8:30 AM on 1/1/12, 1/28/12 and 1/29/12. She was unable to state why she didn't document that it was given. LN #5 was unable to recall any details about Resident #9's condition on 1/8/12. She stated there were times when she got a low blood sugar reading and it was due to a malfunction of the glucometer. LN #5 stated when that happened she re-checked the blood sugar with a different glucometer. She was unable to recall if she re-checked Resident #9's blood sugar on 1/8/12. An interview with LN #6 on 2/3/12 at 10:50 AM about the Glucagon not being documented as given for Resident #9 on 1/10/12, 1/13/12 and 1/17/12. LN#6 stated she gave Glucagon to Resident #9 on 1/10/12, 1/13/12 and 1/17/12. She stated she must have forgotten to document that she gave it.	F 514	checked for the following: 1. MD Order for diabetic medication matched the Medication Administration Record (MAR) 2. The correct diabetic medication was available on the medication cart. 3. MAR was reviewed for accuracy of sliding scale insulin dosage as compared to what was documented as being given per the MD order. 4. Blood Sugars were reviewed to ensure they were documented and re-checked per the protocol. Immediate correction of missing documentation was completed upon identification. No other issues were identified during this audit. The consulting pharmacists completed a 100% medical record review by 02/04/2012 for the maintenance of glucose control.	February 22, 2012

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F 514	Continued From page 8 2. Resident #8 was admitted with diagnoses including Diabetes Mellitus Type II, Alzheimer ' s disease, Hypertension and Peripheral Vascular Disease. A review of the January and February 2012 monthly recapitulation of physician orders included an order for fingerstick blood sugars to be done every day at 6:30 AM and 4:30 PM with Novolog sliding scale insulin to be given as follows: for blood sugars of 151 - 200: 2 units; 201 - 250: 4 units; 251 - 300: 6 units; 301 - 350: 8 units; 351 - 400: 10 units; above 400: 12 units and re-check in two (2) hours. If still above 400, give 6 additional units Humalog insulin; otherwise no treatment. Resident #8 also had orders for Lantus 20 units every day at 8:30 AM and Lantus 25 units every evening at 8:30 PM. According to the January and February 2012 Medication Administration Record (MAR) Resident #8's blood sugar was scheduled to be checked at 6:30 AM and 4:30 PM every day. Also, listed on the MARs was Lantus 20 units daily at 8:30 AM and Lantus 25 units daily at 8:30 PM. A review of the January 2012 MAR revealed no documentation that Resident # 8's blood sugar was checked on January 1,15 or 16 at 6:30 AM or on January 1 at 4:30 PM. A review of the blood sugar summary on the electronic record also did not indicate any blood sugar checks on January 1, 15 or 16 at 6:30 AM or on January 1 at 4:30 PM. Further review of the January 2012 MAR revealed the insulin scheduled to be given on 1/1/12 at	F 514	**Criteria Three:** Beginning on 02/06/2012 the RN-Staff Development Director completed a 100% retraining for Licensed nurses on obtaining, transcribing, delivering the insulin per the physician order, documenting on the MAR. When to call the physician if the Blood Sugar indicates hyper/hypo glycemia and the documentation required when using protocol for standing orders for the treatment of hypo glycemia. The New Hire orientation will include the aforementioned for licensed nurses by 02/06/2012. Medication Pass audits began on 02/03/2012 to observe the correct dose of sliding scale insulin, complete documentation, and appropriate interventions were taken for hypo/hyper glycemic blood sugars.	February 22, 2012

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F 514	Continued From page 9 8:30 PM and on 1/8/12 at 8:30 AM was not documented as given. An interview with LN #2 on 2/3/12 at 9:48 AM about the dosage of insulin scheduled for 1/1/12 at 8:30 PM that was not documented as given and the fingerstick blood sugars at 6:30 AM on 1/1/12, 1/15/12 and 1/16/12 that were not documented as checked. LN #2 stated she remembered giving the dosage of insulin on 1/1/12 at 8:30 PM but must have forgotten to initial the MAR. She also stated she remembers checking Resident #8's blood sugar at 6:30 AM on 1/1/12, 1/15/12 and 1/16/12 and usually documents blood sugars on the MAR and the electronic flow sheet. LN #2 was unable to state why she failed to document the blood sugars. An interview with LN #3 on 2/3/12 at 10:20 AM about the dosage of insulin scheduled for 1/8/12 at 8:30 AM that was not documented as given revealed that she feels sure she gave it because she always does but must have missed initialing the MAR. An interview with LN #4 on 2/3/12 at 10:37 AM about administering the incorrect dosage of sliding scale insulin at 4:30 PM on 1/11/12, 1/12/12 and 2/1/12 revealed that LN #4 could not recall any details about those dates or why Resident #8's blood sugar was not rechecked as ordered. LN #4 stated she usually gave whatever was ordered.	F 514	The Director of Nursing and Registered Nurse Supervisors will review the MAR of the residents that are receiving insulin medication for the documentation of correct insulin dosage, blood sugars and intervention with documentation for episodes of hypo/hyper glycemia daily for daily for seven days, weekly for four weeks and monthly for three months . The consulting pharmacists completed random medication pass audits by 02/04/2012 for the maintenance and documentation of glucose control. **Criteria Four:** The Director of Nursing or Nurse designee will review the completed audits with the Quality Assurance and Assessment Team monthly for further follow up and recommendations as indicated.	February 22, 2012