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 05/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

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F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident, staff and nurse practitioner interviews, and record review, the facility failed to schedule an orthopedic appointment for 1 of 3 sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 04/22/15 with diagnoses which included multiple sclerosis. Review of Resident #3's annual Minimum Data Set dated 04/20/16 revealed an assessment of severely impaired cognition. Review of a nurse practitioner's (NP) order dated 04/15/16 revealed Resident #3 should receive "ASAP (as soon as possible)"orthopedic consultation for knee pain and swelling. The NP progress note dated 04/15/16 documented Resident #1 would "likely need aspiration and/or steroid injection." Review of a NP progress note dated 05/02/16 revealed Resident #3 described the left knee as painful. The NP documented Resident #3 was "waiting to see orthopedics." The NP ordered a steroid medication and continuation of a topical	F 250	Resident #3 had an appointment made with CMC Myers Park Ortho Dr. Bosse on 5/26/2016. On 6/3/2016 a 100% audit of all appointment referrals for the past 30 days to ensure appointments were scheduled and if unable to schedule the MD was notified was completed by the Administrator. There were no negative findings. On 6/8/2016 the Administrator initiated an in-service with the Transportation Aides to notify the nursing staff if an appointment is unable to be scheduled. On 6/7/2016 the Social Workers, LPNS and RNS were in-serviced by the Administrator on notifying the MD and/or NP if an appointment is unable to be scheduled and for further instructions. All appointment referrals will be audited weekly to ensure that if an appointment was not scheduled that the MD and/or NP were notified. The Administrator and/or Director of Nursing will review the completed audits weekly x 4 then every 2	6/17/16

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

Electronically Signed | 06/09/2016

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F 250	Continued From page 1 analgesic medication. Review of Resident #3's clinical record revealed no documentation of an orthopedic consultation. Review of a nursing note dated 05/20/16 revealed Resident #3 requested and received an emergency room evaluation for left knee pain. Resident #3 returned to the facility with a brace on the left knee and orders for a follow-up orthopedic appointment. Interview with Nurse #1 on 05/24/16 at 8:40 AM revealed Resident #3 made decisions and was cognitively intact. Interview with Resident #3 on 05/24/16 at 8:45 AM revealed Resident #3 was oriented to person, place, time and situation. Resident #3 explained the facility did not arrange an orthopedic appointment so he asked to go the emergency room for the knee pain. Interview with the facility's transporter/scheduler on 05/24/16 at 9:20 AM revealed an orthopedic appointment was not scheduled for Resident #3. The transporter/scheduler explained the orthopedic group contacted refused to make an appointment for Resident #3 due to an outstanding bill. The transporter/scheduler explained he informed social worker #1 of the inability to schedule Resident #3's orthopedic appointment. Interview with social worker #1 on 05/24/16 at 9:35 AM revealed Resident #3 would not be seen by the orthopedist. The social worker explained another orthopedist could not be arranged since Resident #3's physician only used a certain	F 250	weeks x 8 weeks, then monthly x 3 months. The results of the 100% audit and the weekly audits will be reviewed by the Administrator. The Administrator and/or DON will present the findings and recommendations of the audits to the monthly QI Committee to the quarterly QI Committee for further recommendations and oversight	

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F 250	Continued From page 2 orthopedic group. Social worker #1 reported he did not inform nursing staff or Resident #3's physician and NP. Telephone interview with the NP on 05/24/16 at 9:55 AM revealed she was not aware an orthopedic appointment had not been scheduled for Resident #3. The NP explained Resident #3 should not wait for an orthopedic appointment since an alternative arrangement could be made. Interview with the Director of Nursing on 05/24/16 at 10:14 AM revealed she was aware of the inability to make Resident #3's orthopedic appointment but thought the NP received notification. Interview with the Administrator on 05/24/16 at 10:24 AM revealed she expected staff to schedule Resident #3's orthopedic appointment and notify the NP or physician if the appointment was unable to be scheduled.	F 250		
F 278 SS=D	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.	F 278		6/17/16

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F 278	Continued From page 3 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 resident and staff interviews and record review, the facility failed to accurately code the Minimum Data Set for 1 of 3 sampled residents (Resident #3). The findings included: Review of the facility provided list of cognitively intact residents dated 05/23/16 revealed Resident #3 listed as able to be interviewed. Resident #3 was admitted to the facility on 04/22/15 with diagnoses which included multiple sclerosis. Resident #3 was listed as the responsible person. Review of Resident #3's annual MDS dated 04/20/16 revealed an assessment of severely impaired cognition. Interview with Nurse #1 on 05/24/16 at 8:40 AM	F 278	On 5/24/2016 the MDS in reference to the BIMS score was modified for Resident #3. A 100% audit was completed by the Administrator on 6/8/2016 to ensure that all BIMS scores are accurate for each of the residents. There were no negative findings. The RAI-CT, RAI/Reimbursement Auditor completed an in-service with the Social Workers related to accurately completing the BIMS Assessment per the RAI manual on 6/7/2016. The results of the 100% audit will be reviewed by the Administrator. The Administrator and/or Director of Nursing will audit 20% of the Resident's BIMS Assessment for accuracy using a QI MDS	

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F 278	Continued From page 4 revealed Resident #3 made decisions and was cognitively intact. Interview with Resident #3 on 05/24/16 at 8:45 AM revealed Resident #3 was oriented to person, place, time and situation. Interview with social worker (SW) #1 on 05/24/16 at 11:07 AM revealed he coded cognition on the MDS. SW #1 reported Resident #3's MDS contained an incorrect coding for cognition. SW #1 explained he made an error and Resident #3 was cognitively intact. Interview with the MDS Registered Nurse coordinator on 05/24/16 at 1:23 PM revealed she signed the MDS as completed by the appropriate discipline and did not check for accuracy of the MDS.	F 278	Accuracy Audit tool. This audit will be completed weekly x4 weeks then every two weeks x 8 weeks then monthly x 3 months by the Administrator and/or the an Administrative Nurse. The monthly QI Committee will review the results of the BIMS Assessment Tool monthly x 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The Administrator and/or DON will present the findings and recommendations of the monthly QI Committee to the Quarterly Executive QA Committee to the Quarterly Executive QA Committee for further recommendations and oversight.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 resident, staff and nurse practitioner interviews, and record review, the facility failed to schedule an orthopedic appointment which prolonged knee pain and delayed treatment for 1 of 3 sampled residents (Resident #3).	F 309	On 5/20/2016 Resident #3 was seen in the Emergency Department and an Immobilizer was put on his left leg. On 5/26/2016 Resident #3 went to an appointment with Dr. Bosse with CMC	6/17/16

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F 309	Continued From page 5 The findings included: Resident #3 was admitted to the facility on 04/22/15 with diagnoses which included multiple sclerosis. Review of Resident #3's annual Minimum Data Set dated 04/20/16 revealed an assessment of severely impaired cognition. Review of a nursing note dated 04/05/16 revealed Resident #3 complained of left knee pain and swelling. The nurse practitioner (NP) received notification and ordered an x-ray of the left knee. Review of an x-ray result dated 04/05/15 revealed no fracture with suggestion of a small joint effusion. Review of a nursing note dated 04/15/16 revealed Resident #3 refused to get into the wheel chair due to left knee pain. The note described Resident #3's left knee as swollen. The NP received notification and pain medication administered. Review of the NP's order dated 04/15/16 revealed Resident #3 should receive "ASAP (as soon as possible)" orthopedic consultation for knee pain and swelling. The NP progress note dated 04/15/16 documented Resident #1 would "likely need aspiration and/or steroid injection." The NP ordered Voltaren gel application (a non-steroidal, anti-inflammatory topical medication) to the left knee three times daily. Review of a nursing note dated 04/29/16 revealed Resident #3 refused a shower due to left knee	F 309	Myers Park. ON 6/3/2016 the Administrator completed a 100% audit of all appointment referrals for the past 30 days to ensure appointments were scheduled and if unable to schedule the MD was notified. No negative findings occurred. The Administrator initiated an in-service on June 8, 2016 with the Social Workers and Transportation Aides to notify the Nursing Staff if an appointment is unable to be scheduled and for further instructions. On 6/7/2016 the Licensed Nursing Staff were in-serviced by the Administrator on notifying the MD and/or NP if an appointment is unable to be scheduled and for further instructions. All appointment referrals will be audited weekly to ensure that if an appointment was not scheduled that the MD and/or NP was notified. The Administrator and/or Director of Nursing will review the completed audits weekly x4, then every 2 weeks x 8 weeks, then monthly x 3 months. The results of the 100% audit and the weekly audits will be reviewed by the Administrator. The Administrator and DON will present the findings and recommendations of the audits to the monthly QI Committee to the Quarterly QI Committee for further recommendations and oversight.	

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F 309	Continued From page 6	F 309		

pain.

Review of a NP progress note dated 05/02/16 revealed Resident #3 described the left knee as painful. The NP documented Resident #3 was "waiting to see orthopedics." The NP ordered Prednisone (steroid) 10 day taper, continuation of the Voltaren gel applications and twenty minute ice applications to the left knee three times daily.

Review of a nursing note dated 05/20/16 revealed Resident #3 requested to be seen at the emergency for left knee pain. Resident #3 returned with a left knee brace and orders for a follow-up orthopedic appointment.

Review of Resident #3's emergency room report dated 05/20/16 revealed the physician documented left knee pain and swelling. Resident #3's left leg x-ray dated 05/20/16 result documented left knee effusion with possible impaction fracture.

Interview with Nurse Aide #1 on 05/23/16 at 4:45 PM revealed Resident #3 complained of left knee pain daily which she reported to the nurse.

Interview with Nurse #1 on 05/24/16 at 8:40 AM revealed Resident #3 made decisions and was cognitively intact.

Interview with Resident #3 on 05/24/16 at 8:45 AM revealed Resident #3 was oriented to person, place, time and situation. Resident #3 explained his left knee pain eased after the application of the brace at the hospital. Resident #3 reported he requested to go to the hospital since his left knee pain did not get better with the medication and ice packs and the orthopedic appointment did

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F 309	Continued From page 7 not occur. Interview with Nurse #2 on 05/24/16 at 9:45 AM revealed Resident #3 complained of left knee pain daily and received ice applications and the medication ordered. Nurse #2 explained she transferred Resident #3 to the emergency room on his request and after receipt of NP's order. Telephone interview with the NP on 05/24/16 at 9:55 AM revealed she was not aware an orthopedic appointment had not been scheduled for Resident #3. The NP explained Resident #3's knee treatment would most likely require injections administered with guidance from ultrasound due his history of blood clots. The NP reported the facility notified her of Resident #3's request to be seen at hospital. The NP explained she was not aware Resident #3 continued to experience left knee pain and did not receive an orthopedic appointment.	F 309		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		6/17/16

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F 520	Continued From page 8 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interviews and facility record reviews the facility's Quality Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place in March of 2016. This was for one recited deficiency which was originally cited in February of 2016 on a recertification survey and on the current Complaint Investigation. The deficiencies were in the area of Assessment Accuracy/Coordination/Certified. The continued failure of the facility during one federal survey of record and the current Complaint Investigation show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: The tag is cross referred to The facility was recited F 278 for failing to accurately code cognition on the Minimum Data Set (MDS) for 1 of 3 sampled residents (Resident #3). F 278 was originally cited at the February 2016 recertification survey during which the facility failed to include active diagnoses and accurately	F 520	On 5/26/2016 the Facility QI Committee held a meeting. The Medical Director, Administrator, DON, QI Nurse, MDS Nurse, Treatment Nurse, Maintenance Supervisor and Housekeeping Supervisor will attend the QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 5/31/2016 the Facility Nurse Consultant in-serviced the Facility Administrator, DON, MDS Nurse, Treatment Nurse, Social Workers, Maintenance Supervisor and Housekeeping Supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F tag 278 Accuracy of MDS related to BIMS. As of June 7, 2016, after the Facility Consultant	

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F 520	Continued From page 9 record the dental status for a resident when completing an admission Minimum Data Set for 1 of 23 sampled residents. On 05/24/16 at 1:40 PM, an interview was conducted with the facility Administrator regarding inaccurate documentation of MDS information. The Administrator stated she had been auditing resident Minimum Data Sets (MDS) and that Executive Quality Improvement (QI) now reviewed annual and old surveys. The Administrator relayed that QI committees had been meeting, had been performing round sheets, and were reviewing MDS CAAS documentation. As a result of the Complaint Investigation on 05/23/16, the Administrator stated she would now include resident's Brief Interview for Mental Status (BIMS) scores in the audit.	F 520	in-serviced the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review work orders, review Point Click Care (Electronic Medical Record), Resident Council Minutes, Resident Concern Logs, Pharmacy Reports, and Regional Facility Consultant Recommendations. Corrective action has been for the identified concerns related to F 278 Quality Assurance related to the accuracy of BIMS Assessment and F520 Quality Assessment and Assurance Committee. The Facility QI Committee will meet at the minimum of monthly. The QI Committee, including the Medical Director, will review monthly complied QI Report information, review trends, and review corrective actions taken and the date's completion. The QI Committee will validate the facility's progress in correction of deficient practices or identified concerns. The Administrator will be responsible for ensuring Committee concerns are addressed through further training and other interventions. The Administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	