PRINTED: 01/17/2017 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		345142	B. WING				1-C
	ROVIDER OR SUPPLIER TY PLACE NURSING AN	D REHABILITATION CENTER	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	E	12/	29/2016
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
{F 431} SS=E	The facility must emp a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliation records are in order a controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance professional principle appropriate accessory instructions, and the eapplicable. In accordance with St facility must store all clocked compartments controls, and permit of have access to the keep the facility must proving the facility must pro	loy or obtain the services of a who establishes a system and disposition of all efficient detail to enable an an; and determines that drug and that an account of all eintained and periodically a used in the facility must be a with currently accepted as, and include the ay and cautionary expiration date when the drugs and biologicals in an under proper temperature and authorized personnel to eys.	{F 4	On 12/29/2016 the expired In	nsulin for		1/16/17
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	TITLE			(X6) DATE

01/13/2017 **Electronically Signed** 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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OL. VIEIV	OT OTT MEDIONATE OF	WEDIO/ ND CERVICES				0.11.0	. 0000 0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDII			R	-C
		345142	B. WING _				29/2016
NAME OF P	ROVIDER OR SUPPLIER	•	,	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HINIVEDSI	ITV DI ACE NI IDSING AN	ND REHABILITATION CENTER		92	200 GLENWATER DRIVE		
				С	HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					BEHOLINOTY		
{F 431}	Continued From page	o 1	{F 4	211			
(101)			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	313	regidents #09 and #102 were disparded		
		ility failed to remove expired e on 1 of 7 medication carts			residents #98 and #192 were discarded	1	
					by the Interim Director of Nursing and		
	and 2 of 2 medication Findings included:	i storage rooms.			ordered from pharmacy. The expired PPD and Pneumovac vials from the		
		ity's insulin storage policy			medication room refrigerators were		
		ed that vials should be dated			discarded by the Interim Director of		
		nused portions should be			Nursing on 12/29/2016 and reordered		
	discarded within 28 c				from pharmacy.		
		admitted 03/18/2014 with					
	diagnoses that include			A 100% audit was completed on			
	Further review of the			12/29/2016 by the Interim Director of			
	Record (MAR) reveal	led the resident had received			Nursing to ensure all medications to		
	, ,	for sliding scale coverage			include Insulin, PPD, and Pneumovac		
		r readings at 4:30 PM on			vials are properly stored, dated and		
	12/12/2016, 12/13/20	016, 12/16/2016, 12/19/2016,			labeled. All identified areas of concern		
	12/21/2016, 12/22/20)16 and 12/27/2016.			were immediately corrected by the Inte	rim	
	Observation on 12/28	3/2016 at 12:06 PM of the			Director of Nursing on 12/29/2016.		
	Garden City medicati	ion storage room revealed					
	Resident #98's Huma	alog insulin was dated as			An in-service was initiated with 100% o	f	
	opened 11/08/2016 a	and had expired 12/08/2016,			all licensed nurses to include nurse #1		
	28 days after being o				and nurse #2 regarding the dating of ar		
		016 at 12:06 PM with Nurse			expiration of medications including Insu		
		h nurse checked and pulled			PPD, and Pneumovac vials by the Staf	f	
	expired medications.				Facilitator. The in-service will be 100%	_	
		/28/2016 at 12:32 PM of the			completed on 1/16/2017. All newly hire	ed	
		n storage area revealed			licensed nurses will be in-serviced		
	·	vial open and dated 08/19.			regarding dating of and expiration of		
		cine in the vial. The vial was			multi-dose vials during new employee		
	_	e. Tuberculin skin test			orientation.		
	multi-dose vial was opened. It was not dated when it was opened so an expiration date 28				The Director of Nursing, Assistant		
	days after opening co				Director of Nursing, Assistant Director of Nursing, Unit Manager, QI	9	
		016 at 12:32 PM with Nurse			Nurse or RN Supervisor will check all		
					medication carts and medication rooms		
	expired medications.	·					
		s admitted 06/29/2016 with			monthly x3 months to ensure each cart		
	diagnosis that include				and medication room including medicat		
	_	MAR revealed Resident			refrigerators are free from expired		
		lin N insulin 8 units every			medications to include Insulin, PPD, an	d l	

Facility ID: 923015

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345142	B. WING				-C
		345142	D. WING _			12/	29/2016
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
IINIVERSI	TY PLACE NURSING AN	ID REHABII ITATION CENTER		920	0 GLENWATER DRIVE		
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER			CH	ARLOTTE, 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 SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 431}	Continued From page	e 2	{F 43	31}			
{F 490} SS=E	morning and Humulin He received the insul 12/25/2016, 12/26/20 12/28/2016. Observation on 12/29 medication cart reveal Humulin insulin label 11/24/2016 and had after being opened. During an Interview on Nurse #2 revealed the for expired medication the medication cart. Interview on 12/29/20 Interim Director of Nua vial was not totally the 28th day after being discarded. We all mamedications. The DO medications that were date when administed Interview on 12/29/20 Medical Director revegiven a couple of day would still be effective days or longer after it day in use, then one have the same effectives to remove expired days after it was open that medications were when administered. 483.75 EFFECTIVE ADMINISTRATION/R	in from the expired vial on 16, 12/27/2016 and 18/2016 at 08:40 AM 900 hall alled Resident #192's indicated it was opened expired 12/24/2016, 28 days on 12/29/2016 at 08:40 AM at all nurses were to check has and remove them from 16 at 10:09 AM with the arsing (DON revealed that if used or they were expired by ng opened, they should be ke rounds and pull expired N's expectation was that all administered should be in red. 16 at 10:55 AM with the realed he believed insuling after the expiration date and the safety of the stated if it was 10 as after the expiration date and not be sure it would inveness. He stated the policy and insuling and medication 28 and. It was his expectation are in date and not expired the infinistered in a manner that	{F 49		Pneumovac vials using the Expired Medication Audit Tool. Audits will inclu ensuring vials of medication are proper dated and stored. All identified areas of concern will be immediately corrected. The monthly QI Committee will review results of the Expired Medications Audit Tool monthly for 6 months for identification of trends, actions taken, and to determ the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrational and/or DON will present the findings are recommendations of the monthly QI committee to the quarterly Executive QC Committee for further recommendation and oversight.	rly of the it ition ine ator ad	1/16/17
	enables it to use its re efficiently to attain or	esources effectively and maintain the highest					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		DATE SURVEY COMPLETED
		345142	B. WING			R-C 12/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	12/29/2010
				9200 GLENWATER DRIVE		
UNIVERS	ITY PLACE NURSING A	AND REHABILITATION CENTER		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	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 490}	Continued From pa practicable physica well-being of each r	l, mental, and psychosocial	{F 49	0}		
	by: Based on observate record review, the facility was record for an arooms. The facility was record to remove expired in opened tuberculin soriginally cited durin 11/03/16 for failure medication. F431 views with the facility was record to remove expired in opened tuberculin soriginally cited durin 11/03/16 for failure medication. F431 views expired medication.	This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's administration failed to utilize its resources effectively to sustain an effective Quality Assurance and Assessment program through implemented procedures and monitoring of these interventions that the committee put into place after three federal survey of record for two repeat deficiencies in the areas of medication storage and Quality Assessment and Assurance. The findings included: This tag is cross referenced to: F431: Based on observations, staff interviews and record review, the facility failed to remove expired medications from use on 1 of 7 medication carts and 2 of 2 medication storage rooms. The facility was recited for F431 regarding failure to remove expired insulin and an undated, opened tuberculin skin test vial. F431 was priginally cited during a survey completed on 11/03/16 for failure to remove an expired pain medication. F431 was also cited on a recertification survey on 02/04/16 for failure to		On 1/16/2017 the facility QI C held a meeting. The Medical I Administrator, DON, ADON, Q MDS Nurse, Maintenance Sup Housekeeping Supervisor will Committee Meetings on an on and will assign additional team as appropriate. On 1/9/2017 the Facility Const in-serviced the Facility Administ DON, ADON, MDS Nurse, Mai Supervisor, Housekeeping Suprelated to the appropriate functing the QI Committee and the purpomittee to include identified related to quality assessment assurance activities as needed developing and implementing a plans of action for identified coinclude F 431 Pharmacy, F490 Administration and F520 Quality Assessment and Assurance Committee will continue to minimum of monthly. The QI Committee will continue to including the Medical Director, monthly complied QI Report for information, review trends, and corrective actions taken and discompletion. The QI Committee validate the facility's progression of deficient practices or identification.	Director, al Nurse, pervisor and attend QI going basis in members ultant strator, intenance pervisor tioning of pose of the I issues and dappropriate procerns, to D Effective ity ommittee. Do meet a Committee will review or direview ate's e will in correction	

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 29/2016
	ROVIDER OR SUPPLIER TY PLACE NURSING AN	D REHABILITATION CENTER		92	REET ADDRESS, CITY, STATE, ZIP CODE 00 GLENWATER DRIVE HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 490} {F 520} SS=E	maintain implemented these interventions the in December, 2016. In December, 2016. In December, 2016. In deficiencies which we facility's current recers on 11/03/16. The defi medication storage at addition, the facility remedication storage at during a recertification 02/04/16. The continuous during three federal is pattern of the facility's effective Quality Assurburing 3 federal survey 2016 Recertification/02/016 Recertification/02/016 Recertification/03/016, the facility's current Revis 2016, the facility's Adan effective Quality A repeat deficiencies in 483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS A facility must maintal assurance committee nursing services; a phacility; and at least 3 facility's staff. The quality assessment committee meets at least assues with respect to the services of the se	urance Committee failed to d procedures and monitor are committee put into place. This was for recited are originally cited during the tification survey completed ciencies were in the area of and facility administration. In acceived citations for and effective administration an survey conducted on used failure of the facility urveys of record show a sinability to sustain an arance Program. Beys of record, February Complaint survey, November Complaint survey and the sit survey of December ministrator failed to sustain assurance Program due to medication storage. ERS/MEET In a quality assessment and a consisting of the director of anysician designated by the other members of the	{F 4		concerns. The Administrator will be responsible for ensuring the Committee concerns are addressed through furthe training and other interventions. The Administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	r	1/16/17

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		LETED
		345142	B. WING_				-C 29/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 121	29/2016
LININ/EDOI	TV DI ACE NUIDOINO A	ND DELIABILITATION CENTED	9200 GLENWATER		200 GLENWATER DRIVE		
UNIVERSI	IT PLACE NURSING A	ND REHABILITATION CENTER		С	HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 520}	Continued From pag	ge 5	{F 5	20}			
		nents appropriate plans of ntified quality deficiencies.					
	disclosure of the rec except insofar as su compliance of such						
	-	by the committee to identify eficiencies will not be used as					
	by: Based on observation record review, the far and Assurance Commimplemented proced interventions the corn December, 2016. The deficiencies which we facility's current recedent on 11/03/16. The demedication storage and addition, the facility of medication storage and addition stor	rere originally cited during the ertification survey completed ficiencies were in the area of and facility administration. In received citations for and effective administration			On 1/16/2017 the Facility QI Committee held a meeting. The Medical Director, Administrator, DON, QI Nurse, MDS Nurse, Maintenance Supervisor, and Housekeeping Supervisor will attend QC Committee Meetings on an ongoing beand will assign additional team members as appropriate. On 1/9/2017 the Facility Consultant in-serviced the Facility Administrator, DON, QI Nurse, MDS nurse, Maintena Supervisor and Housekeeping Supervisor.	ol asis ers nce	
	02/04/16. The continuous three federal pattern of the facility effective Quality Ass Findings included: This tag is cross reference.	erred to:			Supervisor and Housekeeping Supervirelated to the appropriate functioning of the QI Committee and the purpose of the CI Committee to include developing and implementing facility concerns, to inclusive F431 Pharmacy, F490 Effective Administration and F520 Quality Assessment and Assurance Committee As of 1/9/2017, after the Facility Consultant in-service, the facility QI	of he de e.	
	F 431: Based on ob	servations, staff interviews			Committee began identifying other are	as	

Facility ID: 923015

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED
		245440	D WING			R-C
		345142	B. WING	-		12/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	DE	
LIMIVEDO	ITY DI ACE NUDGING	AND DELIABILITATION CENTED		9200 GLENWATER DRIVE		
UNIVERS	ITY PLACE NURSING	AND REHABILITATION CENTER		CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR 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 520}	and record review expired medication carts a rooms. The facility was rectoremove expired opened tuberculin originally cited dur 11/03/16 for failure medication. F431 recertification surveremove expired instance of the survey of and record review, failed to utilize its an effective Quality program through in monitoring of the scommittee put into survey of record for area of medication. Interview with the 11:03 AM revealed Committee met we The Administrator management audit and could not provide and the reason for availability would be interview with the 12/09/16 at 11:30 provide a reason to	the facility failed to remove as from use on 1 of 7 and 2 of 2 medication storage cited for F431 regarding failure insulin and an undated, skin test vial. F431 was ing a survey completed on to remove an expired pain was also cited on a ey on 02/04/16 for failure to sulin. Deservations, staff interviews the facility's administration resources effectively to sustain and as a surventions that the place after three federal or one repeat deficiency in the astorage. Administrator on 12/29/16 at the facility's Quality Assurance eackly since the 11/03/16 survey. The reported the facility's nursing the medication storage weekly inde the reason expired available. The red weekly audits continued the expired medication	{F 52	of quality concern through QI process, for example: review review Pharmacy Reports an Facility Consultant Recomme The Facility QI Committee will minimum of Quarterly to iden related to quality assessment assurance activities as needed develop and implement approof action for identified facility Corrective action has been to the identified concerns related to Pharmacy, F490 Effective Ad and F520 Quality Assessment Assurance Committee. The Committee will continue minimum of monthly. The QI including the Medical Director the monthly complied QI Repinformation, review trends an corrective actions taken and completion. The QI Committee validate the facility's progress of deficient practices or identiconcerns. The Administrator responsible for ensuring Common concerns are addressed throat training and other intervention Administrator or her designed back to the Executive QI Conthe next meeting.	rounds tools d Regional endations. Il meet at a tify issues t and ed and will opriate plans concerns. aken for the F431 Iministration at and to meet at a Committee r, will review ort d review the date's ee will s in correction ified will be amittee ugh further ans. The e will report	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG			LETED
		345142	B. WING _			R-	-C 29/2016
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE NURSING AND REHABILITATION CENTER			1	STREET ADDRESS, CITY, STATE, ZIP C 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	ODE		-0,-0
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B HE APPROPRIA		(X5) COMPLETION DATE
{F 520}	Continued From page removed.	e 7	{F 52	20}			