PRINTED: 02/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	345142 B. '		B. WING _		C 01/12/2018	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE NURSING AND 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 565 SS=E	CFR(s): 483.10(f)(5)(i) §483.10(f)(5) The res and participate in resi (i) The facility must pr group, if one exists, w reasonable steps, wit to make residents and upcoming meetings ir (ii) Staff, visitors, or or resident group or fam the respective group's (iii) The facility must pperson who is approve group and the facility providing assistance arequests that result from (iv) The facility must consider the grievances and regroups concerning is in the facility. (A) The facility must be response and rational (B) This should not be facility must implement request of the resident should be facility must implement request of the resident of the resident in family groups and the facility must implement request of the resident regressentative(s) meeting families or resident regressentative(s)	ident has a right to organize dent groups in the facility. To ovide a resident or family with private space; and take in the approval of the group, defamily members aware of the atimely manner. The guests may attend illy group meetings only at a invitation. To ovide a designated staffed by the resident or family and who is responsible for and responding to written for group meetings. To onsider the views of a sup and act promptly upon the commendations of such the such as recommended every at or family group. The for such response. The construed to mean that the interfer of such response. The for such response to the formulation of such the such as recommended every at or family group. The formulation of such the formulation of such the such that the interfer of such response. The formulation of such the formulation of such that the interfer of such response. The formulation of such the such that the interfer of such response. The formulation of such that the interfer of such response. The formulation of such that the interfer of such response to the formulation of such that the interfer of such response to the formulation of such that the interfer of such response to the formulation of such that the interfer of such response to the formulation of such that the interfer of such response to the formulation of such that the interfer of such t	F 5	The position of University Place Nursi	2/9/18	
APODATORY	DIDECTOR'S OR PROVINER/S	NIPPLIER REPRESENTATIVE'S SIGNATUR	_	TITI F	(X6) DATE	

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.

02/05/2018

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			C 01/12/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	12/2010
				92	200 GLENWATER DRIVE		
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER			С	HARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	F 565 Continued From page 1		F 5	565			
1 303	record review, the facility failed to respond to concerns of 5 of 7 sampled residents who regularly attend resident council meetings for 3 of 3 resident council meetings held on October 10, 2017, November 13, 2017 and December 27, 2017 (Residents #11, #21, #54, #86 and #94). The findings included: Review of the facility's resident council minutes dated 10/10/17, 11/13/17 and 12/27/17 revealed the resident council had no concerns. 1. Review of Resident #86's quarterly Minimum Data Set dated 12/05/17 revealed an assessment of intact cognition. Interview on 01/11/18 at 2:37 PM with Resident #86, resident council president, revealed he encouraged the resident council to not bring concerns or complaints to the resident council meetings. 2. Review of Resident #21's quarterly Minimum Data set dated 10/17/17 revealed an assessment of intact cognition. Interview on 01/11/18 at 2:48 PM with Resident #21 revealed the resident council meeting notes did not reflect concerns of the of the resident council. Resident #21 explained the groups had many concerns regarding the quality of food, staffing, recent personnel changes, lack of activity staff, mail delivery and staff attitudes. 3. Review of Resident #54's annual Minimum Data Set dated 11/03/17 revealed an assessment of intact cognition.		FS	005	and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure on responding to group grievances identified during resident council meetings. On 2/2/2018 a resident council meeting was held with the new activities directed and the administrator present. Concerfrom previous council meetings were addressed to include quality of food, staffing, recent personnel changes, lact of activity staff, mail delivery, and staff attitudes. The resident council were in agreement with resolutions. Administratinformed residents that if they wanted administrator and/or another department head to attend the meeting they could invite them and they would attend. On 2/2/2018 the Administrator in-service.	g or ns k k ttor the	
					the Activities Director and Activity Assistants on writing resident concerns on a resident council concern form and giving the concern to the Administrator a timely manner for follow-up. On 2/2/2018 the Administrator initiated in-service for the Administrative staff of Follow up to Resident Council Concern which included: 1. When addressing resident concerns, you must include detailed information for resolution of the concern to include a date. 2. Any need audits or observations to support monitoring should be documented. The in-service was completed on 2/2/2018.	s up I in an n s e ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING			C 01/12/2018		
NAME OF P	ROVIDER OR SUPPLIER		1	STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 017	12/2010	
				920	00 GLENWATER DRIVE			
UNIVERSI	ITY PLACE NURSING	AND REHABILITATION CENTER		CH	HARLOTTE, NC 28262			
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F 565	Continued From page	age 2	F 5	565				
		/18 at 2:50 PM with Resident esident council voiced			After each resident council meeting the Administrator and/or DON will review	;		
	concerns during the	e meetings regarding staff of activity staff.			meeting minutes X6 months to ensure resident council concern form has been completed for concerns discussed duri	n		
	4. Review of Resid			the meeting and have been addressed	-			
	Data Set dated 10			and the resolution reviewed with the				
	of intact cognition.			resident council in a timely manner to include a written response to the				
	Interview on 01/11	/18 at 2:55 PM with Resident			grievance form to include details of the	:		
		esident council discussed			follow up that occurred with a date.			
	concerns such as	food quality and staff attitudes.			·			
					The Administrator will present all finding	gs		
		dent #94's annual Minimum			at the monthly QI committee meeting.	ha.a.		
	of intact cognition.	30/17 revealed an assessment			The QI committee will review the minut of the resident council meeting monthly			
	of intact cognition.				for 6 months for identification of trends			
	Interview on 01/11	/18 at 3:00 PM with Resident			actions taken, and to determine the ne			
	#94 revealed the a	ctivity assistant took the			for and/or frequency of continued			
		eeting minutes. Resident #94			monitoring, and make recommendation			
		d to take the minutes but the			for monitoring for continued compliance			
		formed her approximately 3			The Administrator and/or DON will pres			
		ould no longer take the			the findings and recommendations for	ine		
		#94 explained her minutes ch information." Resident #94			monthly QI Committee to the quarterly executive QA Committee for further			
		ent council voiced concerns			recommendations and oversight.			
		and lack of activity staff.			recommendations and eversight.			
		,			The Administrator is responsible for			
	A second interview	with Resident #86, the			implementing the acceptable plan of			
		esident, on 01/11/18 at 3:06			correction.			
		paper delivery also was						
		neetings. Resident #86						
		ry improved after he spoke						
		tor directly. Resident #86 to take the group's concerns to						
		he heard the grievances.						
		5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5						
		activity assistant on 01/12/18 at I she relieved Resident #94 of						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345142	B. WING			C 01/12/2018	
	ROVIDER OR SUPPLIER TY PLACE NURSING AN	D REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	,		
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F 636 SS=D	The activity assistant contained the busines activity assistant expl voiced after adjournment of the council minerported she would on the group voiced commeeting. Interview with the addraward of the concernance of the resident council minurate resident council minurate residents discuss Comprehensive Assection (CFR(s): 483.20(b)(1) §483.20 Resident Assimpted for the facility must concernance of the concerna	nen Resident #54 person could not be cretary at the same time. reported the minutes as part of the meeting. The ained resident complaints nent did not get recorded as nutes. The activity assistant complete a grievance form if cerns during the actual ministrator on 01/12/18 at he resident council should as and grievances to her herns could be considered administrator reported the hetes should accurately reflect historia and concerns. Saments & Timing (2)(i)(iii) Seessment Auct initially and periodically curate, standardized hent of each resident's Hensive Assessments hent Assessments hent Assessments hent Assessment Instrument. He comprehensive hent's needs, strengths, hereferences, using the hinstrument (RAI) specified himent must include at least Hemographic information		636		2/9/18	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING		C 01/12/2018		
	NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		01/12/2016	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 636	(ix) Continence. (x) Disease diagnos (xi) Dental and nutri (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications. (xv) Special treatme (xvi) Discharge plar (xvii) Documentatio regarding the additi on the care areas tr the Minimum Data S (xviii) Documentatic assessment. The a include direct obser with the resident, as licensed and nonlice members on all shift §483.20(b)(2) When timeframes prescribe chapter, a facility m assessment of a rest timeframes specifie through (iii) of this s prescribed in §413.3 apply to CAHs. (i) Within 14 calend excluding readmiss significant change in mental condition. (F	vior patterns. vell-being. poning and structural problems. sis and health conditions. tional status. s. ents and procedures. nning. n of summary information onal assessment performed iggered by the completion of Set (MDS). on of participation in ssessment process must vation and communication s well as communication with ensed direct care staff	F 63				

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		345142	B. WING			C 01/12/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	7171272010	
	TV DI 405 MUDONIO 41			9200 GLENWATER DRIVE			
UNIVERSI	IY PLACE NURSING AN	ID REHABILITATION CENTER		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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 636	Continued From page	e 5	F 63	36			
	or therapeutic leave.) (iii)Not less than once This REQUIREMENT by:	e every 12 months. is not met as evidenced		The position of University Place	a Nursing		
	record review, the factor comprehensive asset analyze how condition quality of life related to	no required comprehensive		The position of University Place and Rehabilitation center regard process that lead to this deficienthe staff failure to follow establist procedure in accurately comple Care Area Assessment related the Activities.	ding the necy was shed ting the		
	04/24/13 with diagnost and schizophrenia. Review of Resident # Set (MDS) dated 01/2 assessment of severe MDS indicated particles staying up past 8:00 news was very import MDS triggered the Action and schizophrenia.	mitted to the facility on ses which included dementia 70's annual Minimum Data		On 2/2/2018 the MDS nurse condetailed general care plan progrish for resident #70. The documen resident #70 is detailed to the ACare Area Assessment (CAA). documentation includes a describle focus of activities being triggincluding causes, contributing farisk factors. The documentation an analysis of the findings supp decision to proceed or not to procare plan.	ress note tation for ctivities The ription of gered actors, and includes orting the occeed to		
	(CAA). Review of Resident # 01/20/17 revealed no with a description of t factors and risk factor CAA listed Resident visits due to no attend There was no docum findings supporting the to proceed to the care	270's Activity CAA dated of documentation of findings the problem, contributing related to activities. The 470 required one to one dance in group activities. entation of an analysis of the decision to proceed or not		On 2/5/2018, Care Plan Team be auditing each resident with a trigactivities CAA for the past 30 days ensure the activities CAA was caccurately. A detailed general of progress note was completed or resident where a concern was raudit was completed on 2/9/2010 On 1/26/2018 the Facility Constacompleted an in-service with the Coordinator, MDS Nurse, Activity Director, and Dietary Manager in	ggered ays to completed care plan n each noted. The 8. ultant e MDS ties		

Facility ID: 923015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
						С	
		345142	B. WING _		01	/12/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
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UNIVERSI	ITY PLACE NURSING	S AND REHABILITATION CENTER		CHARLOTTE, NC 28262			
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F 636	Continued From p	page 6	F	536			
		dent #70 awake, alert and	'		Cara Araa		
		nintelligible words when		when completing Section V Assessments (CAA Summa			
	addressed.	Till telligible words when		meet the requirements by d			
	addressed.			resident's clinical status inc			
	Observation on 0	1/10/18 at 8:50 AM and 3:22 PM		description of the problem,	•		
	Observation on 01/10/18 at 8:50 AM and 3:22 PM revealed Resident #70 awake, alert and			factors, risk factors, and an			
	responsive with unintelligible words when			findings impacting care plan			
	addressed.			The analysis should include			
				interventions. Care plan an	d CAA should		
	Observation on 0	1/11/18 at 8:22 AM revealed		be resident specific, this inc	ludes the		
	Resident #70 awa	ike, alert and responsive with		Activities CAA and Care Pla	n. You should		
	unintelligible word	s when addressed.		refer to the RAI manual or f	acility MDS		
				consultant for questions or	guidance.		
		se Aide (NA) #1 on 01/11/18 at					
		Resident #70 remained in bed		On 2/5/2018 the MDS Coor	_		
		e day shift. NA #1 explained		auditing the Activity CAA's t			
		imary language was not English		Activity CAA Audit Tool. Th			
		nicate needs such as thirst or		completed weekly x four we			
		rted Resident #70 conversed ers who came to visit.		biweekly x eight weeks by t Coordinator.	HE MIDS		
	with family member	cra who came to visit.		Coordinator.			
	Observation on 0	1/11/18 at 2:09 PM revealed		The monthly QI committee	will review the		
	Resident #70 awa	ike, alert and responsive with		results of the Activity CAA A			
	unintelligible word	s when addressed.		monthly for 3 months for ide			
				trends, actions taken, and to			
		#2 on 01/11/18 at 3:48 PM		the need for and/or frequen	•		
		t #70 remained in bed and		continued monitoring, and r			
	"talked in words I	do not recognize."		recommendations for monit	•		
	Interview with the	MDS Coordinator on 01/12/18		continued compliance. The and/or DON will present the			
		aled the facility's previous		recommendations of the mo	-		
		and the facility's previous and ucted and documented the		committee to the quarterly			
		MDS Coordinator reported		committee for further recom			
		ctivity CAA did not contain a		and oversight.	oridationio		
		orehensive assessment.					
				The Administrator is respon	sible for		
	Interview with the	Administrator on 01/12/18 at		implementing the acceptabl			
		d she expected staff to		correction.	·		
document a comprehensive assessment with		•					

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345142	B. WING _			C 01/12/2018	
ROVIDER OR SUPPLIER TY PLACE NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	·		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
analysis of findings. Accuracy of Assessr CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mu resident's status. This REQUIREMEN by: Based on staff inter medical record, the fi code the minimum of for 4 of 27 sampled i assessment for resid not include all active assessment for resid resident's prognosis #235 and #88). The findings included 1. Resident #20 was 8/20/16. Diagnoses and cognitive commothers. Review of the electror Resident #20 reveal diagnoses did not infor this resident. Review of the medic physician's order for for Zyprexa (anti-anx	of Assessments. It is not met as evidenced Views and review of the Facility failed to accurately ata set (MDS) assessment residents. The MDS Idents #20, #97 and #88 did diagnoses and the MDS Ident #88 did not include the for life (Resident #20, #97, Id: It admitted to the facility on included anxiety, dementia unication deficit, among Included anxiety, dementia unication deficit, among Included anxiety as a diagnoses Included anxiety as a diagnoses		The position of University Place and Rehabilitation center regar process that lead to this deficie the staff failure to follow establi procedure in accurately coding diagnosis and residents receiving services to reflect life expectant months or less. On 2/2/2018 resident #20 mining set (MDS) assessment dated 1 was modified to accurately code #20's diagnosis of anxiety by the nurse. On 2/2/2018 resident #3 assessment dated 12/5/2017 with modified to accurately code residiagnosis of anxiety by the MD On 2/2/2018 the resident #235 assessment dated 4/30/2017 with modified to accurately code resident #235's MDS to reflect life experiments or less related to reside receiving hospice services by the Nurse. On 2/2/2018 resident #4 assessment dated 11/22/2017	rding the ency was ished active ing hospice icy of 6 mum data 0/16/2017 le resident ne MDS 97 MDS was sident #97 S nurse. MDS was sident ctancy of 6 ent he MDS was was		
each evening.			diagnosis of anxiety by the MD On 2/2/2018 the modified asse	S nurse.	S	
	CORRECTION ROVIDER OR SUPPLIER TY PLACE NURSING A SUMMARY S (EACH DEFICIENT REGULATORY OR Continued From page analysis of findings. Accuracy of Assessr CFR(s): 483.20(g) §483.20(g) Accuracy The assessment muresident's status. This REQUIREMEN by: Based on staff intermedical record, the frode the minimum of for 4 of 27 sampled assessment for resident include all active assessment for resident's prognosis #235 and #88). The findings include 1. Resident #20 was 8/20/16. Diagnoses and cognitive commothers. Review of the electron Resident #20 revealed diagnoses did not incomply the for this resident. Review of the medicing physician's order for for Zyprexa (anti-analytic table and medical each evening.	ROVIDER 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 7 analysis of findings. Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the medical record, the facility failed to accurately code the minimum data set (MDS) assessment for 4 of 27 sampled residents. The MDS assessment for residents #20, #97 and #88 did not include all active diagnoses and the MDS assessment for resident #88 did not include the resident's prognosis for life (Resident #20, #97, #235 and #88). The findings included: 1. Resident #20 was admitted to the facility on 8/20/16. Diagnoses included anxiety, dementia and cognitive communication deficit, among others. Review of the electronic medical record for Resident #20 revealed the list of cumulative diagnoses did not include anxiety as a diagnoses for this resident. Review of the medical record, revealed a physician's order for Resident #20 dated 3/1/17 for Zyprexa (anti-anxiety) 2.5 miligrams (mg), take 1/2 tab each morning and Zyprexa 2.5 mg	A BUILDIN 345142 ROVIDER 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 7 analysis of findings. Accuracy of Assessments CFR(s): 483.20(g) \$483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the medical record, the facility failed to accurately code the minimum data set (MDS) assessment for residents #20, #97 and #88 did not include all active diagnoses and the MDS assessment for resident #88 did not include the resident's prognosis for life (Resident #20, #97, #235 and #88). The findings included: 1. Resident #20 was admitted to the facility on 8/20/16. Diagnoses included anxiety, dementia and cognitive communication deficit, among others. Review of the electronic medical record for Resident #20 revealed the list of cumulative diagnoses did not include anxiety as a diagnoses for this resident. Review of the medical record, revealed a physician's order for Resident #20 dated 3/1/17 for Zyprexa (anti-anxiety) 2.5 miligrams (mg), take 1/2 tab each morning and Zyprexa 2.5 mg each evening.	A BUILDING 345142 STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLEWMATER DRIVE CHARLOTTE, NC 28262 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 analysis of findings. ACCUracy of Assessments CFR(s): 483.20(g) \$483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the medical record, the facility failed to accurately code the minimum data set (MDS) assessment for resident #80 did not include the resident's prognosis for life (Resident #20, #97, #235 and #88). The findings included: 1. Resident #20 was admitted to the facility on 8/20/16. Diagnoses included anxiety, dementia and cognitive communication deficit, among others. Review of the electronic medical record for Resident #20 revealed the list of cumulative diagnoses for anxiety by the MDN on 2/2/2018 the resident #23 assessment dated 4/30/2017 wondified to accurately code residences for this resident. Review of the medical record, revealed a physician's order for Resident #20 dated 3/1/17 for Zyprexa (anti-anxiety) 2.5 milligrams (mg), take 1/2 tab each morning and Zyprexa 2.5 mg each evening. Denotinue Front Provincies CHARLOTTE, NC 28262 PREFEIX TAG TRESTADDRESS, CITY, STATE, ZIP CODE 28206 LEARLOTTE, NC 28262 CHARLOTTE, NC 28262 PREFEIX TAG PREFIX TAG PREFEIX TAG PREFEIX TAG PREFEIX TAG PREFEIX TAG PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTIONS ADDRESS PLAN OF COR (EACH CORRECTIVE ACTIO	A BUILDING 345142 STREET ADDRESS, CITY, STATE, 2IP CODE 200 GLENWATER DRIVE TY PLACE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DESCRIPTIONS (EACH DEFICIENCY MUST EE PRECEDED BY PULL REPULLATION OR LSC IDENTIFYING INFORMATION) Continued From page 7 Continued From page 7 Accuracy of Assessments CFR(s): 483.20(g) \$483.20(g) Accuracy of Assessments CFR(s): 483.20(g) Accuracy of Assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the medical record, the facility failed to accurately code the minimum data set (MDS) assessment for 4 of 27 sampled residents. The MDS assessment for resident #88 did not include the resident's status diagnoses and the MDS assessment for resident #88 did not include the resident's proposals for life (Resident #20, #97, #235 and #88). The findings included: 1. Resident #20 was admitted to the facility on 8/20/16. Diagnoses included anxiety, dementia and cognitive communication deficit, among others. Review of the electronic medical record for Resident #20 revealed the list of cumulative diagnoses of anxiety by the MDS nurse. On 2/2/2018 resident #97 MDS assessment dated 4/30/2017 was modified to accurately code resident #20 revealed the list of cumulative diagnoses of anxiety by the MDS nurse. On 2/2/2018 resident #88 MDS assessment dated 4/30/2017 was modified to accurately code resident #20 revealed the list of cumulative diagnoses of anxiety by the MDS nurse. On 2/2/2018 resident #88 MDS assessment dated 4/30/2017 was modified to accurately code resident receiving hospice services by the MDS nurse. On 2/2/2018 resident #88 MDS assessment dated 4/30/2017 was modified to accurately code resident receiving hospice services by the MDS nurse. On 2/2/2018 resident #88 MDS assessment dated 4/30/2017 was modified to accurately code resident modified assessment services by the MDS nurse. On 2/2/2018 resident #88 MDS assessment dated 4/30/2017 was modified to accurately code re	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345142 B. WI				С	
NAME OF D	DOMED OF SURPLIED	345142	B. WING _			01/12/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
UNIVERS	ITY PLACE NURSING	AND REHABILITATION CENTER		9200 GLENWATER DRIVE			
				CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From p	page 8	F6	641			
		ord and the October 2017 Sheet (POS) for Resident #20		Repository by the MDS Coo 2/8/2018 the modified asses			
	revealed the diagr	noses of anxiety was		accepted by the National Re			
	by the physician.	he received Zyprexa as ordered		On 2/5/2018, the MDS Coor	rdinator began		
	by the physician.			auditing all assessments co	_		
	The quarterly mini	imum data set (MDS) dated		past 30 days to ensure resid			
	· ·	I, Active Diagnoses, did not		diagnosis of anxiety and/or			
	code the diagnose	of anxiety.		receiving hospice services a			
	The MDS Coordin	nator stated in interview on		accurately. The audit will be by 2/9/2018. Assessments			
		AM that when she completed		modified for accuracy of coo			
	the quarterly 10/16/17 MDS for Resident #20, she			necessary.			
		ident's cumulative diagnoses,		0 4/00/0040 !! 1470 0			
		bber 2017 POS, but did not		On 1/26/2018 the MDS Coo MDS nurse were in-serviced			
		S included the diagnoses of Coordinator further stated that		Facility Consultant on correct			
	T	ere may be some diagnoses on		active diagnosis and resider			
		not on the cumulative diagnoses		hospice services to be code			
	list, I will pay close	er attention."		life expectancy of 6 months	or less.		
	The administrator	stated in an interview on		On 2/5/2018 the Administrat	tive Nurses will	ı	
		PM that she expected the MDS		begin auditing MDS assessi			
		ccurately and to include all		correct active diagnosis and			
	active diagnoses t	that were being treated.		receiving hospice services of the Accuracy Audit Tool. 25			
				completed assessments will			
				weekly x 4 weeks, then 25%			
		as admitted to the facility on es included dementia with		assessments biweekly x 8 w			
	behaviors, cognitiv	ve communication deficit, and		The monthly QI committee v			
	anxiety.			results of the Accuracy Audi	-		
	Dovious of the class	otronio modinal rocard for		for 3 months for identificatio	·		
		ctronic medical record for ealed the list of cumulative		actions taken and to determ for and/or frequency of cont			
		include anxiety as a diagnose		monitoring, and make recon			
	for this resident.			for monitoring for continued			
				The Administrator and/or D0	•	:	
	Review of the med	dical record, revealed a		the findings and recommend			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345142	B. WING _			C 01/12/2018	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		1712/2010	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
for Xanax (anti-anxiedaily. Continued review of a Behavioral Health a Nurse Practitioner 12/27/17 and the Deadministration recorded for anxiety as ordered anxiety as ordered to the diagnose of anxiety 12/5/17 referred to the reside looked at the Decender reviewed the medicate the diagnose of anxiety at 12/5/17 referred to the reside looked at the Decender reviewed the medicate the diagnose of anxiety that should be completed according to the completed according to the diagnoses that the diagnose that the diagnoses that the diagnose that the dia	Resident #97 dated 7/8/17 ety) 0.5 miligrams (mg), twice I the medical record revealed progress note dated 11/3/17, 1/2 progress note dated exember 2017 medication do (MAR), all documented that ed Xanax 0.5 mg twice daily ed by the physician. The medical record revealed progress note dated at the exember 2017 medication do (MAR), all documented that ed Xanax 0.5 mg twice daily ed by the physician. The medical record revealed progress note dated at the exemptor of the physician dated at the exemptor of	F	monthly QI committee to the executive QA committee for recommendations and over. The Administrator is responsimplementing the acceptable correction.	further sight.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345142	B. WING_		C 01/12/2018		
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 9200 GLENWATER DRIVE CHARLOTTE, NC 28262		01/12/2018	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 641	Continued From pag	ne 10	F 6	41			
	The Minimum Data Specified the resider he was receiving Ho Section J1400 of the resident had 6 month. On 01/12/18 at 9:20 was interviewed and determining if a residue consisted of revidocumentation. The Resident #235's Mi should have been colive. She added that section no longer we have known better. 4. Resident #88 was 11/12/2014 with diag schizophrenia and a A review of the a prorecorded by the Nurseident #88 was perfected a psychiatr 11/15/17 and signed The form listed schiz diagnoses for Resident A review of the most	Set (MDS) dated 04/30/17 at 's cognition was intact and spice services. Review of MDS did not identify the as or less to live. AM the MDS Coordinator explained the process for dent had 6 months or less to ewing Hospice MDS Coordinator reviewed DS and stated the resident oded for 6 months or less to an urse that completed the orked in the facility but should admitted to the facility on proses which included express note dated 10/06/17 se Practitioner revealed ositive for anxiety. It #88's medical record y consultation report dated by the psychiatric physician.					
	An interview with the	e MDS Coordinator on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345142	B. WING		C	
	ROVIDER OR SUPPLIER TY PLACE NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	01/12/2018	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 641	the most recent MDS MDS Coordinator ind refer to the cumulative medical record and in indicated the anxiety it was not listed on the sheet in the medical restated she would be not to make sure all active on the MDS assessments to be conclude all active diagree to include all active diagree (CFR(s): 483.24(c)(1) S483.24(c)(1) The fact the comprehensive at and the preferences of program to support reactivities, both facility individual activities and each resident, encour and interaction in the This REQUIREMENT by: Based on observation record review, the fact ongoing activity programs.	evealed she had completed for Resident #88. The icated her process was to be diagnosis sheet in the authorized the e-record. She diagnosis was missed since the ecumulative diagnosis record or e-record. She more thorough in her review the diagnoses were captured the ent. In 1/12/18 at 4:22pm, the she expected MDS completed accurately and to moses currently being st/Needs Each Resident Stillity must provide, based on the essessment and care plan of each resident, an ongoing the each resident, an ongoing the essessment and care plan of each resident activities, interests of and support the psychosocial well-being of reaging both independence community. The interviews and the individual is the individual in the individual interviews and the indivi	F 64	The position of University Place Nursi and Rehabilitation center regarding the process that lead to this deficiency wa	e	
		enhance the quality of life sidents with cognitive deficits		the staff failure to provide an ongoing activity program which met the individu	ıal	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		(C
		345142	B. WING			01/	12/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVERSI	TY PLACE NURSING A	ND REHABILITATION CENTER			200 GLENWATER DRIVE		
				С	CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 679	Continued From pag	e 12	F	679			
	(Residents #70 and #			0,0	interest and needs to enhance the qua	litv	
	(1 toolaonto 11 o ana 1	, 50).			of life.		
	The findings included	d :					
	4 5 :1 4 #=0				On January 16, 2018 the new Activity		
		s admitted to the facility on			Director and an Activity Assistant were	ın	
	and schizophrenia.	ses which included dementia			orientation. The Activity Director and Activity staff established a schedule for		
	and somzopmenia.				1:1/Social Visits for the residents who		
	Review of Resident # Set (MDS) dated 01/	#70's annual Minimum Data 17/17 revealed an			not attend group activities.		
	, ,	rely impaired cognition. The			On February 2, 2018 1:1/Social Visits		
		sipation in religious activities,			were scheduled for Resident #70 and		
		PM and keeping up with			Resident #99. Residents who prefer to	,	
	news was very impoi	rtant to Resident #70.			only do Independent Activities or		
	Paview of Pasident t	#70's Activity CAA dated			occasionally participates in group activities will receive 1:1 Visit or a Soci	al	
		70 required one to one visits			Visit. The residents will be offered	ai	
	due to no attendance				independent leisure material, board		
					games, magazines, and books. The		
		#70's quarterly MDS dated			residents will be encouraged to attend		
		assessment of severely			groups of choice and will be invited to t	he	
	impaired cognition w directed toward other	ith behavioral symptoms not			next big event.		
	directed toward other	15.			On February 2, 2018 the Administrator		
	Review of Resident #	#70's care plan dated			initiated an in-service for the Activity St		
	l	alteration in recreation			on 1:1 and Social Visits.		
	characterized by little	e or no involvement, lack of					
		cognitive impairment.			On February 5, 2018 the Administrator		
		rovide 1 to 1 visits weekly,			and QI Nurse will begin auditing the		
		schedule and respect			1:1/Social Visits using the 1:1/Social Vi		
	choice regarding limi	ted or no activities.			Audit tool for residents who prefer to or	ıly	
	Observation on 01/0	9/18 at 12:39 PM and 3:26			to do independent activities or occasionally participates in group		
		nt #70 awake, alert and			activities. This audit will be completed		
	responsive with unin	•			weekly x four weeks then biweekly x ei		
		evision was tuned to talk			weeks.	5 -	
					The monthly QI Committee will review	the	
	Observation on 01/10	0/18 at 8:50 AM and 3:22 PM			results of the 1:1/Social Visits Audit Too		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345142	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	343142	B: Willo _	STREET ADDRESS, CITY, STATE, ZIP C		01/12/2018	
				9200 GLENWATER DRIVE			
UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 679	Continued From page	e 13	F 6	79			
F 0/9	revealed Resident #7 responsive with unint addressed. The telev situation comedy. Observation on 01/11 Resident #70 awake, unintelligible words w Interview with Nurse 8:25 AM revealed Re in her room on the da Resident #70's prima but could communica pain. NA #1 reported with family members Observation on 01/11 Resident #70 awake, unintelligible words w television was tuned Interview with medica 01/11/18 at 2:13 PM remained in the room member came to visi #70 could not initiate conversations. Resident #70's family for interview. Observation on 01/11 Resident #70 awake,	elligible words when ision was tuned to a 1/18 at 8:22 AM revealed alert and responsive with when addressed. Aide (NA) #1 on 01/11/18 at isident #70 remained in bed by shift. NA #1 explained ry language was not English atteneds such as thirst or I Resident #70 conversed who came to visit. 1/18 at 2:09 PM revealed alert and responsive with when addressed. The into a situation comedy. ation aide (MA) #1 on revealed Resident #70 except when a family the except when	F 6	monthly for 3 months for idea trends, actions taken, and the need for and/or frequer continued monitoring, and recommendations for monitorinued compliance. The and/or DON will present the recommendations for the monittee to the quarterly Committee for further recommendations for the monitorinued complementing the acceptab correction.	to determine ancy of make toring for the Administrator to findings and the nonthly QI the executive QA the mmendations to determine the for		
	Interview with NA #2	on 01/11/18 at 3:48 PM					

	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345142	B. WING		01/12	/2018
	ROVIDER OR SUPPLIER TY PLACE NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	01/12	72016
(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 APPROVIDER OF THE	D BE	(X5) COMPLETION DATE
F 679	Resident #70 awake, unintelligible words words words words with the act 10:15 AM revealed R not occur. The activities difficult to arrange activity assistant Resident #70 weekly provide 1:1 visits or compared to the activity assistant Resident #70. Interview with the add 11:00 AM revealed streceive an activity provinterests and needs. an activity director was week which would less activity assistant. 2. Resident #99 was 09/08/17 with diagnosiand schizophrenia.	2/18 at 10:03 AM revealed alert and responsive with when addressed. ivity assistant on 01/12/18 at resident #70's 1:1 visits did ty assistant explained it was tivities for Resident #70 of other activity employees. reported she tried to see but did not have the time to other activities for Resident ministrator on 01/12/18 at the expected residents to be a the expected resident to the expected residents to be a the expected resident to the expected residents to be a the expected resident to the	F 67	,		
	Data Set (MDS) date assessment of severe MDS indicated acces music, animals and to	e99's admission Minimum d 09/20/17 revealed an ely impaired cognition. The es to books and newspapers, be outdoors when the e very important to Resident				

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 _			01/1	; 2/2018
	ROVIDER OR SUPPLIER TY PLACE NURSING AN	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVI CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 679	Continued From page	e 15	F 6	79			
	#99. The MDS did not Area Assessment.	ot trigger an Activity Care					
		9/18 at 10:00 AM and at 3:19 nt #99 asleep in a wheel					
	Resident #99 seated Resident #99 was ale Resident #99 reporte	0/18 at 8:38 AM revealed in a wheel chair in the room. ert and conversed socially. d the breakfast meal was member the food items					
		0/18 at 10:00 AM revealed in a wheel chair in the room. rned on.					
	Resident #99 seated doorway to the room.	/18 at 12:11 PM revealed in a wheel chair in the Resident #99 attempted to ho walked by his doorway.					
		/18 at 2:10 PM revealed ppelled a wheel chair in his					
	self-propelled in the v	revealed Resident #99 wheelchair. MA #1 explained nake his needs known and					
		Aide #2 on 01/11/18 at 3:50 at #99 usual evening was in the hallway.					
	I .	ivity assistant on 01/12/18 at esident #99 usually refused					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345142	B. WING		C 01/12/2018	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	1 01/12/2010	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 679	Continued From page		F 679	Ð		
	assistant explained it	activities. The activity was difficult to arrange t #99 since the departure of ees.				
	11:00 AM revealed some receive an activity prointerests and needs. an activity director was	ministrator on 01/12/18 at the expected residents to ogram which met their The administrator reported as to begin employment next essen the demand on the				
F 698 SS=D	Dialysis CFR(s): 483.25(l)		F 698	3	2/9/18	
33-0	§483.25(I) Dialysis. The facility must ens require dialysis receivith professional state comprehensive perset the residents' goals at This REQUIREMENT by: Based on observation record review the faccommunication regards.	is not met as evidenced on, staff interviews and ility failed to provide ding the resident's condition modialysis services for 1 of 1		The position of University Place Nurs and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to provide communical regarding the resident's condition prioritical regarding the resident regarding the	ne as tion	
	The findings included			receiving hemodialysis services. On 2/2/18 a new communication for w		
	stage renal disease, diabetes, hypertension disease. The most re (MDS) dated 12/29/2	idmitted to the facility nosis that included end heart failure, disease., on and peripheral vascular ecent Minimum Data Set 017 specified the resident's participate in daily decision		initiated for better communication to we initiated for better communication between the facility and the dialysis center. The communication form inclusing BP before/BP after Dialysis, Pre/Post Weights, Complete Tx Y/N, and New Orders Y/N, and Communication.	udes	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING						
						(С
		345142	B. WING _			01/	12/2018
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LININ/EDOI	TV DI ACE NUDCINO AN	ID DELIABILITATION CENTED		920	00 GLENWATER DRIVE		
UNIVERSI	IT PLACE NURSING AN	ID REHABILITATION CENTER		СН	IARLOTTE, 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 698	Continued From page	e 17	F 69	98			
	making and received				On 2/5/2018 The Administrative Nurse	3	
	making and received	didiyolo.			will begin auditing each dialysis resider		
	The Care Area Asses	sment (CAA) dated			communication documentation for any		
		on indicated Resident #133			changes or communications and		
		disease and was on dialysis.			implementation of any new orders.		
					,		
	A care plan revised or	n 12/17/2017 for End stage			On 2/2/2018 the Administrator initiated	an	
	•	ented an intervention as			in-service on the new communication		
	communication with the dialysis treatment center				form and the process involved in		
	and adjust the care pl	lan and/or treatment plan.			completing the form and ensuring that	the	
					communications were followed through	١.	
	A document titled "Co	mmunication Form for					
		s reviewed. The document			On 2/5/2018 the Administrative Nurses	will	
	included pre dialysis i	information included:			begin auditing the new dialysis		
					communication documentation form us	ing	
	-Blood Pressure before	re dialysis			the Dialysis Communication Audit tool.		
					This audit will be completed weekly x for	our	
	-Blood Pressure after	dialysis			then biweekly x eight weeks by the		
	Ob	- A . d - iA. /ia - I dia -			Administrative Nurses.		
	-Changes since the la				The manufacture of the control of th	l	
	antibiotics, new medic	· •			The monthly QI committee will review t	ne	
	non-compliance with	diet or fluids, edema)			results of the Dialysis Communication		
	On 01/00/2019 at 11:	EQ AM Nurso #6 assigned to			Audit tool monthly x 3 months for identification of trends, actions taken, a	und	
		59 AM Nurse #6 assigned to sterviewed and revealed a			to determine the need for and/or	iiiu	
					frequency of continued monitoring, and	1	
		sent to dialysis with Resident lysis sent the book with the			make recommendations for monitoring		
		et back to the facility. Lab			continued compliance. The Administra		
		were put in the Doctor's			and/or DON will present the findings ar		
	communication book.	-			recommendations of the monthly QI	iu	
	communication book.				committee to the Quarterly Executive C	A	
	On 01/10/2018 at 5:1	5 PM Nurse # 3 was			Committee for further recommendation		
		ained all dialysis residents			and oversight.	-	
		nunications sheets sent to					
		alert them of the resident's			The Administrator is responsible for		
	_	ting hemodialysis. The			implementing the acceptable plan of		
		on sheet was returned to the			correction.		
	•	ysis treatment with the					
	resident.	,					

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
NAME OF PI	ROVIDER OR SUPPLIER	343142		STREET ADDRESS, CITY, STATE, ZIP CODE		01/12/2018
				9200 GLENWATER DRIVE		
UNIVERSI	TY PLACE NURSING A	ND REHABILITATION CENTER		CHARLOTTE, NC 28262		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 698	Continued From pag	e 18	F 6	98		
	On 01/11/2018 at 2:3 the Dialysis Communication show of each month. She at the folder for the Nov Communications show month of Nov. 2018. On 01/12/2018 at 12 Practitioner (NP) #1 Center know someth communication sheed dialysis with them. The eded to know after communication book On 01/12/2018 at an Receptionist #1 reversevening 3:30 PM-8:00 came from the dialyst resident to be picked all calls in a log book She did not have the to be reviewed. She specific calls from the On 01/12/2018 at 2:30 Administrator reveals the Dialysis Communication and Center with the resident to be reviewed. She specific calls from the dialysis Communication before the dialysis Communication completed before the dialysis Communication communication communication communication communication completed before the dialysis Communication commun	30 PM with the DON revealed nication sheets were filed in a tored in her office at the end stated she could not locate v. 2017 for the Dialysis eets for Resident #133 for the case of PM with the Nurse if I need to let the Dialysis ing I wrote it on the tin the book that went to the nurses put anything we redialysis in the Doctor there for us to review. Interview with the aled she received calls in the pool of PM. She the calls that his center were for the lup. She stated she logged is or just on a piece of paper. I log book there at the facility could not remember any the dialysis center.				
	including laboratory would be placed in the	y. Any communication results or order changes ne doctor's communication ew. The monthly sheets				

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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F 698	Nursing. Resident Records - Id	and filed by the Director of dentifiable Information	F 6			2/9/18	
SS=D	(i) A facility may not resident-identifiable to (ii) The facility may resident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance with a resident are- (i) Complete; (ii) Accurately docum (iii) Readily accessibl (iv) Systematically or §483.70(i)(2) The facall information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, par operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic vision agreement in the resident in the residen	int-identifiable information. elease information that is on the public. elease information that is on an agent only in intract under which the agent disclose the information in the facility itself is permitted. cords. Indiance with accepted is and practices, the facility all records on each resident is ented; e; and its ganized is interested in the resident's records, in or storage method of the interested is retheir resident in permitted by applicable law; by ment, or health care ted by and in compliance					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 842	Continued From pag		F 8	342			
	law enforcement pur purposes, research propurposes, a serious threat to he by and in compliance §483.70(i)(3) The fact for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yelegal age under State §483.70(i)(5) The me (i) Sufficient information (ii) A record of the receive (iii) The comprehens provided; (iv) The results of an and resident review determinations cond (v) Physician's, nurse professional's progres (vi) Laboratory, radio services reports as rathis REQUIREMEN' by: Based on staff interfacility failed to have	poses, organ donation ourposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. Cility must safeguard medical gainst loss, destruction, or all records must be retained e required by State law; or ne date of discharge when ent in State law; or he ars after a resident reaches e law. Dedical record must containcion to identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and fucted by the State; e's, and other licensed ess notes; and sology and other diagnostic equired under §483.50. To is not met as evidenced by iews and record review the documentation that a		The position of University Place and Rehabilitation center regard	ling the		
	provider and failed to	ed as ordered by the medical o document a resident's fall in or 2 of 27 sampled residents #235).		process that lead to this deficier the staff failure to follow establis procedure in accurately docume resident refusals and falls.	shed		

PRINTED: 02/09/2018 FORM APPROVED OMB NO. 0938-0391

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An interview on 01/12/2018 at 10:52 AM with the audit will be completed 5x a week x 4		know he had refus	sed.				
·					1		
D' ((A) ' (DOA))					- I		
Director of Nursing (DON) revealed a treatment weeks then weekly x 8 weeks.					weeks then weekly x 8	s weeks.	
like removing the dressing from the dialysis					The meanth is Of an	itta a suill massi tl	
access site should be documented on the MAR. If the resident refuses it should be documented on The monthly QI committee will review the results of the Documentation Audit Tool							

Facility ID: 923015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345142	B. WING			С	
		345142	B. WING _			1/12/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
UNIVERS	TY PLACE NURSING	AND REHABILITATION CENTER		9200 GLENWATER DRIVE			
				CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	Continued From p	age 22	F8	42			
	the MAR with the	nurse's initials and a circle		monthly for 3 months for ide	ntification of		
	around the initials.			trends, actions taken, and to			
				the need for and/or frequence			
		/12/2018 at 2:22 PM with the		continued monitoring, and m			
		aled her expectation was that		recommendations for monito	-		
		the residents' records was		continued compliance. The			
		urate. She expected the tation policies and procedures		and/or DON will present the recommendations of the mo			
		uding documentation of		committee to the quarterly E	•		
	refusals on the MA			committee for further recommittee			
				and oversight.			
	04/17/17 diagnose Minimum Data Se specified the resid he required limited daily living (ADL) a facility. A nurse's entry da family inquired about their eview of their was no entry	was admitted to the facility on ed with terminal cancer. The t (MDS) dated 04/30/17 ent's cognition was intact and dassistance with activities of and had not fallen while in the ented 07/16/17 specified the put an unwitnessed fall.		The Administrator is respons implementing the acceptable correction			
	Resident #235.						
		ed an incident report for ted 07/16/17 that specified the on 07/15/17.					
	interviewed and re #235. Nurse #5 s called by nurse aid because the resid Nurse #5 added th	28 PM Nurse #5 was ecalled caring for Resident tated that one morning she was de #3 to Resident #235's room ent had fallen in the bathroom. nat it was end of shift when the and she forgot to document that					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION (X3) DAT COM	
		345142	B. WING		C 01/12/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/12/2010
UNIVERSI	TY PLACE NURSING AN	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 842	Continued From page	e 23	F 84	2	
		ord. The nurse added that ident for injury and none			
F 867 SS=D	interviewed and state	ent Activities	F 86	7	2/9/18
	§483.75(g) Quality as	ssessment and assurance.			
	assurance committee (ii) Develop and imple action to correct ident This REQUIREMENT by: Based on record rev interviews, the facility Assurance Committee implemented procedu interventions that the December 1, 2016 or The deficiencies were coding the Minimum I Comprehensive Asse Findings included: This tag is cross refer 483.20: Accuracy of A interviews and review facility failed to accur. Data Set (MDS) asse	ement appropriate plans of tified quality deficiencies; is not met as evidenced iew, observations, and staff i's Quality Assessment and e failed to maintain ares to monitor these committee put into place in a recertification survey. In the areas of accurately Data Set (MDS) and essment.		The position of University Place Nu and Rehabilitation center regarding process that lead to this deficiency failure to follow established facility prelated to QAPI. On 1/25/2018 the facility QAA Comheld a meeting to review the purposfunction of the QAA committee and on-going compliance issues. The Normal Director, Administrator, DON, MDS staff facilitator, treatment nurse, maintenance director, and houseke supervisor will attend QAPI Commit Meetings on an ongoing basis and assign addition team members as appropriate. ON 1/25/2018 the corporate facility	the was policy mittee se and review Medical nurse, eping ttee will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			B 14/11/0			1	С	
		345142	B. WING _			01/	12/2018	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER				920	0 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)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From page 24		F 8	367				
	#20, #97 and #88 d			consultant in-serviced the facility				
	diagnoses and the			administrator, director of nursing, MDS	;			
	#88 did not include			nurses, admissions, activities director,				
	life (Resident #20, #97, #235 and #88).				dietary manager, maintenance director,	,		
				and housekeeping supervisor related to	0			
	On a federal recerti			the appropriate functioning of the QAP	1			
	2016 the facility failed to accurately code the				Committee and the purpose of the			
	MDS for contractures. On the current				committee to include identify issues an			
	recertification survey the facility continued to fail				correct repeat deficiencies related to M			
	to accurately code the MDS for all active diagnoses and the resident's prognosis of life.				accuracy, Comprehensive Assessmen and Quality Assurance.	is,		
	diagnoses and the	resident's prognosis of life.			and Quality Assurance.			
	483.20: Comprehensive Assessment and Timing:				As of 1/25/2018 after the facility			
	Based on observations, staff interviews, and				consultant in-service, the facility QAPI			
	record review, the facility failed to conduct a				Committee will begin identifying other			
	comprehensive assessment to identify and				areas of quality concern through the Q			
	analyze how condit		- 1	review process, for example: review of				
	quality of life related			rounds tools, review of work orders,				
	sampled residents			review of Point Click Care (Electronic				
	assessments for activities (Resident #70).				Medical Record), review of resident council minutes, review of resident			
	On a federal recertification survey in November				concern logs, review of pharmacy repo	orte		
	2016 the facility failed to conduct a				and review of regional facility consultar			
	comprehensive assessment to identify and				recommendations.			
		dition affected the function and						
	quality of life related			The Facility QAPI Committee will meet	а			
	current recertification the facility continued to fail				minimum of monthly and Executive QA	νPI		
	to conduct a comprehensive assessment to				committee meeting a minimum of			
	identify and analyze how a condition affected				quarterly to identify issues related to			
	function and quality	of life related to activities.			quality assessment and assurance			
	An interview on 01/12/2018 at 4:32 PM the				activities as needed and will develop a			
					implementing appropriate plans of action for identified facility concerns. Corrective			
	Administrator stated they had 3 MDS nurses during the past year. The one with the most				action has been taken for the identified			
				concerns related to MDS accuracy,	1			
	experience quit, so it may be a training and knowledge issue why there are repeat				Comprehensive Assessments, and			
	_	e MDS. Our Quality Assurance			Quality Assurance.			
	committee meets m			,				
	issues comes up we do four point plan and				The executive QAPI committee will			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245442	B. WING _			С		
345142			B. WING _			01/12/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER		9200 GLENWATER DRIVE				
ONIVERS	TTT LAGE NORONG AN	D KENADIENATION CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO		(X5) COMPLETION DATE		
F 867			F 8	continue to meet a minimum of Quarterly, and QAPI committee monthly with oversight by a corporate staff member. The Executive QAPI Committee, including the Medical Director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The Administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The Administrator is responsible for implementation of the acceptable plan of correction.		rly, ding erly ew e		