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	345142	A. BUILDING ______ B. WING ______	C 01/12/2018

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UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	**9200 GLENWATER DRIVE CHARLOTTE, NC 28262**

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F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and	F 565	The position of University Place Nursing	2/9/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/05/2018

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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F 565	Continued From page 1 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.	F 565	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 director and the administrator present. Concerns from previous council meetings were addressed to include quality of food, staffing, recent personnel changes, lack of activity staff, mail delivery, and staff attitudes. The resident council were in agreement with resolutions. Administrator informed residents that if they wanted the 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-serviced the Activities Director and Activity Assistants on writing resident concerns up on a resident council concern form and giving the concern to the Administrator in a timely manner for follow-up. On 2/2/2018 the Administrator initiated an in-service for the Administrative staff on Follow up to Resident Council Concerns which included: 1. When addressing resident concerns, you must include detailed information for resolution of the concern to include a date. 2. Any needed audits or observations to support monitoring should be documented. This in-service was completed on 2/2/2018.	

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Interview on 01/11/18 at 2:50 PM with Resident #54 revealed the resident council voiced concerns during the meetings regarding staff changes and lack of activity staff.

4. Review of Resident #11's quarterly Minimum Data Set dated 10/10/17 revealed an assessment of intact cognition.

Interview on 01/11/18 at 2:55 PM with Resident #11 revealed the resident council discussed concerns such as food quality and staff attitudes.

5. Review of Resident #94's annual Minimum Data Set dated 11/30/17 revealed an assessment of intact cognition.

Interview on 01/11/18 at 3:00 PM with Resident #94 revealed the activity assistant took the resident council meeting minutes. Resident #94 explained she used to take the minutes but the activity assistant informed her approximately 3 months ago, she could no longer take the minutes. Resident #94 explained her minutes contained "too much information." Resident #94 reported the resident council voiced concerns regarding staffing and lack of activity staff.

A second interview with Resident #86, the resident council president, on 01/11/18 at 3:06 PM revealed newspaper delivery also was discussed during meetings. Resident #86 reported the delivery improved after he spoke with the administrator directly. Resident #86 explained he tried to take the group's concerns to the administrator if he heard the grievances.

Interview with the activity assistant on 01/12/18 at 10:23 AM revealed she relieved Resident #94 of

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After each resident council meeting the Administrator and/or DON will review meeting minutes X6 months to ensure a resident council concern form has been completed for concerns discussed during the meeting and have been addressed and the resolution reviewed with the resident council in a timely manner to include a written response to the grievance form to include details of the follow up that occurred with a date.

The Administrator will present all findings at the monthly QI committee meeting. The QI committee will review the minutes of the resident council meeting monthly for 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 for the monthly QI Committee to the quarterly executive QA Committee for further recommendations and oversight.

The Administrator is responsible for implementing the acceptable plan of correction.

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F 565	Continued From page 3 taking the minutes when Resident #54 complained that one person could not be vice-president and secretary at the same time. The activity assistant reported the minutes contained the business part of the meeting. The activity assistant explained resident complaints voiced after adjournment did not get recorded as part of the council minutes. The activity assistant reported she would complete a grievance form if the group voiced concerns during the actual meeting. Interview with the administrator on 01/12/18 at 10:49 AM revealed the resident council should bring issues, concerns and grievances to her attention so the concerns could be considered and addressed. The administrator reported the resident council minutes should accurately reflect the residents' discussions and concerns.	F 565		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 636		2/9/18

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F 636	Continued From page 4 (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility	F 636		

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following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to activities for 1 of 3 sampled residents who required comprehensive assessments for activities (Resident #70).

The findings included:

Resident #70 was admitted to the facility on 04/24/13 with diagnoses which included dementia and schizophrenia.

Review of Resident #70's annual Minimum Data Set (MDS) dated 01/17/17 revealed an assessment of severely impaired cognition. The MDS indicated participation in religious activities, staying up past 8:00 PM and keeping up with news was very important to Resident #70. The MDS triggered the Activity Care Area Assessment (CAA).

Review of Resident #70's Activity CAA dated 01/20/17 revealed no documentation of findings with a description of the problem, contributing factors and risk factor related to activities. The CAA listed Resident #70 required one to one visits due to no attendance in group activities. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.

Observation on 01/09/18 at 12:39 PM and 3:26

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The position of University Place Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately completing the Care Area Assessment related to Activities.

On 2/2/2018 the MDS nurse completed a detailed general care plan progress note for resident #70. The documentation for resident #70 is detailed to the Activities Care Area Assessment (CAA). The documentation includes a description of the focus of activities being triggered including causes, contributing factors, and risk factors. The documentation includes an analysis of the findings supporting the decision to proceed or not to proceed to care plan.

On 2/5/2018, Care Plan Team began auditing each resident with a triggered activities CAA for the past 30 days to ensure the activities CAA was completed accurately. A detailed general care plan progress note was completed on each resident where a concern was noted. The audit was completed on 2/9/2018.

On 1/26/2018 the Facility Consultant completed an in-service with the MDS Coordinator, MDS Nurse, Activities Director, and Dietary Manager related to

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PM revealed Resident #70 awake, alert and responsive with unintelligible words when addressed.

Observation on 01/10/18 at 8:50 AM and 3:22 PM revealed Resident #70 awake, alert and responsive with unintelligible words when addressed.

Observation on 01/11/18 at 8:22 AM revealed Resident #70 awake, alert and responsive with unintelligible words when addressed.

Interview with Nurse Aide (NA) #1 on 01/11/18 at 8:25 AM revealed Resident #70 remained in bed in her room on the day shift. NA #1 explained Resident #70's primary language was not English but could communicate needs such as thirst or pain. NA #1 reported Resident #70 conversed with family members who came to visit.

Observation on 01/11/18 at 2:09 PM revealed Resident #70 awake, alert and responsive with unintelligible words when addressed.

Interview with NA #2 on 01/11/18 at 3:48 PM revealed Resident #70 remained in bed and "talked in words I do not recognize."

Interview with the MDS Coordinator on 01/12/18 at 10:41 AM revealed the facility's previous activity director conducted and documented the activity CAA. The MDS Coordinator reported Resident #70's Activity CAA did not contain a documented comprehensive assessment.

Interview with the Administrator on 01/12/18 at 11:00 AM revealed she expected staff to document a comprehensive assessment with an

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when completing Section V-Care Area Assessments (CAA Summary) you must meet the requirements by describing the resident's clinical status including a description of the problem, contributing factors, risk factors, and an analysis of findings impacting care plan decisions. The analysis should include goals and interventions. Care plan and CAA should be resident specific, this includes the Activities CAA and Care Plan. You should refer to the RAI manual or facility MDS consultant for questions or guidance.

On 2/5/2018 the MDS Coordinator began auditing the Activity CAA's using the Activity CAA Audit Tool. This audit will be completed weekly x four weeks the biweekly x eight weeks by the MDS Coordinator.

The monthly QI committee will review the results of the Activity CAA Audit Tool monthly for 3 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 for further recommendations and oversight.

The Administrator is responsible for implementing the acceptable plan of correction.

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F 636	Continued From page 7 analysis of findings.	F 636		
F 641 SS=D	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 each evening. Review of the October 2017 medication	F 641	The position of University Place Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately coding active diagnosis and residents receiving hospice services to reflect life expectancy of 6 months or less. On 2/2/2018 resident #20 minimum data set (MDS) assessment dated 10/16/2017 was modified to accurately code resident #20's diagnosis of anxiety by the MDS nurse. On 2/2/2018 resident #97 MDS assessment dated 12/5/2017 was modified to accurately code resident #97 diagnosis of anxiety by the MDS nurse. On 2/2/2018 the resident #235 MDS assessment dated 4/30/2017 was modified to accurately code resident #235's MDS to reflect life expectancy of 6 months or less related to resident receiving hospice services by the MDS Nurse. On 2/2/2018 resident #88 MDS assessment dated 11/22/2017 was modified to accurately code resident #88's diagnosis of anxiety by the MDS nurse. On 2/2/2018 the modified assessments were transmitted to the National	2/9/18

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F 641	Continued From page 8 administration record and the October 2017 Physician's Order Sheet (POS) for Resident #20 revealed the diagnoses of anxiety was documented and he received Zyprexa as ordered by the physician. The quarterly minimum data set (MDS) dated 10/16/17, section I, Active Diagnoses, did not code the diagnose of anxiety. The MDS Coordinator stated in interview on 01/12/18 at 11:02 AM that when she completed the quarterly 10/16/17 MDS for Resident #20, she referred to the resident's cumulative diagnoses, looked at the October 2017 POS, but did not notice that the POS included the diagnoses of anxiety. The MDS Coordinator further stated that "Now that I see there may be some diagnoses on the POS that are not on the cumulative diagnoses list, I will pay closer attention." The administrator stated in an interview on 01/12/18 at 4:22 PM that she expected the MDS to be completed accurately and to include all active diagnoses that were being treated. 2. Resident #97 was admitted to the facility on 10/12/16. Dignoses included dementia with behaviors, cognitive communication deficit, and anxiety. Review of the electronic medical record for Resident #97 revealed the list of cumulative diagnoses did not include anxiety as a diagnose for this resident. Review of the medical record, revealed a	F 641	Repository by the MDS Coordinator. On 2/8/2018 the modified assessment was accepted by the National Repository. On 2/5/2018, the MDS Coordinator began auditing all assessments completed in the past 30 days to ensure residents with diagnosis of anxiety and/or residents receiving hospice services are coded accurately. The audit will be completed by 2/9/2018. Assessments will be modified for accuracy of coding as necessary. On 1/26/2018 the MDS Coordinator and MDS nurse were in-serviced by the Facility Consultant on correctly coding active diagnosis and residents receiving hospice services to be coded as having a life expectancy of 6 months or less. On 2/5/2018 the Administrative Nurses will begin auditing MDS assessments for correct active diagnosis and residents receiving hospice services coding using the Accuracy Audit Tool. 25% of completed assessments will be audited weekly x 4 weeks, then 25% of completed assessments biweekly x 8 weeks. The monthly QI committee will review the results of the Accuracy Audit Tool monthly for 3 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	

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F 641	Continued From page 9 physician's order for Resident #97 dated 7/8/17 for Xanax (anti-anxiety) 0.5 miligrams (mg), twice daily. Continued review of the medical record revealed a Behavioral Health progress note dated 11/3/17, a Nurse Practitioner's progress note dated 12/27/17 and the December 2017 medication administration record (MAR), all documented that Resident #97 received Xanax 0.5 mg twice daily for anxiety as ordered by the physician. The quarterly minimum data set (MDS) dated 12/5/17, section I, Active Diagnoses, did not code the diagnose of anxiety. The MDS Coordinator stated in interview on 01/12/18 at 11:02 AM that when she completed the quarterly 12/5/17 MDS for Resident #97, she referred to the resident's cumulative diagnoses, looked at the December 2017 MAR, and reviewed the medical record, but did not notice the diagnose of anxiety. The MDS Coordinator further stated that she would pay closer attention when coding the MDS. The administrator stated in an interview on 01/12/18 at 4:22 PM that she expected the MDS to be completed accurately and to include all active diagnoses that were being treated. 3. Resident #235 was admitted to the facility on 04/17/17 diagnosed with terminal cancer.	F 641	monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Administrator is responsible for implementing the acceptable plan of correction.	

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A Hospice contract dated 04/18/17 specified the Resident ' s cancer was terminal.

The Minimum Data Set (MDS) dated 04/30/17 specified the resident ' s cognition was intact and he was receiving Hospice services. Review of Section J1400 of the MDS did not identify the resident had 6 months or less to live.

On 01/12/18 at 9:20 AM the MDS Coordinator was interviewed and explained the process for determining if a resident had 6 months or less to live consisted of reviewing Hospice documentation. The MDS Coordinator reviewed Resident #235 ' s MDS and stated the resident should have been coded for 6 months or less to live. She added that nurse that completed the section no longer worked in the facility but should have known better.
4. Resident #88 was admitted to the facility on 11/12/2014 with diagnoses which included schizophrenia and anxiety.

A review of the a progress note dated 10/06/17 recorded by the Nurse Practitioner revealed Resident #88 was positive for anxiety.

A review of Resident #88's medical record revealed a psychiatry consultation report dated 11/15/17 and signed by the psychiatric physician. The form listed schizophrenia and anxiety as diagnoses for Resident #88.

A review of the most recent MDS dated 11/22/17 revealed in section I5700 Anxiety Disorder, an unchecked box.

An interview with the MDS Coordinator on

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UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11 1/12/18 at 3:56 pm, revealed she had completed the most recent MDS for Resident #88. The MDS Coordinator indicated her process was to refer to the cumulative diagnosis sheet in the medical record and in the e-record. She indicated the anxiety diagnosis was missed since it was not listed on the cumulative diagnosis sheet in the medical record or e-record. She stated she would be more thorough in her review to make sure all active diagnoses were captured on the MDS assessment. During an interview on 1/12/18 at 4:22pm, the administrator stated she expected MDS assessments to be completed accurately and to include all active diagnoses currently being treated.	F 641		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide an ongoing activity program which met the individual interest and needs to enhance the quality of life for 2 of 2 sampled residents with cognitive deficits	F 679	The position of University Place Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to provide an ongoing activity program which met the individual	2/9/18

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F 679 Continued From page 12
(Residents #70 and #99).

The findings included:

1. Resident #70 was admitted to the facility on 04/24/13 with diagnoses which included dementia and schizophrenia.

Review of Resident #70's annual Minimum Data Set (MDS) dated 01/17/17 revealed an assessment of severely impaired cognition. The MDS indicated participation in religious activities, staying up past 8:00 PM and keeping up with news was very important to Resident #70.

Review of Resident #70's Activity CAA dated 01/20/17 Resident #70 required one to one visits due to no attendance in group activities.

Review of Resident #70's quarterly MDS dated 11/16/17 revealed an assessment of severely impaired cognition with behavioral symptoms not directed toward others.

Review of Resident #70's care plan dated 12/20/17 revealed an alteration in recreation characterized by little or no involvement, lack of attendance related to cognitive impairment. Interventions listed provide 1 to 1 visits weekly, post personal activity schedule and respect choice regarding limited or no activities.

Observation on 01/09/18 at 12:39 PM and 3:26 PM revealed Resident #70 awake, alert and responsive with unintelligible words when addressed. The television was tuned to talk shows.

Observation on 01/10/18 at 8:50 AM and 3:22 PM

F 679 (Plan of Correction)

interest and needs to enhance the quality of life.

On January 16, 2018 the new Activity Director and an Activity Assistant were in orientation. The Activity Director and Activity staff established a schedule for 1:1/Social Visits for the residents who do not attend group activities.

On February 2, 2018 1:1/Social Visits were scheduled for Resident #70 and Resident #99. Residents who prefer to only do Independent Activities or occasionally participates in group activities will receive 1:1 Visit or a Social Visit. The residents will be offered independent leisure material, board games, magazines, and books. The residents will be encouraged to attend groups of choice and will be invited to the next big event.

On February 2, 2018 the Administrator initiated an in-service for the Activity Staff on 1:1 and Social Visits.

On February 5, 2018 the Administrator and QI Nurse will begin auditing the 1:1/Social Visits using the 1:1/Social Visits Audit tool for residents who prefer to only to do independent activities or occasionally participates in group activities. This audit will be completed weekly x four weeks then biweekly x eight weeks.

The monthly QI Committee will review the results of the 1:1/Social Visits Audit Tool

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F 679	Continued From page 13 revealed Resident #70 awake, alert and responsive with unintelligible words when addressed. The television was tuned to a situation comedy. Observation on 01/11/18 at 8:22 AM revealed Resident #70 awake, alert and responsive with unintelligible words when addressed. Interview with Nurse Aide (NA) #1 on 01/11/18 at 8:25 AM revealed Resident #70 remained in bed in her room on the day shift. NA #1 explained Resident #70's primary language was not English but could communicate needs such as thirst or pain. NA #1 reported Resident #70 conversed with family members who came to visit. Observation on 01/11/18 at 2:09 PM revealed Resident #70 awake, alert and responsive with unintelligible words when addressed. The television was tuned into a situation comedy. Interview with medication aide (MA) #1 on 01/11/18 at 2:13 PM revealed Resident #70 remained in the room except when a family member came to visit. MA #1 explained Resident #70 could not initiate or participate in conversations. Resident #70's family member was not available for interview. Observation on 01/11/18 at 3:48 PM revealed Resident #70 awake, alert and responsive with unintelligible words when addressed. The television was tuned into a situation comedy. Interview with NA #2 on 01/11/18 at 3:48 PM revealed Resident #70 remained in bed and	F 679	monthly for 3 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 for the monthly QI committee to the quarterly executive QA Committee for further recommendations and oversight. The Administrator is responsible for implementing the acceptable plan of correction.	

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F 679		F 679		

Continued From page 14
"talked in words I do not recognize."

Observation on 01/12/18 at 10:03 AM revealed Resident #70 awake, alert and responsive with unintelligible words when addressed.

Interview with the activity assistant on 01/12/18 at 10:15 AM revealed Resident #70's 1:1 visits did not occur. The activity assistant explained it was difficult to arrange activities for Resident #70 since the departure of other activity employees. The activity assistant reported she tried to see Resident #70 weekly but did not have the time to provide 1:1 visits or other activities for Resident #70.

Interview with the administrator on 01/12/18 at 11:00 AM revealed she expected residents to receive an activity program which met their interests and needs. The administrator reported an activity director was to begin employment next week which would lessen the demand on the activity assistant.

2. Resident #99 was admitted to the facility on 09/08/17 with diagnoses which included dementia and schizophrenia.

Review of an activity note dated 09/18/17 revealed Resident #99 enjoyed social groups, sports, gospel music, and field trips.

Review of Resident #99's admission Minimum Data Set (MDS) dated 09/20/17 revealed an assessment of severely impaired cognition. The MDS indicated access to books and newspapers, music, animals and to be outdoors when the weather is good were very important to Resident

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F 679	Continued From page 15	F 679		

#99. The MDS did not trigger an Activity Care Area Assessment.

Observation on 01/09/18 at 10:00 AM and at 3:19 PM revealed Resident #99 asleep in a wheel chair.

Observation on 01/10/18 at 8:38 AM revealed Resident #99 seated in a wheel chair in the room. Resident #99 was alert and conversed socially. Resident #99 reported the breakfast meal was good but could not remember the food items consumed.

Observations on 01/10/18 at 10:00 AM revealed Resident #99 seated in a wheel chair in the room. The television was turned on.

Observation on 01/11/18 at 12:11 PM revealed Resident #99 seated in a wheel chair in the doorway to the room. Resident #99 attempted to converse with staff who walked by his doorway.

Observation on 01/11/18 at 2:10 PM revealed Resident #99 self-propelled a wheel chair in his room.

Interview with medication aide (MA) #1 on 01/11/18 at 2:15 PM revealed Resident #99 self-propelled in the wheelchair. MA #1 explained Resident #99 could make his needs known and liked to move around the facility.

Interview with Nurse Aide #2 on 01/11/18 at 3:50 PM revealed Resident #99 usual evening was spent self-propelling in the hallway.

Interview with the activity assistant on 01/12/18 at 10:15 AM revealed Resident #99 usually refused

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F 679	Continued From page 16 attendance at group activities. The activity assistant explained it was difficult to arrange activities for Resident #99 since the departure of other activity employees. Interview with the administrator on 01/12/18 at 11:00 AM revealed she expected residents to receive an activity program which met their interests and needs. The administrator reported an activity director was to begin employment next week which would lessen the demand on the activity assistant.	F 679		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to provide communication regarding the resident's condition prior to receiving hemodialysis services for 1 of 1 sampled residents (Resident # 133). The findings included: Resident #133 was admitted to the facility 09/14/2014 with diagnosis that included end stage renal disease, heart failure, disease., diabetes, hypertension and peripheral vascular disease. The most recent Minimum Data Set (MDS) dated 12/29/2017 specified the resident's cognition was able to participate in daily decision	F 698	The position of University Place Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to provide communication regarding the resident's condition prior to receiving hemodialysis services. On 2/2/18 a new communication for was initiated for better communication between the facility and the dialysis center. The communication form includes BP before/BP after Dialysis, Pre/Post Weights, Complete Tx Y/N, and New Orders Y/N, and Communication.	2/9/18

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F 698 Continued From page 17

making and received dialysis.

The Care Area Assessment (CAA) dated 07/07/2017 for nutrition indicated Resident #133 had end stage renal disease and was on dialysis.

A care plan revised on 12/17/2017 for End stage renal disease documented an intervention as communication with the dialysis treatment center and adjust the care plan and/or treatment plan.

A document titled "Communication Form for Dialysis Patients" was reviewed. The document included pre dialysis information included:

-Blood Pressure before dialysis

-Blood Pressure after dialysis

-Changes since the last visit: (including antibiotics, new medications, pain, non-compliance with diet or fluids, edema)

On 01/09/2018 at 11:59 AM Nurse #6 assigned to Resident #133 was interviewed and revealed a sheet in a book was sent to dialysis with Resident # 133. She stated dialysis sent the book with the communications sheet back to the facility. Lab results or new orders were put in the Doctor's communication book.

On 01/10/2018 at 5:15 PM Nurse # 3 was interviewed and explained all dialysis residents had a book with communications sheets sent to the dialysis center to alert them of the resident's condition prior to starting hemodialysis. The dialysis communication sheet was returned to the facility after each dialysis treatment with the resident.

F 698

On 2/5/2018 The Administrative Nurses will begin auditing each dialysis resident's communication documentation for any changes or communications and implementation of any new orders.

On 2/2/2018 the Administrator initiated an in-service on the new communication form and the process involved in completing the form and ensuring that the communications were followed through.

On 2/5/2018 the Administrative Nurses will begin auditing the new dialysis communication documentation form using the Dialysis Communication Audit tool. This audit will be completed weekly x four then biweekly x eight weeks by the Administrative Nurses.

The monthly QI committee will review the results of the Dialysis Communication Audit tool monthly x 3 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 for further recommendations and oversight.

The Administrator is responsible for implementing the acceptable plan of correction.

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On 01/11/2018 at 2:30 PM with the DON revealed the Dialysis Communication sheets were filed in a monthly folder and stored in her office at the end of each month. She stated she could not locate the folder for the Nov. 2017 for the Dialysis Communications sheets for Resident #133 for the month of Nov. 2018.

On 01/12/2018 at 12:25 PM with the Nurse Practitioner (NP) #1 if I need to let the Dialysis Center know something I wrote it on the communication sheet in the book that went to dialysis with them. The nurses put anything we needed to know after dialysis in the Doctor communication book here for us to review.

On 01/12/2018 at an interview with the Receptionist #1 revealed she received calls in the evening 3:30 PM-8:00 PM. She the calls that came from the dialysis center were for the resident to be picked up. She stated she logged all calls in a log book or just on a piece of paper. She did not have the log book there at the facility to be reviewed. She could not remember any specific calls from the dialysis center.

On 01/12/2018 at 2:30 PM an interview with the Administrator revealed her expectation was that the Dialysis Communication sheets were completed before the residents leave for their dialysis treatment and be sent to the Dialysis Center with the residents. She expected the Dialysis Communication sheets have been reviewed by the nursing staff when the residents returned to the facility. Any communication including laboratory results or order changes would be placed in the doctor's communication book for them to review. The monthly sheets

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F 698	Continued From page 19 were to be removed and filed by the Director of Nursing.	F 698		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		2/9/18

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F 842	Continued From page 20 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to have documentation that a dressing was removed as ordered by the medical provider and failed to document a resident's fall in the medical record for 2 of 27 sampled residents (Resident #133 and #235).	F 842	The position of University Place Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately documenting resident refusals and falls.	

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The findings included:

1. Resident #133 was admitted to the facility on 09/14/2014 with diagnoses that included End Stage Renal Disease. The Minimum Data Set (MDS) dated 12/29/2017 assessed the resident's cognition as intact to participate in daily decision making. It specified he received dialysis.

Review of the Medication Administration Record (MAR) documented had an order "Remove access dressing at 7 PM on HD days MWF." During the month of November 2017 removal of the access dressing was documented on 11/22/2017 and 11/29/2017. There was no documentation on the MAR for November 1,4,6,8,11,13,15,18,20,24,27, 2017 that the access dressing had been removed. The key on the MAR indicated if there was a refusal it needed staff initials and they were to be circled.

An interview on 01/11/2017 at 4:00 PM Nurse # 4 stated the resident refused to have his dialysis access dressing removed frequently in the evening after he returned from dialysis. She stated the resident was belligerent and would not let her look at his dialysis access site.

A second interview on 01/11/2018 at 4:15 PM with Nurse #4 revealed she had not documented Resident #133's refusal on the MAR. She stated she should have documented it and let someone know he had refused.

An interview on 01/12/2018 at 10:52 AM with the Director of Nursing (DON) revealed a treatment like removing the dressing from the dialysis access site should be documented on the MAR. If the resident refuses it should be documented on

F 842

On 2/5/2018 the staff nurses were educated and began documenting on resident #133's refusals to have the dialysis dressing removed on the medication administration record (MARS). On 2/5/2018 staff nurse #5 was educated related to failing to document resident #235's fall in the electronic progress note.

On 2/5/2018, the Administrative Nurses began auditing each MARS for the past 30 days to ensure all refusals are being documented. On 2/5/2018, the Administrative Nurses began auditing all residents falls for the past 30 days to ensure there is documentation in the resident progress notes. The audits will be 100% complete by 2/9/2018. Any concerns were immediately addressed.

On 2/5/2018 the Staff Facilitator began in-servicing all RN's and LPN's related to documentation on resident refusals and resident falls. The in-service will be 100% complete by 2/9/2018. After 2/9/2018 no RN or LPN will be allowed to work a shift until the in-service is complete. All new employees will receive this in-service during orientation.

On 2/5/2018 the Administrative Nurses began auditing the resident MARS and falls to ensure documentation is correct using the Documentation Audit Tool. This audit will be completed 5x a week x 4 weeks then weekly x 8 weeks.

The monthly QI committee will review the results of the Documentation Audit Tool

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the MAR with the nurse's initials and a circle around the initials.

An interview on 01/12/2018 at 2:22 PM with the Administrator revealed her expectation was that documentation of the residents' records was complete and accurate. She expected the facility's documentation policies and procedures to be followed including documentation of refusals on the MARs.

2. Resident #235 was admitted to the facility on 04/17/17 diagnosed with terminal cancer. The Minimum Data Set (MDS) dated 04/30/17 specified the resident's cognition was intact and he required limited assistance with activities of daily living (ADL) and had not fallen while in the facility.
A nurse's entry dated 07/16/17 specified the family inquired about an unwitnessed fall.

Further review of the medical record revealed there was no entry or reference to a fall for Resident #235.

The facility provided an incident report for Resident #235 dated 07/16/17 that specified the resident had fallen on 07/15/17.

On 01/11/18 at 3:28 PM Nurse #5 was interviewed and recalled caring for Resident #235. Nurse #5 stated that one morning she was called by nurse aide #3 to Resident #235's room because the resident had fallen in the bathroom. Nurse #5 added that it was end of shift when the fall had occurred and she forgot to document that

F 842

monthly for 3 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 for further recommendations and oversight.

The Administrator is responsible for implementing the acceptable plan of correction

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 01/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 23 fall in the medical record. The nurse added that she assessed the resident for injury and none were noted. On 01/12/18 at 9:51 AM the Administrator as interviewed and stated she would expect Nurse #5 to have taken time to document Resident #235's fall in the medical record.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures to monitor these interventions that the committee put into place December 1, 2016 on a recertification survey. The deficiencies were in the areas of accurately coding the Minimum Data Set (MDS) and Comprehensive Assessment. Findings included: This tag is cross referenced to: 483.20: Accuracy of Assessments: 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	F 867	The position of University Place Nursing and Rehabilitation center regarding the process that lead to this deficiency was failure to follow established facility policy related to QAPI. On 1/25/2018 the facility QAA Committee held a meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The Medical Director, Administrator, DON, MDS nurse, staff facilitator, treatment nurse, maintenance director, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign addition team members as appropriate. ON 1/25/2018 the corporate facility	2/9/18

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F 867 Continued From page 24

#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).

On a federal recertification survey in November 2016 the facility failed to accurately code the MDS for contractures. On the current recertification survey the facility continued to fail to accurately code the MDS for all active diagnoses and the resident's prognosis of life.

483.20: Comprehensive Assessment and Timing: Based on observations, staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to activities for 1 of 3 sampled residents who required comprehensive assessments for activities (Resident #70).

On a federal recertification survey in November 2016 the facility failed to conduct a comprehensive assessment to identify and analyze how a condition affected the function and quality of life related to contractures. On the current recertification the facility continued to fail to conduct a comprehensive assessment to identify and analyze how a condition affected function and quality of life related to activities.

An interview on 01/12/2018 at 4:32 PM the Administrator stated they had 3 MDS nurses during the past year. The one with the most experience quit, so it may be a training and knowledge issue why there are repeat deficiencies with the MDS. Our Quality Assurance committee meets monthly and we do audits. If an issues comes up we do four point plan and

F 867

consultant in-serviced the facility administrator, director of nursing, MDS nurses, admissions, activities director, dietary manager,maintenance director, and housekeeping supervisor related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to MDS accuracy, Comprehensive Assessments, and Quality Assurance.

As of 1/25/2018 after the facility consultant in-service, the facility QAPI Committee will begin identifying other areas of quality concern through the QI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, and review of regional facility consultant recommendations.

The Facility QAPI Committee will meet a minimum of monthly and Executive QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to MDS accuracy, Comprehensive Assessments, and Quality Assurance.

The executive QAPI committee will

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F 867	Continued From page 25 monitor that. We had not had an actual Quality Improvement (QI) person in that position since July 2017. That person's responsibility was to oversee the QI process, catch things and be instrumental to correct repeat deficiencies with accuracy and comprehensive assessments.	F 867	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.	