

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 000	INITIAL COMMENTS An onsite unannounced complaint investigation was conducted on 08/21/24 and 8/22/24. The survey team returned to the facility on 8/26/24 to investigate additional complaint allegations and exited on 8/27/24. Therefore, the exit date was changed to 8/27/24. Event ID: DCEU11. The following intakes were investigated: NC00220886, NC00220392, and NC00220907.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, and Physician Assistant interviews the facility failed to dispose of a plastic bag that had been used to crush medications for Resident #24 and the plastic bag ended up on Resident #23's breakfast tray. Resident #23 believed the crushed white substance was powdered sugar and sprinkled it on his breakfast. This affected 1 of 5 residents reviewed for medication errors. The findings included: Resident #23 was admitted to the facility on 05/03/24 with diagnoses that included chronic pain.	F 658	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/29/2024

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.

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 658	<p>Continued From page 1</p> <p>A physician order dated 05/06/24 read, Acetaminophen 500 milligram (mg) by mouth give 2 tablets 3 times a day for chronic pain.</p> <p>The quarterly Minimum Data Set (MDS) dated 08/05/24 revealed that Resident #23 was cognitively intact and had no behaviors. The MDS further revealed that Resident #23 frequently reported pain of a 9 on a pain scale.</p> <p>Resident #24 was admitted to the facility on 07/08/19 with diagnoses that included Alzheimer's disease and dementia.</p> <p>A physician order dated 10/18/23 read, Acetaminophen 325 mg by mouth, give 2 tablets every 8 hours for pain.</p> <p>The quarterly MDS dated 08/01/24 revealed that Resident #24 was severely cognitively impaired and had no nonverbal signs of pain.</p> <p>Review of the Medication Administration Record (MAR) dated July 2024 revealed that Resident #24's acetaminophen had been initialed by staff indicating it had been administered as prescribed.</p> <p>Review of the MAR dated August 2024 revealed that Resident #24's acetaminophen had been initialed by staff indicating it had been administered as prescribed.</p> <p>Resident #23 was interviewed on 08/26/24 at 11:44 AM who stated about a month ago he received his breakfast tray, and he had French toast. Resident #23 stated he loved French toast and was excited that it was on his tray. He stated that on the side of his tray was a plastic bag that had a white powder in it, and he believed it was</p>	F 658			

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 658	<p>Continued From page 2</p> <p>powdered sugar for his French toast. Resident #23 stated he sprinkled the white powder on his French toast and took a bite and the white powder was bitter and tasted like medication, so he spit the food out and did not eat anything else on his tray. Resident #23 stated he flipped the plastic bag over and it had another resident's name written on the bag and then he believed that the white powder was a medication but stated he did not ingest any because it was bitter, and he spit it out. He also did not know which resident's name was written on the plastic bag. Resident #23 stated he summoned Nurse Aide (NA) #1 to his room and told her what had occurred. Resident #23 stated that later he was interviewed by Unit Manager #1, the former Social Worker, and the Director of Nursing (DON). He also stated that Nurse #1 was giving meds that day and came back to him later and stated she had the plastic bag in her pocket, and it had accidentally fallen on his tray. Resident #23 was unable to quantify how much powder was in the bag but stated "it was enough that I thought it was powdered sugar." He picked up a plastic sleeve that was on his lunch tray and approximated that the white powdered substance was one third of the plastic sleeve. Resident #23 also confirmed that nothing like that had happened since that day.</p> <p>Review of the facility's menu revealed that French toast was on the menu for breakfast on 07/09/24.</p> <p>NA #1 was interviewed on 08/26/24 at 12:42 PM. NA #1 stated that she recalled the incident but could not recall when it occurred. She stated that Resident #23 called her to his room and stated he had sprinkled powdered sugar on his French toast and when he put it in his mouth it was bitter,</p>	F 658			

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 658	<p>Continued From page 3</p> <p>and he thought it was medication that was not his. NA #1 stated she told Resident #23 that they did not have powdered sugar and added that she did not see the white powder or bag on his tray at the time, but she had reported what he said to Nurse #1, and Nurse #1 went and talked to him.</p> <p>Nurse #1 was interviewed via phone on 08/27/24 at 10:15 AM. Nurse #1 stated that she recalled the incident but could not recall when it occurred. She stated she was working and passing medications, and she was asked to help pass out breakfast trays. She stated she had crushed 2 acetaminophen tablets for Resident #24 and administered them to her but the plastic bag that she crushed them in had Resident #24's name on it and she could not throw it in the trash. Nurse #1 stated she put the plastic bag in her pocket of her scrub top with the intention of throwing it in the shred box for destruction. Nurse #1 stated after she passed trays, she reached in her pocket to get the plastic bag out to dispose of it and it was gone. Nurse #1 stated she returned to each room that she had delivered trays to and found the bag in Resident #23's room. Nurse #1 stated that Resident #23 stated he thought it was sugar and she replied to Resident #23 "you know that had a name on it and was not sugar" "but for my protection I reported to my supervisor" which was Unit Manager #1. Nurse #1 stated Resident #23 did not report to her that he had tasted it only that he thought it was sugar. Nurse #1 again stated that there was no medication in the plastic bag that she had already given the acetaminophen to Resident #24 and could not explain how Resident #23 sprinkled it on his French toast.</p> <p>Unit Manager (UM) #1 was interviewed on 08/27/24 at 10:42 AM. She stated that she</p>	F 658			

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 658	<p>Continued From page 4</p> <p>recalled walking up on a conversation between the DON and Nurse #1 about the incident but was not aware of what had occurred. UM #1 stated she had not been informed of the situation by anyone else and was not aware of any of the details, nor was she aware when it occurred or how the situation was handled.</p> <p>The former Social Worker (SW) was interviewed via phone on 08/27/24 at 10:07 AM. The SW explained that she used to be the full-time social worker and had switched to working evenings at the facility. She stated she came in one evening and NA #1 told her what had occurred and that she needed to go and speak to Resident #23. The SW stated she immediately went to talk to Resident #23 who stated that he got a breakfast tray and had French toast and when he was fixing his tray, he found a plastic bag that he thought was powdered sugar, and he had sprinkled it on his French toast and took a bite and it was bitter. Resident #23 stated he spit the food out and did not ingest the substance, but he looked at the plastic bag and it had a resident's name on it. The SW stated she reported the incident to Unit Manager #1 and to the DON and they were going to talk to him. The SW could not recall when the incident occurred but stated she thought it was reported to her on a Monday and the incident had occurred over the weekend, but she was not for sure.</p> <p>The DON was interviewed on 08/27/24 at 11:49 AM. The DON stated she could not recall when the incident occurred, but Nurse #1 had reported to her that she had dropped an empty pouch that had been used to crush medications on Resident #23's tray. The DON stated she asked Nurse #1 if the medication had been given to the correct</p>	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 658	<p>Continued From page 5</p> <p>resident and Nurse #1 replied "yes" so, the DON stated she did not think anything else about it. She added that she had instructed Nurse #1 to properly dispose of the packaging and to not put it in her pocket. The DON stated Resident #23 had not said anything to her about the situation and the former SW had not reported it to her. The DON stated she was not aware that Resident #23 had sprinkled the medication on his food which she found highly unlikely because Nurse #1 stated the plastic bag was empty. She added that it surprised her that Resident #23 would sprinkle that on his food.</p> <p>The Physician Assistant was interviewed via phone on 08/27/24 at 1:29 PM. He stated that Resident #23 took a lot of acetaminophen for his chronic pain but his dosage was within the acceptable parameters. The Physician Assistant stated if Resident #23 had ingested or taken an extra dose of acetaminophen 650 mg one time there would have been no adverse outcome to him.</p> <p>The facility provided the following corrective action plan with a completion date of 8/5/24.</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>At the time of the incident Resident #23 spit out the food and did not consume it and sent the tray back to the kitchen.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p>	F 658			

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 658	<p>Continued From page 6</p> <p>On 07/30/24 the DON did an audit of all resident rooms to ensure no medications were noted at bedside or in the room unless the resident had an order to keep medications at bedside including Resident #23.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur:</p> <p>From 07/30/24 through 08/05/24 all facility nurses and Medication Aides received a medication pass observation by the corporate clinic management team.</p> <p>From 07/24/24 through 08/05/24 all Nurses and Medication Aides received training from the facility DON or corporate clinical management team on the 6 rights of medication administration, medication storage, and limiting interruptions during medication pass for example not taking phone calls or text during medication pass times. The education included the facility's system for disposing of protected health information during medication pass. The system included that any medication packaging that contained protected health information was to be placed in a cardboard box on each medication cart and at the end of the medication pass and taken to the shred box for destruction.</p> <p>Any Nurses or Medication Aides that did not receive the education or medication pass observation were not permitted to work a shift until both had been completed.</p> <p>The education used for the Nurses and Medication Aides was included in the new hire orientation program.</p>	F 658			

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 658	<p>Continued From page 7</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>Daily audits were completed by the Medical Records clerk from 08/05/24 through 08/08/24 observing for any medication at bedside or in the resident's room. Weekly audits continue until directed by the QAPI committee.</p> <p>The plan had been approved by the QAPI committee on 07/26/24.</p> <p>Facility date of compliance was 08/05/24.</p> <p>The plan of correction was validated on 08/26/24 through 08/27/24. Alert and oriented residents were interviewed about medications in their room or on their meal tray with no issues reported including Resident #23. A medication pass observation was completed with 30 opportunities and no errors, and no other concerns noted. Nursing staff were interviewed on the 6 rights of medication administration and how and where to dispose of resident's medication packaging that included protected health information. They were able to verbalize that the medication packaging that included protected health information was not placed in the trash can, it was placed in a small cardboard box that sat on top of the medication cart and after the medication pass was completed the box was emptied into the shred box for destruction. The new hire orientation packet was verified to include the medication administration education and medication pass observation. The daily and weekly audits were reviewed. Staff interviews revealed that they observed 10 different resident rooms to ensure there were no</p>	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 658	Continued From page 8 medications at bedside unless the resident had an order to keep medications at bedside. The compliance date of 08/05/24 was validated.	F 658		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, a resident interview, interviews with staff and record review, the facility failed to provide food in a form to meet the individual needs of a resident with a physician order for a regular diet with mechanical soft texture (Resident #19). This failure occurred for 1 of 3 sampled residents reviewed for mechanically altered diets. The findings included: A review of menus, recipes and the "Diets" policy, revised 9/2010 revealed residents with a physician order for a regular diet, mechanical soft texture should receive regular mechanical soft textured foods and meats from the regular menu would be ground, easy to chew and easy to swallow. Resident #19 was admitted to the facility on 3/31/15. Diagnoses included dysphagia, oropharyngeal phase, dementia (mild) with mood disturbance, cognitive communication deficit, and psychosis.	F 805	University Place -F805 Food Prepared in a Form to Meet Individual Needs Problem Statement: " On 08/26/24, Resident #19 was served bacon cut into smaller pieces and is on a mechanical soft diet. The bacon served was not prepared in a manner consistent with mechanical soft diet. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " On 8/26/24, the resident was provided another tray by the Unit Manager consistent with a mechanical soft diet. " On 8/26/24, the Dietary Manager/Registered Dietician verified the resident's diet and updated the meal tray card to remove the bacon as a preference. " On 8/26/24, the Unit Manager explained the risk and benefits of eating foods outside of the resident's prescribed diet, to Resident #19, as the resident's preferences and requests fluctuate.	8/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 805	<p>Continued From page 9</p> <p>A review of the August 2024 Physician Order Summary revealed Resident #19 had a physician order for a regular diet with mechanical soft texture.</p> <p>A 8/7/24 quarterly Minimum Data Set assessment, recorded Resident #19's speech was clear, he was understood by others, able to understand, his hearing was adequate, his vision was impaired, he wore corrective lenses, his cognition was intact and he received a mechanically altered diet.</p> <p>A care plan, revised 8/16/24 recorded Resident #19 had a care deficit related to his dentures as he was edentulous, received a mechanically altered diet and that he was resistive to treatment/care (refused to wear his dentures). Interventions included providing his diet as ordered and referrals for dietary concerns related to any swallowing difficulties.</p> <p>A review of the medical record for Resident #19 revealed there was no documentation that he requested to receive crispy bacon or that he was educated on the risks of crispy bacon associated with a mechanically altered diet.</p> <p>Resident #19 was observed on 8/26/24 at 9:19 AM in the Activity Room with other residents and staff for the breakfast meal. Resident #19's breakfast tray was in front of him, but he was not eating. Resident #19 was not wearing dentures. His breakfast tray remained with a partially eaten cheese omelet, a small portion of grits, and crisp bacon that was cut into large pieces and was not ground. Resident #19 did not eat the bacon. The tray card recorded a mechanical soft diet, and the notes section recorded "give crispy bacon daily."</p>	F 805	<p>" On 8/26/24, the Unit Manager obtained a physician order for Resident #19 to have regular diet texture foods upon request. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 8/28/24, the Dietary Manager and the Registered Dietician initiated a 100% audit of all resident meal tray cards in comparison to their diet order. Any concerns will be addressed immediately, and education provided at that time. The initial audit will be concluded by 8/29/24. The Unit Manager/ Registered Nurse/ Director of Nursing will explain the risks and benefits of eating foods outside of the resident's prescribed diet for any residents that wishes to do so. " The Dietician observed the entire tray line on 08/29/24 to ensure meal trays were accurate according to the resident's tray card. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " In-service education was initiated on 8/28/24 by the Dietary Manager/Staff Development Coordinator/Registered Dietician to ensure all residents are served the appropriate diet as indicated on the resident's meal tray card. The education will include to provide a meal tray with the appropriate diet. This education will be provided to all nurses, certified nursing assistants, administrative staff, activities, and dietary staff to included agency and contract staff who</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 805	<p>Continued From page 10</p> <p>Resident #19 stated he did not finish eating because he did not like his food. He described that he did not eat the bacon because of his "throat issues" and stated that he could not eat food that was "too hard or too big" because if he did, the food got "caught" in his throat and caused him to cough. Resident #19 stated that every time bacon was on the breakfast menu, which was once or twice per week, he stated, "This is what I get, and I can't eat it, so I don't." Resident #19 stated that "They have been telling me they are going to fix it on my card for years and they never do, I'm supposed to get my meat ground up, I don't like this bacon because I can't chew it and I can't swallow it, but every time it's on the menu, I get it cut up like this, but I can't eat it, so I don't." Resident #19 further stated that he did not know why the "crispy bacon daily" was on his tray card, he stated "I don't know where that came from, I never asked for bacon, I try not to eat pork/ham." Resident #19 stated that he was supposed to get his breakfast meat "ground up", he did not know what kind of meat it was, but ground meat was what he needed and stated, "that's what the doctor ordered and that's what I should get." He stated that he was told "in therapy" that he would receive ground meat and that he agreed to that. Resident #19 stated that Nurse Aide (NA) #1 knew that he was supposed to get ground meat, so when he received foods that he did not like or could not eat, if NA #1 was working that day, she took his tray back to the kitchen and brought him something he could eat. He stated that as many times as NA #1 took his tray back to the kitchen, he thought his card would get corrected, but that it never got fixed.</p> <p>A review of the Spring/Summer cycle breakfast menus revealed bacon was served three times in</p>	F 805	<p>serve resident meals. All education will be completed by 8/29/24. Any staff member not receiving the education by 8/29/24 will receive it prior to their next scheduled shift. Any newly hired staff members to include agency or contract staff members will receive education during orientation prior to their first scheduled shift.</p> <p>" In-service education was initiated on 8/28/24 by the Dietary Manager/Registered Dietician to ensure that the dietary staff will observe that all trays served on the tray line are validated that the correct diet order is being followed when preparing the resident's meal tray by reviewing the meal tray card prior to the tray being placed on the cart. All dietary staff will be educated, and all education will be completed by 8/29/24. Any staff member not receiving the education by 8/29/24 will receive it prior to their next scheduled shift. Any newly hired staff members, to include agency and contract staff members will receive education during orientation prior to their first scheduled shift.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>" The Nurse/Nurse supervisors will audit 5 resident meal trays per week on varying days of the week and varying meals, 3 days per week x8 weeks, at point of service, using the Food Form/Preference audit tool to ensure all trays are being served with the correct diet order as indicated on the resident meal tray card. Any concerns will be addressed immediately, and education</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 805	<p>Continued From page 11</p> <p>weeks one and four and twice in weeks two and three.</p> <p>An 8/26/24 interview at 12:00 PM with NA #1 revealed she worked at the facility for over a year and Resident #19 was on her regular assignment. NA #1 stated she did not set up his breakfast tray that morning (8/26/24) and did not know which staff member did, but that he was supposed to receive ground meat with his meals. NA #1 stated that when she did set up his breakfast tray, she made sure he received a mechanical soft diet with ground meat. NA #1 stated that sometimes she had to return his meal tray back to the kitchen, to get it "fixed", but that she did not recall if that was because he did not receive something he wanted or if something else was wrong. NA #1 stated that as far as she knew, Resident #19 received a mechanical soft diet, and that she had not noticed before if he received bacon that was cut up and not ground, but that she did not always set up his tray. NA #1 stated that she was not sure why he received bacon that was in pieces too big for him to eat, but that his food came from the kitchen that way. NA #1 stated that on the days she worked, if she saw that he was not eating his food, she checked on him and if he said he did not want his food, she took his tray back to the kitchen to get him something else to eat.</p> <p>An 8/27/24 interview at 10:05 AM with Unit Manager (UM) #1 revealed she worked in the facility for the past four months. UM #1 stated she assisted another resident with his breakfast on 8/26/24 in the Activity Room when she noticed Resident #19 did not finish eating his breakfast. She described "he was just looking ahead." UM #1 said she asked Resident #19 if he was okay,</p>	F 805	<p>provided at the time the concern is identified.</p> <p>" The Dietary Manager/Dietary Cook will audit 10 resident meal trays per day on varying days of the week and varying meals, 3 days per week x8 weeks using the Food Form/Preference audit tool prior to being placed on the carts to be served to the residents to ensure all trays are being served with the correct diet order as indicated on the resident meal tray card. Any concerns will be addressed immediately, and education provided at the time the concern is identified.</p> <p>" The Food Form/Preference audit tools that will be completed 3 days per week x8 weeks will be taken to Quality Assurance Performance Improvement monthly times 2 months and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring.</p> <p>" The Administrator is ultimately responsible for implementing the plan of correction and ensuring it is followed.</p>		

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 805	<p>Continued From page 12</p> <p>but he did not tell her what was wrong. UM #1 stated that since she was assisting another resident, she did not go over to Resident #19 to see what was wrong. UM #1 stated she did not work with Resident #19 that often, and that she was not familiar with his care needs. UM #1 stated she did not set up his breakfast tray on 8/26/24 so she did not notice that his diet order was mechanical soft but that he received large pieces of bacon.</p> <p>During an interview and observation on 8/26/24 at 9:26 AM of Resident #19 with his breakfast tray with the Speech Therapist (ST) and the Rehab Director, the ST stated that she worked in the facility for the past 18 months and Resident #19 discharged from ST caseload in 2023. The ST reviewed the tray card and observed the breakfast meal for Resident #19 and stated she saw on his tray card instructions to "give crispy bacon daily" and stated that the large pieces of bacon he received did not meet the requirement for ground meat texture for a resident with a diet order for mechanical soft foods. The ST stated that his diet recommendation from ST was for a mechanical soft diet with ground meat and that she assumed he requested the crispy bacon because it was on his tray card, but she wasn't sure. The ST stated that she saw the crispy bacon on his tray card today (8/26/24), but she did not talk to him previously about the risks of eating crispy bacon. The ST stated Resident #19 was his own responsible party and that he could have crispy bacon if he wanted but that he should be educated on the risks associated with receiving foods that were not part of his diet order. The ST stated that she educated Resident #19 on the risks associated with his difficulty swallowing when he was treated in 2023, but that</p>	F 805			

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 805	<p>Continued From page 13</p> <p>she did not know when the crispy bacon was added to his tray card, and she did not know if he was educated on the risks of eating crispy bacon. The ST stated that Resident #19 refused to be evaluated for ST services since he was discharged from ST in 2023 and expressed at discharge that he would continue to receive a mechanical soft diet.</p> <p>During an interview on 8/27/24 at 2:00 PM with the Certified Foodservice Manager (CFM), he stated that he was the CFM for the past three weeks, he was familiar with Resident #19 because he attended Food Committee Meetings. The CFM stated he received bacon for breakfast that morning (8/26/24) because it was recorded on his tray card and that the bacon was cut up because of his diet order for mechanical soft foods. He reviewed the therapeutic spread sheet during the interview and confirmed that residents with diet orders for mechanical soft foods should receive ground meats.</p> <p>During an observation of Resident #19 on 8/26/24 at 9:25 AM with his breakfast meal and interview with the Registered Dietitian (RD), the RD stated she was not aware that Resident #19 received bacon with his breakfast meal, but that he attended Food Committee Meetings weekly and his concern with receiving bacon had not been discussed. The RD stated that at the Food Committee Meeting on Monday, 8/19/24, Resident #19 communicated that he wanted gravy biscuits, but because his tray card recorded "no gravy" he did not receive it, so that was corrected, but that he did not mention the bacon, nor had she been informed by staff that he did not want crispy bacon. The RD stated that she assumed Resident #19 must have told someone</p>	F 805			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 805	<p>Continued From page 14</p> <p>in the dietary department at some point that he wanted crispy bacon, in order for it to be recorded on his tray card, but she was not sure who because there had been several different dietary managers employed at the facility in just a few months. The RD stated she did not know if Resident #19 was educated on the risks associated with receiving crispy bacon with a diet order for mechanical soft foods, but that ground crispy bacon was impossible to make. The RD stated she had not spoken to Resident #19 about the risks associated with eating crispy bacon since his diet order was for mechanical soft foods. The RD stated Resident #19 should receive ground meat per his diet order and if he requested the crispy bacon, he should be educated on the risks.</p> <p>During an interview on 8/27/24 at 4:15 PM the Rehab Director reviewed the ST notes for Resident #19 and stated he was referred for ST services in 2023 from nursing when he was observed coughing repeatedly with his meal. The Rehab Director stated that nursing immediately downgraded his diet from a regular diet to a mechanical soft diet. The Rehab Director stated that after some time, ST offered to re-evaluate and treat him to upgrade his diet, but although he had dentures, he usually refused to wear them, and he never wore dentures with his meals. The Rehab Director stated that Resident #19 understood safe swallowing techniques, he was able to communicate the techniques, but that he did not implement safe swallowing techniques consistently. The Rehab Director stated that he had not received ST services since 2023, because he stated that he did not like the ST at the facility, so the Rehab Director asked another ST to eval him yesterday (8/26/24). The Rehab</p>	F 805			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 805	<p>Continued From page 15</p> <p>Director stated that Resident #19 expressed during the 8/26/24 evaluation that he still did not want to wear his dentures to eat, and if his food was not soft and ground up, he could not swallow it. He stated that he did not like pork and wanted to stay away from bacon. He declined ST treatment services and stated that he would continue with his current diet of mechanical soft foods with ground meats. The Rehab Director stated that since Resident #19 would not wear his dentures to eat, his diet order would remain mechanically soft for his safety.</p> <p>The Administrator stated in an interview on 8/26/24 at 11:45 AM that Resident #19 attended the weekly Food Council Meetings and had not brought up a concern about receiving bacon. The Administrator stated that Resident #19 was his own responsible party and since crispy bacon was recorded on his tray card, she assumed that it was per his request. She stated she was the Administrator at the facility since February 2024 and that in that time staff had not brought to her attention that Resident #19 did not want crispy bacon and that she was not aware if Resident #19 was educated on the risks associated with a diet order for mechanical soft foods and eating crispy bacon.</p> <p>The Nurse Consultant stated on 8/27/24 at 4:00 PM that she did not find documentation in the medical record for Resident #19 that he was educated on the risks associated with crispy bacon and his diet order, but that he should have been educated. She stated that she felt the education occurred, but since it was not documented, she could not be certain. She stated that residents should receive their diet as ordered.</p>	F 805			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 806 SS=B	<p>Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)</p> <p>§483.60(d) Food and drink Each resident receives and the facility provides-</p> <p>§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;</p> <p>§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, a resident interview, interviews with staff and record review, the facility failed to provide a resident scrambled eggs for breakfast per his preference. This failure occurred for 1 of 3 sampled residents reviewed for food intolerances and preferences (Resident #19).</p> <p>The findings included:</p> <p>Resident #19 was admitted to the facility on 3/31/15. Diagnoses included dementia (mild) with mood disturbance, cognitive communication deficit, major depressive disorder and psychosis.</p> <p>A review of the August 2024 Physician Order Summary revealed Resident #19 had a physician order for a regular diet with mechanical soft texture.</p> <p>A 8/7/24 quarterly Minimum Data Set assessment recorded Resident #19's speech was clear, he was understood by others, able to understand, his hearing was adequate, his vision was impaired, he wore corrective lenses, and his cognition was</p>	F 806	<p>University Place -F806 Food that accommodates resident allergies, intolerances, and preference</p> <p>Problem Statement: " On 08/26/24, Resident #19 was served an omelet instead of scrambled eggs. The resident's preference was scrambled eggs. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " On 8/26/24, the resident was provided another tray by the Unit Manager consistent with his preferences. " On 8/26/24, the Dietary Manager/Registered Dietician verified the resident's preferences and updated the meal tray card. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 8/29/24, the Dietary Manager and the Registered Dietician initiated a 100%</p>	8/30/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 806	<p>Continued From page 17 intact.</p> <p>A care plan revised 8/16/24 recorded Resident #19 was at risk for nutritional decline due to a history of weight loss, varying appetite and a diet order for a mechanically altered diet. Interventions included providing his diet as ordered, assessing for and providing food preferences.</p> <p>A review of the Spring/Summer cycle breakfast menus revealed cheese omelet was served once in weeks one, three, and four and cheese eggs was served once in weeks two and three.</p> <p>Resident #19 was observed on 8/26/24 at 9:19 AM in the Activity Room with other residents and staff for the breakfast meal. Resident #19's breakfast tray was in front of him, but he was not eating. His breakfast tray remained with a partially eaten cheese omelet, a small portion of grits, and bacon. The tray card recorded "standing orders: 4 oz (ounces) scrambled eggs." Resident #19 stated he did not finish eating because he did not like his food. He described that he preferred scrambled eggs for breakfast, it was written on his tray card, but when the breakfast menu included cheese eggs or an omelet, which was about once or twice per week, this is what he got instead of the scrambled eggs. He stated, "I don't like the omelet, but I have to eat something, so I ate it. I go to these meetings every week to talk about the food, but it does no good, nothing ever gets done, I don't mean any disrespect, but I don't expect anything to change, it hasn't in 10 years, so I just don't say anything anymore." Resident #19 stated that Nurse Aide (NA) #1 knew what he was supposed to get and knew what he liked, so when he received foods</p>	F 806	<p>audit of all resident meal tray cards in comparison to their diet order and obtained updated resident preferences. Any concerns will be addressed immediately, and education provided at that time. The initial audit will be concluded by 8/29/24.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>" In-service education was initiated on 8/29/24 by the Dietary Manager/Staff Development Coordinator/Registered Dietician to ensure all residents are served their meal in accordance with the preferences listed on the resident's meal tray card. This education will be provided to all nurses, certified nursing assistants, administrative staff, activities, and dietary staff to include agency and contract staff who serve resident meals. All education will be completed by 8/29/24. Any staff member not receiving the education by 8/29/24 will receive it prior to their next scheduled shift. Any newly hired staff members to include agency or contract staff members will receive education during orientation prior to their first scheduled shift.</p> <p>" In-service education was initiated on 8/28/24 by the Dietary Manager/Registered Dietician to ensure that the dietary staff will observe that all trays served on the tray line are validated that the resident preferences are being followed by reviewing the meal tray card prior to the tray being placed on the cart. All dietary staff will be educated, and all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 806	<p>Continued From page 18</p> <p>that he did not like or could not eat, if NA #1 was working that day, she took his tray back to the kitchen and brought him something he could eat.</p> <p>A 8/26/24 interview at 12:00 PM with NA #1 revealed she worked at the facility for over a year and Resident #19 was on her regular assignment. NA #1 stated she did not set up his breakfast tray that morning (8/26/24) and did not know which staff member did. NA #1 stated that when she did set up his breakfast tray, she made sure he received the foods per his diet order and preferences. NA #1 stated that sometimes she had to return his meal tray back to the kitchen, to get it "fixed", but that she did not recall if that was because he did not receive something he wanted or if something else was wrong. NA #1 stated that on the days she worked, if she saw that he was not eating his food, she checked on him and if he said he did not want his food, she took his tray back to the kitchen to get him something else to eat.</p> <p>A 8/27/24 interview at 10:05 AM with Unit Manager (UM) #1 revealed she worked in the facility for the past four months. UM #1 stated she assisted another resident with his breakfast on 8/26/24 in the Activity Room when she noticed Resident #19 did not finish eating his breakfast. She described "he was just looking ahead." UM #1 said she asked Resident #19 if he was okay, but he did not tell her what was wrong. UM #1 stated that since she was assisting another resident, she did not go over to Resident #19 to see what was wrong. UM #1 stated she did not work with Resident #19 that often, and that she was not familiar with his care needs. UM #1 stated she did not set up his breakfast tray on 8/26/24 so she did not notice that he received a</p>	F 806	<p>education will be completed by 8/29/24. Any staff member not receiving the education by 8/29/24 will receive it prior to their next scheduled shift. Any newly hired staff members, to include agency and contract staff members will receive education during orientation prior to their first scheduled shift.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>" The Nurse/Nurse supervisors will audit 5 resident meal trays per week using the Food form/Preference audit tool, 3 days per week x8 weeks on varying days of the week and varying meals, to ensure all trays are being served honoring the preferences as indicated on the resident meal tray card. Any concerns will be addressed immediately, and education provided at the time the concern is identified.</p> <p>" The Dietary Manager/Dietary Cook will audit 10 resident meal trays per day using the Food form/Preference audit tool, 3 days per week x4 weeks on varying days of the week and varying meals prior to being placed on the carts to be served to the residents to ensure all trays are being served honoring the preferences according to the food tray card. Any concerns will be addressed immediately, and education provided at the time the concern is identified.</p> <p>" The Food form/Preference audit tools that will be completed 3 days per week x8 weeks on varying days of the week and varying meals, to ensure all trays are being served honoring the preferences as</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
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	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 806	<p>Continued From page 19</p> <p>cheese omelet instead of scrambled eggs.</p> <p>During an interview on 8/27/24 at 2:00 PM with the Certified Foodservice Manager (CFM), he stated that he was the CFM for the past three weeks, he was familiar with Resident #19 because he attended Food Committee Meetings. The CFM reviewed the tray card for Resident #19 and stated that the tray card recorded his preference for scrambled eggs so as best he could tell it was just an oversight.</p> <p>During a 8/26/24 9:25 AM observation of Resident #19 with his breakfast meal and interview with the Registered Dietitian (RD), the RD stated Resident #19 received scrambled eggs with his breakfast meal on 8/26/24, due to an oversight. The RD stated that she assisted on the tray line often and if she saw an error with preferences, she would ask staff to correct it. The RD stated that Resident #19 attended Food Committee Meetings weekly and his concern with receiving scrambled eggs had not been discussed nor had she been informed by staff that he did not receive scrambled eggs. The RD stated that the facility had employed several different dietary managers in just a few months and that the current manager had been at the facility for three weeks.</p> <p>The Administrator stated in an interview on 8/26/24 at 11:45 AM that Resident #19 attended the weekly Food Committee Meetings and had not brought up a concern about receiving scrambled eggs. The Administrator stated that resident preferences should be provided as recorded on the tray cards.</p>	F 806	<p>indicated on the resident meal tray card will be taken to Quality Assurance Performance Improvement monthly x2month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring.</p> <p>" The Administrator is responsible for implementing the plan of correction and ensuring it is followed.</p>		