|  |   |   |  | FORM APPROVED  |
|--|---|---|--|--|
| RS FOR MEDICARE &  | MEDICAID SERVICES   |   |  | OMB NO. 0938-0391  |
|  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |   |  | (X3) DATE SURVEY<br>COMPLETED  |
|  | 345142  | B. WING   |  | C<br>08/14/2015  |
| PROVIDER OR SUPPLIER   | ·   |   | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |
|  |   |   | 9200 GLENWATER DRIVE   |  |
| SITY PLACE NURSING AN  | ID REHABILITATION CENTER  |   | CHARLOTTE, NC 28262  |  |
| (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   |  |
| MISTREATMENT/NE<br>The facility must deve<br>policies and procedur<br>mistreatment, neglec   | elop and implement written<br>res that prohibit<br>t, and abuse of residents  | F 224   | 4  | 9/11/15  |
| by:<br>Based on observatio<br>interview, and staff in<br>provide assistance w<br>sampled dependent r<br>(Resident #2).<br>The findings included<br>Resident #2 was adm<br>04/22/15. His diagno<br>bladder. The admiss<br>(MDS) dated 04/29/1<br>cognition, requiring to<br>and extensive assista<br>hygiene. He was coo<br>using an external cat | ns, record review, resident<br>terviews, the facility failed to<br>ith pericare to 1 of 1<br>resident who requested care.   |   | Resident #2 was assessed on 8/13/20<br>by the Interim Director of Nursing and<br>provided care in a manner which prohi<br>neglect.<br>All residents were reviewed on 8/13/20<br>by the Interim Director of Nursing and<br>Assistant Director of Nursing via facility<br>rounds for potential neglect related<br>issues. No other issues were identified<br>during the rounds.<br>The involved CNA was retrained on<br>8/14/2015 by the Interim Director of<br>Nursing on responding to the residents<br>care in a timely manner. Nursing staff<br>retraining was initiated on 8/14/2015 a<br>completed on 8/31/2015 by the Staff | was<br>bits<br>015<br>y<br>d<br>d<br>s'<br>nd  |
| activities of daily livin<br>Resident #1 was alwa<br>condom catheter was<br>assistance.<br>A care plan was deve  | g skills (ADLs) revealed<br>ays incontinent when the<br>off and he required<br>eloped on 05/06/15 for an  |   | Facilitator regarding responding to the<br>residents' care in a timely manner. An<br>newly hired nursing staff will be trained<br>responding to residents' care in a time<br>manner during orientation. Seventy (7<br>audits will be conducted by the<br>Administrative Nurses and Charge Nur<br>to ensure all residents' care is met in a   | y<br>1 on<br>ly<br>0)<br>rses  |
|  | RS FOR MEDICARE &         OF DEFICIENCIES<br>OF CORRECTION         PROVIDER OR SUPPLIER         SITY PLACE NURSING AN         SUMMARY ST.<br>(EACH DEFICIENC<br>REGULATORY OR I         483.13(c) PROHIBIT<br>MISTREATMENT/NE         The facility must dever<br>policies and procedur<br>mistreatment, neglec<br>and misappropriation         This REQUIREMENT<br>by:<br>Based on observation<br>interview, and staff in<br>provide assistance w<br>sampled dependent r<br>(Resident #2).         The findings included         Resident #2 was adm<br>04/22/15. His diagnos<br>bladder. The admiss<br>(MDS) dated 04/29/1<br>cognition, requiring to<br>and extensive assista<br>hygiene. He was coor<br>using an external cattl<br>incontinent of bladder         The Care Area Assess<br>activities of daily living<br>Resident #1 was alwa<br>condom catheter was<br>assistance.         A care plan was dever | PROVIDER OR SUPPLIER         SITY PLACE NURSING AND REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         4         483.13(c) PROHIBIT<br>MISTREATMENT/NEGLECT/MISAPPROPRIATN         The facility must develop and implement written<br>policies and procedures that prohibit<br>mistreatment, neglect, and abuse of residents<br>and misappropriation of resident property.         This REQUIREMENT is not met as evidenced<br>by:         Based on observations, record review, resident<br>interview, and staff interviews, the facility failed to<br>provide assistance with pericare to 1 of 1<br>sampled dependent resident who requested care.<br>(Resident #2).         The findings included:         Resident #2 was admitted to the facility on<br>04/22/15. His diagnoses included neurogenic<br>bladder. The admission Minimum Data Set<br>(MDS) dated 04/29/15 coded him with intact<br>cognition, requiring total assistance for transfers<br>and extensive assistance with toileting and<br>hygiene. He was coded as being nonambulatory,<br>using an external catheter and always being<br>incontinent of bladder.         The Care Area Assessment dated 05/05/15 for<br>activities of daily living skills (ADLs) revealed<br>Resident #1 was always incontinent when the<br>condom catheter was off and he required | RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPL<br>A. BUILDING         345142       B. WING   | RS FOR MEDICARE & MEDICAID SERVICES           or DEFICIENCIES         (N) PROVIDERSUPPLIENCLIA<br>IDENTIFICATION NUMBER:         (A) MULTIPLE CONSTRUCTION<br>A BULIDING           ad\$142         E. WING           BITY PLACE NURSING AND REHABILITATION CENTER         STREET ADDRESS, CITY, STATE, ZIP CODE<br>9200 GLEWWATER DRIVE<br>CHARLOTTE, NC 28282           SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LISCIDENTIFYING INFORMATION)         PROVIDERS NAM OF CORRECTION<br>(EACH CORRECTIVE ACTION BIOLD D<br>CROSS-REFERENCE TO THE APPROPRIA<br>TAG           483.13(c) PROHIBIT         PROVIDER SILVANOF CORRECTION<br>(EACH CORRECTIVE ACTION BIOLD D<br>CROSS-REFERENCE TO THE APPROPRIA<br>MISTREATMENTINEGLECT/MISAPPROPRIATIN         F 224           This REQUIREMENT is not met as evidenced<br>by:         Based on observations, record review, resident<br>interview, and staff interviews, the facility failed to<br>provide assistance with proincare to 1 of 1<br>sampled dependent resident who requested care.<br>(Resident #2).         Resident #2 was assessed on 8/13/27<br>by the Interim Director of Nursing and<br>provided care in a manner which prohi<br>assistance with poincing and<br>provided care in a manner which prohi<br>sampled dependent resident who requested care.<br>(Resident #2).         All residents were reviewed on 8/13/27<br>by the Interim Director of Nursing and<br>Assistant Director of Nursing and<br>State OF AUXING or Nursing and<br>provide dare in a manner which prohi<br>assistance with toileting and<br>hydrein. He was coded as being nonambulatory,<br>using an extensive assistance with toileting and<br>hydrein. He was coded as being nonambulatory,<br>using an extensive assistance with seleing non-<br>solutivities of daily living skill (ADLS) revealed<br>Resident #1 was always incontinent when the |

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

09/02/2015

| STATEMENT  | OF DEFICIENCIES<br>CORRECTION   | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                  | E CONSTRUCTION  | (X3) DA  | 10. 0938-039<br>FE SURVEY<br>MPLETED |
|--|---|--|----------------------|---|--|--------------------------------------|
|  | CONNECTION  | BENTH IOATION NOMBER.  | A. BUILDING          |   | C  |                                      |
|  |   | 345142   | B. WING              |   | 0  | 8/14/2015                            |
| NAME OF P  | ROVIDER OR SUPPLIER   | I  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE   |  |                                      |
| UNIVERSITY PLACE NURSING AND REHABILITATION CENTER |   |  | 9200 GLENWATER DRIVE |   |  |                                      |
| UNIVERS  | ITY PLACE NURSING AN  | ID REHABILITATION CENTER   |                      | CHARLOTTE, NC 28262   |  |                                      |
| (X4) ID<br>PREFIX<br>TAG                           | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY)   | ULD BE   | (X5)<br>COMPLETIO<br>DATE            |
| F 224  | Continued From page   | <u>م</u> 1   | E 22                 | 1   |  |                                      |
| F 224  | condom catheter. Or<br>to be clean, dry and f<br>down. Interventions is<br>closed drainage syste<br>urine flow. Another c<br>incontinence dated 09<br>interventions to provid<br>incontinent episode.<br>The most recent quar<br>also coded him with it<br>extensive to total ass<br>daily living skills, usin<br>being totally incontine<br>were made to the exis<br>On 08/13/15 at 11:21<br>observed in his room,<br>catheter bag was em<br>he was very frustrater<br>catheter had come of<br>been waiting for 3 ho<br>At 11:36 AM, Nurse #<br>In the presence of the<br>Resident #2 that staff<br>Resident #2 stated N<br>needed care after bre<br>resident that NA #1 w<br>and she had to finish<br>NA #1 would get the I<br>Resident #2 again sta<br>breakfast time he need<br>discussing the time fr<br>period. Nurse #1 star<br>minutes ago, when sf<br>#2 needed assistance<br>urinated 3 times since | he goal was for Resident #2<br>ree of odor or skin break<br>included maintaining a<br>em with an unobstructed<br>are plan for urinary<br>5/06/15 included the<br>ded pericare after each<br>terly MDS dated 07/22/15<br>intact cognition and requiring<br>istance with all activities of<br>g an external catheter and<br>ent of urine. No changes<br>sting care plan.<br>AM, Resident #2 was<br>, in a gerichair and his<br>pty. At this time he stated<br>d due to his condom<br>f, he was wet, and he had<br>urs to have care provided.<br>E1 entered with medication.<br>e surveyor, Nurse #1 told<br>f was coming to give care.<br>urse Aide (NA) #2 knew he<br>eakfast. Nurse #1 told the<br>vas his assigned nurse aide<br>another resident's care then<br>lift and change him. | F 224                | <ul> <li>timely manner daily x 4 weeks, we weeks, and monthly x 3 months u an audit tool. Any issues identifie corrected immediately with further retraining and or other interventio appropriate. Resident Council wi questioned regarding response to care needs timely at the next 3 m meetings. Any issues reported w forwarded to the Administrator for up.</li> <li>The results of the completed Audi will be reviewed weekly by the Administrator and the Director of The QA&amp;A Committee will review audits monthly x 3 months to dete the continued need for and freque monitoring. Any recommended ci will be discussed and carried out agreed upon at that time.</li> </ul> | tilizing<br>d will be<br>ns as<br>l be<br>their<br>onthly<br>ll be<br>follow<br>t Tools<br>Nursing.<br>the<br>rmine<br>ency of<br>nanges |                                      |

If continuation sheet Page 2 of 11

|                          |   | ID HUMAN SERVICES  |                   |       |  | FORM      | APPROVED<br>0. 0938-0391   |
|--------------------------|---|--|-------------------|-------|--|-----------|----------------------------|
|                          |   | MEDICAID SERVICES  | (X2) MUL          | TIPLE | CONSTRUCTION   | (X3) DATE |                            |
|                          | CORRECTION  | IDENTIFICATION NUMBER:   | · /               |       |  |           | LETED                      |
|                          |   |  |                   |       |  |           | C                          |
|                          |   | 345142   | B. WING           |       |  | 08/       | 14/2015                    |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                   |       | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                            |
| UNIVERS                  | TY PLACE NURSING AN   | ID REHABILITATION CENTER   |                   |       | 200 GLENWATER DRIVE<br>CHARLOTTE, NC 28262   |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |           | (X5)<br>COMPLETION<br>DATE |
| F 224                    | Continued From page   | 2  | F                 | 224   |  |           |                            |
|                          | During interview on 0<br>stated she had not gir<br>she was supposed to<br>NA #1 proceeded to t<br>to lunch, poked her h<br>door and left the unit.<br>have expected NA #1<br>before going to lunch<br>provide the care for h<br>she had told NA #1 R<br>On 08/13/15 at 11:50<br>about his morning inter<br>NA #2 stated that aro<br>him his catheter had<br>put back on. NA #2 s<br>around 10:15 AM and<br>needed care.<br>Care was observed o<br>Resident #2 was tran<br>into bed from his geri<br>pad, the pad he had th<br>pants were observed<br>catheter was off, and<br>wearing was heavy a<br>was provided. The ca<br>urine as it had not be<br>Interview with the Adr<br>Director of Nursing (II<br>AM revealed they exp<br>Resident #2 prior to g<br>Administrator and inter | 8/13/15 at 11:44 AM, NA #1<br>ven Resident #2 care and<br>go to lunch at 11:30 AM.<br>ell Nurse #1 she was going<br>ead inside Resident #2's<br>Nurse #1 stated she would<br>to provide Resident #2 care<br>or ask another nurse aide to<br>er. Nurse #1 verified that<br>tesident #2 was wet.<br>AM, NA #2 was interviewed<br>eraction with Resident #2.<br>und 10 AM Resident #2 told<br>come off and he needed it<br>stated he passed NA #1<br>d told her Resident #2<br>m 08/13/15 at 11:52 AM.<br>sferred via mechanical lift<br>chair. Resident #2's lift<br>been sitting on, and his<br>wet with urine, his condom<br>the incontinent brief he was<br>nd soaked in urine. Pericare<br>atheter bag was empty of<br>en on the resident.<br>ministrator and interim<br>DON) on 08/14/15 at 8:31<br>bected NA #1 to change<br>going for lunch. The<br>erim DON stated they did not<br>s the resident's needs were |                   |       |  |           |                            |
|                          | Phone interview with  | NA #1 on 08/14/15 at 8:38  |                   |       |  |           |                            |

| ATEMENT (                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPI        | E CONSTRUCTION  | (X3) DATE SURVEY |  |
|--------------------------|--|---|---------------------|---|------------------|--|
|                          | CORRECTION   | IDENTIFICATION NUMBER:  | . ,                 |   | COMPLETED        |  |
|                          |  |   |                     |   |                  |  |
|                          |  | 345142  | B. WING             |   | 08/14/2015       |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                  |  |
| JNIVERSI                 | ITY PLACE NURSING AN   | ID REHABILITATION CENTER  |                     | 9200 GLENWATER DRIVE<br>CHARLOTTE, NC 28262   |                  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)   | DATE             |  |
| F 224                    | Continued From page  | 23  | F 224               |   |                  |  |
| F 241<br>SS=D            | speaker phone, revea<br>her Resident #2 need<br>another resident. NA<br>around 10 AM the resident. NA<br>around 10 AM the resident<br>off of him. NA #1 der<br>wet. NA #2 then said<br>resident up for therap<br>shower. NA #2 states<br>she had to do before<br>fine with it. NA #2 states<br>she had to do before<br>fine with it. NA #2 states<br>she had to do before<br>fine with it. NA #2 states<br>comes off, he just get<br>stated it was a very b<br>confirmed that she did<br>have done which was<br>Resident #2 care.<br>483.15(a) DIGNITY A<br>INDIVIDUALITY<br>The facility must prom-<br>manner and in an em- | note care for residents in a<br>vironment that maintains or<br>ent's dignity and respect in | F 241               |   | 9/11/15          |  |
|                          | by:<br>Based on observatio<br>record review and sta<br>to promote the dignity<br>by providing persona  | esident #2 being saturated  |                     | Resident #2 was assessed on 8/13/201<br>by the Interim Director of Nursing and w<br>provided care in a manner in which<br>enhances dignity and respect.<br>All residents were reviewed on 8/13/201<br>by the Interim Director of Nursing and<br>Assistant Director of Nursing via facility<br>rounds for potential dignity related issue<br>No other issues were identified during th | s.               |  |

Event ID:60P011

Facility ID: 923015

If continuation sheet Page 4 of 11

| TATEMENT                 | OF DEFICIENCIES  | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPL        | E CONSTRUCTION   | (X3) DATE SURVEY  |
|--------------------------|--|---|---------------------|--|---|
| ND PLAN OF               | CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING         |  | COMPLETED   |
|                          |  | 245440  | P. WING             |  | С   |
|                          |  | 345142  | B. WING             |  | 08/14/2015  |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |
| UNIVERS                  | NIVERSITY PLACE NURSING AND REHABILITATION CENTER  |   |                     | 9200 GLENWATER DRIVE<br>CHARLOTTE, NC 28262  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | ULD BE COMPLETIC  |
| F 241                    | Continued From page<br>04/22/15. His diagno<br>bladder.  | e 4<br>ses included neurogenic  | F 24                | 1<br>The involved CNA was retrained o<br>8/14/2015 by the Interim Director o   |   |
|                          | The Care Area Assessment dated 05/05/15 for activities of daily living skills (ADLs) revealed Resident #1 was always incontinent when the condom catheter was off and he required assistance.  |   |                     | Nursing on responding to residents<br>in a timely manner. Nursing staff<br>retraining was initiated on 8/14/20<br>completed on 8/31/2015 by the Sta<br>Facilitator regarding responding to<br>residents' care in a timely manner.  | s' care<br>15 and<br>aff  |
|                          | altered pattern of urir<br>condom catheter. Or<br>to be clean, dry and f<br>down. Interventions<br>closed drainage syste<br>urine flow. Another c<br>incontinence dated 0  |   |                     | newly hired nursing staff will be tra-<br>responding to residents' care in a to<br>manner during orientation. Seven<br>audits will be conducted by the<br>Administrative Nurses and Charge<br>to ensure residents' care is met in<br>manner daily x 4 weeks, weekly s<br>and monthly x 3 months utilizing a<br>tool. Any issues identified will be<br>corrected immediately with further | ained on<br>timely<br>ty (70)<br>e Nurses<br>a timely<br>4 weeks<br>n audit |
|                          | The most recent quarterly MDS dated 07/22/15<br>coded him with intact cognition and requiring<br>extensive to total assistance with all activities of<br>daily living skills, using an external catheter and<br>being totally incontinent of urine. No changes<br>were made to the existing care plan. |   |                     | retraining and or other intervention<br>appropriate. Resident Council will<br>questioned regarding response to<br>the next 3 monthly meetings. Any<br>reported will be forwarded to the<br>Administrator for follow up.  | be<br>care at   |
|                          | observed in his room<br>catheter bag was em<br>he was very frustrate<br>catheter had come of<br>been waiting for 3 ho<br>At 11:36 AM, Nurse #<br>In the presence of the<br>Resident #2 that staff  | AM, Resident #2 was<br>, in a gerichair and his<br>pty. At this time he stated<br>d due to his condom<br>f, he was wet, and he had<br>urs to have care provided.<br>e1 entered with medication.<br>e surveyor, Nurse #1 told<br>f was coming to give care.<br>urse Aide (NA) #2 knew he |                     | The results of the completed Audi<br>will be reviewed weekly by the<br>Administrator and the Director of N<br>The QA&A Committee will review t<br>audits monthly x 3 months to deter<br>the continued need for and frequer<br>monitoring. Any recommended ch<br>will be discussed and carried out a<br>agreed upon at that time.   | Nursing.<br>the<br>rmine<br>ncy of<br>langes                                |

If continuation sheet Page 5 of 11

|  | S FOR MEDICARE &              |   | ()(0)                                       |  |                              | O. 0938-039                |  |
|--|-------------------------------|---|---|--|------------------------------|----------------------------|--|
|  | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | · ,   | LE CONSTRUCTION  | · · ·                        | E SURVEY                   |  |
|  |                               |   | A. BUILDING                                 |  |                              | C                          |  |
|  |                               | 345142  |   |  |                              |                            |  |
|  | ROVIDER OR SUPPLIER           | 040142  |   | STREET ADDRESS, CITY, STATE, ZIP CO  |                              | 8/14/2015                  |  |
| NAME OF Pr   | CONDER OR SUPPLIER            |   |   |  | DE                           |                            |  |
| UNIVERSITY PLACE NURSING AND REHABILITATION CENTER |                               |   | 9200 GLENWATER DRIVE<br>CHARLOTTE, NC 28262 |  |                              |                            |  |
|  |                               |   |   |  |                              |                            |  |
| (X4) ID<br>PREFIX<br>TAG                           | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                         | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETIOI<br>DATE |  |
| F 241  | Continued From page           | e 5   | F 24  | 1  |                              |                            |  |
|  |                               | another resident's care then  |   |  |                              |                            |  |
|  | NA #1 would get the           |   |   |  |                              |                            |  |
|  | Resident #2 again sta         | •   |   |  |                              |                            |  |
|  | 5                             | eded care. They began   |   |  |                              |                            |  |
|  |                               | ame of his request and wait   |   |  |                              |                            |  |
|  | •                             | ted she told NA #1 just 30  |   |  |                              |                            |  |
|  | •                             | he became aware Resident  |   |  |                              |                            |  |
|  | •                             | e. Resident #2 stated he had  |   |  |                              |                            |  |
|  |                               | e first letting staff know his  |   |  |                              |                            |  |
|  |                               | come off. The nurse went  |   |  |                              |                            |  |
|  | to locate NA #1.              |   |   |  |                              |                            |  |
|  | On 08/13/15 at 11:44          | AM, NA #1 was located   |   |  |                              |                            |  |
|  |                               | ay of another resident's  |   |  |                              |                            |  |
|  | -                             | veyor asked if she was going  |   |  |                              |                            |  |
|  |                               | ent #2, NA #1 stated she  |   |  |                              |                            |  |
|  | •                             | to lunch at 11:30 AM but  |   |  |                              |                            |  |
|  |                               | the surveyor wanted her to  |   |  |                              |                            |  |
|  | do it then. The surve         | yor stated that staff should  |   |  |                              |                            |  |
|  | do what she normally          | would do and NA #1 stated   |   |  |                              |                            |  |
|  | she would normally g          | o to lunch. NA #1 then  |   |  |                              |                            |  |
|  | proceeded to tell Nur         | se #1 she was going to  |   |  |                              |                            |  |
|  |                               | head inside Resident #2's   |   |  |                              |                            |  |
|  |                               | Nurse #1 stated to the  |   |  |                              |                            |  |
|  | -                             | stop her medication pass  |   |  |                              |                            |  |
|  | •                             | e aide to provide Resident  |   |  |                              |                            |  |
|  | #2 care. Nurse #1 st          |   |   |  |                              |                            |  |
|  |                               | ovide Resident #2 care  |   |  |                              |                            |  |
|  |                               | or ask another nurse aide to  |   |  |                              |                            |  |
|  |                               | vide the resident care.   |   |  |                              |                            |  |
|  |                               | had told NA #1 previously   |   |  |                              |                            |  |
|  |                               | . Nurse #1 immediately  |   |  |                              |                            |  |
|  |                               | e services of NA #2 and NA  |   |  |                              |                            |  |
|  |                               | his time, NA #2 was asked   |   |  |                              |                            |  |
|  |                               | with Resident #2. NA #2   |   |  |                              |                            |  |
|  |                               | AM Resident #2 told him   |   |  |                              |                            |  |
|  |                               | e off and he needed it put<br>ed he passed NA #1 around                               |   |  |                              |                            |  |
|  |                               |   |   |  |                              |                            |  |

Facility ID: 923015

If continuation sheet Page 6 of 11

|                          | -  | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                     |     |   | FORM              | APPROVED<br>0. 0938-0391   |
|--------------------------|--|--|---------------------|-----|---|-------------------|----------------------------|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 |     | CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY<br>PLETED           |
|                          |  | 345142   | B. WING             |     |   |                   | C<br>14/2015               |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  |                     |     | REET ADDRESS, CITY, STATE, ZIP CODE   |                   |                            |
| UNIVERSI                 | TY PLACE NURSING AN  | D REHABILITATION CENTER  |                     |     | 00 GLENWATER DRIVE<br>HARLOTTE, NC 28262  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | <   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI/<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 241                    | Continued From page  |  | F 2                 | 241 |   |                   |                            |
|                          | Resident #2 was tran<br>lift into bed from his g   | n 08/13/15 at 11:52 AM.<br>sferred via total mechanical<br>eri chair. Resident #2's lift<br>been sitting on, and his   |                     |     |   |                   |                            |
|                          | catheter was off, and wearing was heavy a  | wet with urine, his condom<br>the incontinent brief he was<br>nd soaked in urine. Pericare<br>atheter bag was empty of<br>en on the resident.  |                     |     |   |                   |                            |
|                          |  | PM, Resident #2 stated that<br>staff don't care about him<br>wait so long for care.  |                     |     |   |                   |                            |
|                          | Director of Nursing (D   | ninistrator and interim<br>OON) on 08/14/15 at 8:31<br>pected NA #1 to change<br>joing for lunch.  |                     |     |   |                   |                            |
|                          | AM, with the Administ<br>speaker phone, revea<br>her Resident #2 need<br>another resident. NA<br>around 10 AM the res        | NA #1 on 08/14/15 at 8:38<br>trator and surveyor on<br>aled that when NA #2 told<br>led care, she was showering<br>.#1 stated NA #2 told her<br>sident's catheter had come<br>nied she was told he was |                     |     |   |                   |                            |
|                          | wet. NA #1 then said<br>resident up for therap<br>shower. NA #1 stated<br>she had to do before<br>fine with it. NA #1 stated | she had to get another<br>y after she completed the<br>d she told Resident #2 what<br>giving him are and he was<br>ated that when his catheter<br>as a little wet. NA #1 again                         |                     |     |   |                   |                            |
| F 312<br>SS=D            | confirmed that she di  | d what she normally would<br>going to lunch before giving<br>RE PROVIDED FOR   | F 3                 | 312 |   |                   | 9/11/15                    |
|                          |  |  |                     |     |   |                   |                            |

Facility ID: 923015

If continuation sheet Page 7 of 11

|                          |  | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                     |  | FORM APPROVED<br>OMB NO. 0938-0391              |
|--------------------------|--|---|---------------------|--|---|
| STATEMENT (              | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                   |
|                          |  | 345142  | B. WING             |  | C<br>08/14/2015                                 |
| NAME OF PI               | ROVIDER OR SUPPLIER  | •   | · ·                 | STREET ADDRESS, CITY, STATE, ZIP CODE  | •   |
|                          |  |   |                     | 9200 GLENWATER DRIVE   |   |
| UNIVERSI                 | IT PLACE NURSING AN  | ID REHABILITATION CENTER  |                     | CHARLOTTE, NC 28262  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APF<br>DEFICIENCY)   | OULD BE COMPLETION                              |
| F 312                    | Continued From page  | e 7   | F 312               | 2  |   |
|                          | daily living receives the  | able to carry out activities of<br>he necessary services to<br>on, grooming, and personal   |                     |  |   |
|                          | by:<br>Based on observatio<br>interview, and staff in<br>reattach a condom ca<br>incontinence care upo | ☐ is not met as evidenced<br>ons, record review, resident<br>iterviews, the facility failed to<br>atheter and provide<br>on request to 1 of 1 resident<br>om catheter. (Resident #2). |                     | Resident #2 was assessed on 8<br>by the Interim Director of Nursing<br>provided care for incontinence.<br>All residents were reviewed on 8<br>by the Interim Director of Nursing   | g and was<br>/13/2015                           |
|                          | 04/22/15. His diagno   | l:<br>nitted to the facility on<br>oses included neurogenic<br>ion Minimum Data Set   |                     | Assistant Director of Nursing via rounds for potential need of assis with ADLS. No other issues were identified during the rounds.   | facility<br>stance                              |
|                          | cognition, requiring to<br>and extensive assista<br>hygiene. He was coo                                | 5 coded him with intact<br>otal assistance for transfers<br>ance with toileting and<br>ded as being nonambulatory,<br>heter and always being<br>r.                                    |                     | The CNA involved was retrained<br>8/14/2015 by the Interim Director<br>Nursing on responding to the res<br>care in a timely manner. Nursing<br>retraining was initiated on 8/14/2<br>completed on 8/31/2015 by the S<br>Facilitator regarding responding | r of<br>sidents'<br>g staff<br>015 and<br>Staff |
|                          | activities of daily living   | ssment dated 05/05/15 for<br>g skills (ADLs) revealed<br>ays incontinent when the<br>s off and he required  |                     | residents' care in a timely manne<br>newly hired nursing staff will be t<br>responding to residents' care in a<br>manner during orientation. Seve<br>audits will be conducted by the<br>Administrative Nurses and Charg                                  | er. All<br>rained on<br>a timely<br>enty (70)   |
|                          | altered pattern of urin<br>condom catheter. Or<br>to be clean, dry and f                               | eloped on 05/06/15 for an<br>nary elimination with a<br>ne goal was for Resident #2<br>free of odor or skin break<br>included maintaining a   |                     | to ensure residents' care is met i<br>manner daily x 4 weeks, weekly<br>and monthly x 3 months utilizing<br>tool. Any issues identified will be<br>corrected immediately with furthe   | n a timely<br>x 4 weeks<br>an audit             |

Facility ID: 923015

If continuation sheet Page 8 of 11

| TATEMENT                 | OF DEFICIENCIES  | MEDICAID SERVICES   | · ,                 | LE CONSTRUCTION   | (X3) DATI   | D. 0938-039               |
|--------------------------|--|---|---------------------|---|---|---------------------------|
| IND PLAN OF              | CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING         |   |   | PLETED                    |
|                          |  | 245442  | B. WING             |   |   | С                         |
|                          |  | 345142  |                     |   |   | /14/2015                  |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZI   | PCODE   |                           |
| UNIVERS                  | ITY PLACE NURSING AN   | ID REHABILITATION CENTER  |                     | 9200 GLENWATER DRIVE<br>CHARLOTTE, NC 28262   |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED T<br>DEFICIE  | ACTION SHOULD BE<br>TO THE APPROPRIATE  | (X5)<br>COMPLETIO<br>DATE |
| F 312                    | Continued From page  | 2 8   | F 31                | 2   |   |                           |
|                          | closed drainage syste<br>urine flow. Another of<br>incontinence dated 02<br>interventions to provid<br>incontinent episode.<br>The most recent quar<br>also coded him with i<br>extensive to total ass<br>daily living skills, usin<br>being totally incontine<br>were made to the exi<br>On 08/13/15 at 11:21<br>observed in his room<br>catheter bag was em<br>he was very frustrate<br>catheter had come of<br>been waiting for 3 ho<br>At 11:36 AM, Nurse #<br>In the presence of the<br>Resident #2 that staff<br>Resident #2 stated N<br>needed care after bre<br>resident that NA #1 w<br>and she had to finish<br>NA #1 would get the I<br>Resident #2 again sta<br>breakfast time he need<br>discussing the time fr<br>period. Nurse #1 sta<br>minutes ago, when sl<br>#2 needed assistance<br>urinated 3 times since | em with an unobstructed<br>bare plan for urinary<br>5/06/15 included the<br>ded pericare after each<br>the ded pericare after each<br>the def ded pericare after each<br>the def ded the def ded the def<br>the ded the def def def def<br>the def def def def def def def<br>the def def def def def def def def<br>the def def def def def def def def<br>the def def def def def def def def def de |                     | retraining and or other in<br>appropriate. Resident Co<br>questioned regarding res<br>residents' care at the ner<br>meetings. Any issues re<br>forwarded to the Adminis<br>up.<br>The results of the compl<br>will be reviewed weekly<br>Administrator and the Di<br>The QA&A Committee w<br>audits monthly x 3 month<br>the continued need for a<br>monitoring. Any recomm<br>will be discussed and ca<br>upon at that time. | ouncil will be<br>sponse to<br>xt 3 monthly<br>eported will be<br>strator for follow<br>eted Audit Tools<br>by the<br>rector of Nursing.<br><i>i</i> ll review the<br>hs to determine<br>and frequency of<br>nended changes |                           |
|                          |  | AM, NA #1 was located<br>ay of another resident's   |                     |   |   |                           |

|  | S FOR MEDICARE &       | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MI II T        |                   | DNSTRUCTION   |           | NO. 0938-039<br>ATE SURVEY |
|--|------------------------|---|---------------------|-------------------|---|-----------|----------------------------|
|  | CORRECTION             | IDENTIFICATION NUMBER:  | · , ,               |                   |   | · · · ·   | MPLETED                    |
|  |                        |   |                     |                   |   |           | С                          |
|  |                        | 345142  | B. WING             |                   |   |           | 08/14/2015                 |
| NAME OF PR   | ROVIDER OR SUPPLIER    | ·   |                     | STRE              | EET ADDRESS, CITY, STATE, ZIP CODE  | E         |                            |
| UNIVERSITY PLACE NURSING AND REHABILITATION CENTER |                        |   | 9200                | GLENWATER DRIVE   |   |           |                            |
| UNIVERSITY FEASE NORSING AND REHABILITATION CENTER |                        |   | СНА                 | ARLOTTE, NC 28262 |   |           |                            |
| (X4) ID<br>PREFIX<br>TAG                           | (EACH DEFICIENC        | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | x                 | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETIO<br>DATE  |
| F 312  | Continued From page    | <b>2</b> Q  | E 3                 | 312               |   |           |                            |
|  |                        | veyor asked if she was going  |                     | 512               |   |           |                            |
|  |                        | ent #2, NA #1 stated she  |                     |                   |   |           |                            |
|  | -                      | b go to lunch at 11:30 AM but   |                     |                   |   |           |                            |
|  |                        | the surveyor wanted her to  |                     |                   |   |           |                            |
|  |                        | eyor stated that staff should   |                     |                   |   |           |                            |
|  |                        | would do and NA #1 stated   |                     |                   |   |           |                            |
|  | she would normally g   |   |                     |                   |   |           |                            |
|  |                        | se #1 she was going to<br>head inside Resident #2's                                   |                     |                   |   |           |                            |
|  | -                      | Nurse #1 stated to the  |                     |                   |   |           |                            |
|  |                        | stop her medication pass  |                     |                   |   |           |                            |
|  |                        | e aide to provide Resident  |                     |                   |   |           |                            |
|  | #2 care. Nurse #1 st   | ated she would have   |                     |                   |   |           |                            |
|  |                        | ovide Resident #2 care  |                     |                   |   |           |                            |
|  |                        | or ask another nurse aide to  |                     |                   |   |           |                            |
|  |                        | vide the resident care.   |                     |                   |   |           |                            |
|  |                        | had told NA #1 previously<br>. Nurse #1 immediately                                   |                     |                   |   |           |                            |
|  |                        | e services of NA #2 and NA  |                     |                   |   |           |                            |
|  |                        | nis time, NA #2 was asked   |                     |                   |   |           |                            |
|  |                        | with Resident #2. NA #2   |                     |                   |   |           |                            |
|  | stated that around 10  | AM Resident #2 told him   |                     |                   |   |           |                            |
|  |                        | e off and he needed it put  |                     |                   |   |           |                            |
|  |                        | ed he passed NA #1 around   |                     |                   |   |           |                            |
|  | 10:15 AIVI and told he | er Resident #2 needed care.   |                     |                   |   |           |                            |
|  | Care was observed o    | on 08/13/15 at 11:52 AM.  |                     |                   |   |           |                            |
|  |                        | sferred via mechanical lift   |                     |                   |   |           |                            |
|  |                        | chair. Resident #2's lift   |                     |                   |   |           |                            |
|  | -                      | been sitting on, and his  |                     |                   |   |           |                            |
|  |                        | wet with urine, his condom  |                     |                   |   |           |                            |
|  |                        | the incontinent brief he was  |                     |                   |   |           |                            |
|  |                        | nd soaked in urine. Pericare  |                     |                   |   |           |                            |
|  | urine as it had not be | atheter bag was empty of<br>en on the resident.                                       |                     |                   |   |           |                            |
|  | Interview with the Adı | ministrator and interim   |                     |                   |   |           |                            |
|  |                        |   |                     |                   |   |           |                            |
|  |                        | DON) on 08/14/15 at 8:31  |                     |                   |   |           |                            |

Facility ID: 923015

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|                          | -  | D HUMAN SERVICES<br>MEDICAID SERVICES  |                     |  | FORM  | D: 09/03/2015<br>MAPPROVED<br>D. 0938-0391 |
|--------------------------|--|--|---------------------|--|---|--|
| STATEMENT O              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                | . ,                 | E CONSTRUCTION                             | (X3) DATE<br>COMF   | SURVEY<br>PLETED                           |
|                          |  | 345142   | B. WING             |  |   | C<br>14/2015                               |
| NAME OF PI               | NAME OF PROVIDER OR SUPPLIER   |  | 5                   | STREET ADDRESS, CITY, STATE, 2             |   |  |
| UNIVERSI                 | TY PLACE NURSING AN  | D REHABILITATION CENTER  |                     | 200 GLENWATER DRIVE<br>CHARLOTTE, NC 28262 |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE<br>CROSS-REFERENCED       | N OF CORRECTION<br>ACTION SHOULD BE<br>TO THE APPROPRIATE<br>IENCY) | (X5)<br>COMPLETION<br>DATE                 |
|                          | Continued From page<br>Resident #2 prior to g<br>Phone interview with<br>AM, with the Administ<br>speaker phone, revea<br>her Resident #2 need<br>another resident. NA<br>around 10 AM the resident wat not<br>around 10 AM the resident wet. NA #1 then said<br>resident up for therap<br>shower. NA #1 then said<br>resident up for therap<br>shower. NA #1 stated<br>she had to do before<br>fine with it. NA #1 stated<br>stated it was a very b<br>confirmed that she did | SC IDENTIFYING INFORMATION)  |                     | CROSS-REFERENCED<br>DEFIC                  | TO THE APPROPRIATE  |  |
|                          |  |  |                     |  |   |  |

Facility ID: 923015

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