

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

PRINTED: 12/13/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 585 SS=E	<p>Grievances CFR(s): 483.10(j)(1)-(4)</p> <p>§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for</p>	F 585		12/15/18	

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

TITLE

(X6) DATE

Electronically Signed

12/11/2018

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

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

PRINTED: 12/13/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 585	Continued From page 1 completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be	F 585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 585	<p>Continued From page 2</p> <p>taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and review of facility records, the facility failed to provide a written response to grievances for 3 of 5 sampled residents reviewed for follow up to grievances (Residents #196, #42 and #143).</p> <p>The findings included:</p> <p>1. Review of the following written grievances filed by the family and family friend of Resident #196 revealed that the facility provided a verbal response in lieu of a written explanation for how these grievances were resolved:</p> <p>A grievance dated 5/21/18 documented the family visited Resident #196 and could not find staff to assist the family with seeing injuries sustained by the Resident after a fall. The resolution was documented as provided in person to the family.</p> <p>A grievance dated 6/4/18 documented that a family friend filed a grievance regarding scarcity of staff when the family visited. The resolution was documented as provided in person to the</p>	F 585	<p>University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. University Place Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, University Place Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 585	<p>Continued From page 3</p> <p>family friend.</p> <p>A grievance dated 6/11/18 documented that family filed a grievance that staff only fed Resident #196 small portions of food and sips of water. The resolution was documented as provided in person to the family.</p> <p>A grievance dated 8/5/18 documented that the family filed a grievance regarding staff 's expectation for the family to assist with providing care to Resident #196. The resolution was documented as provided in person to the family.</p> <p>A grievance dated 8/13/18 documented that the family filed a grievance that staff were not following the Resident's care guide when providing care. A verbal response regarding the resolution was provided to the family.</p> <p>A grievance dated 9/4/18 documented that the family filed a grievance requesting reimbursement for torn clothes and for staff not to thrust the Resident's body when providing care. The resolution was documented as provided in person to the family.</p> <p>A grievance dated 9/11/18 documented that the family filed a grievance that staff was disrespectful. The resolution was documented as provided via phone to the family.</p> <p>During an interview on 11/14/18 at 1:30 PM, the administrator stated that she was the grievance officer for the facility and that the facility currently did not provide written responses to grievances filed by residents/families. The administrator further stated that a written response to grievances was only provided to residents/families upon request. The interview also revealed that this was the current practice and had been the facility's practice since she began as the administrator in August 2018.</p>	F 585	<p>F585</p> <p>Corrective action has been accomplished for the alleged deficient practice in regards to resident #196, #42, and #143. Resident #196's responsible party (RP) was mailed written response on 12/7/18 for grievances filed on 9/4 and 9/11. Resident #196 RP was mailed written response to grievances filed on 5/21, 6/4, 6/11, 8/5, 8/13 on 12/10/18. Resident #42 family was mailed written response to grievance filed on 9/26/18, 10/29/18 and 11/4/18 on 12/7/18. As of 11/14/18 all filed grievance have been sent written response.</p> <p>Residents currently residing in the facility have the potential to be affected by the same alleged deficient practice. As of 11/14/18 all grievances filed have receive written response. Grievance log will be updated to include written notification given. Administrator will track written notification by conducting a weekly audit of grievance log.</p> <p>Measures put into place to ensure that the alleged deficient practice does not recur include: All grievances will continue to be brought to morning meeting daily. Social worker (SW) will bring written notification letters to be signed by Administrator daily. Grievance log to be checked weekly x 4 weeks, then biweekly x 2 months and then monthly x 3 months.</p> <p>The SW/ Administrator will review data related to written response to grievance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 585	<p>Continued From page 4</p> <p>A telephone interview on 11/15/18 at 9:22 AM with the prior administrator revealed she was the administrator for the facility until July 2018. The interview also revealed that starting in June 2018, the facility's practice was to provide a written response to grievances if requested.</p> <p>During a telephone interview with the prior director of nursing (DON) on 11/16/18 at 10:45 AM, she stated that she was the DON for the facility from June - October 2018. The DON stated that she was involved in resolving most of the grievances filed by the family of Resident #196. The DON further stated that while she was DON at the facility, the facility's practice was to respond to grievances either in person or via phone unless a written response was requested. The DON also said that follow up to grievances filed by Resident #196's family was always provided in person/phone unless follow up was requested in writing.</p> <p>2. Review of a written grievance filed by the family of Resident #42 revealed the facility failed to identify the method used to report to the family the investigational findings. The form had no date for written notification.</p> <p>A grievance dated 8/20/18 documented the family filed a grievance regarding Resident #42 having on the same clothes for two days. The grievance also noted the family stated the resident had on a soiled brief and the son of the resident had requested the nurse to help. The grievance noted the outcome expectation of person voicing concern was the family requested Resident #42 to be bathed daily and checked to assure brief was dry. The family also requested Resident #42 to be up daily.</p>	F 585	and report to QAPI (Quality Assurance Performance Improvement) monthly x 3 months and will evaluate the effectiveness and continued compliance.		

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

PRINTED: 12/13/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 585	Continued From page 5  An interview was conducted on 11/16/18 at 5:50 PM with Resident #42's family member. The family member reported the family had not received a written response from the facility regarding the grievance submitted in August 2018. Resident #42's family member stated responses from the facility have been by phone or during a visit by family members.  During an interview on 11/14/18 at 1:30 PM, the administrator stated she was the grievance officer for the facility and the facility currently does not provide written responses to grievances filed by residents and families. The administrator further stated a written response to grievances was only provided to residents and families upon request. The interview also revealed this was the current practice and had been the facility's practice since she began as the administrator in August 2018.  A telephone interview on 11/15/18 at 9:22 AM with the prior administrator revealed she was the administrator for the facility until July 2018. The interview also revealed starting in June 2018, the facility's practice was to provide a written response to grievances if requested by residents and families.  A telephone interview was conducted with the prior director of nursing (DON) on 11/16/18 at 10:45 AM. The prior DON stated she was the DON for the facility from June 2018 through October 2018. The prior DON stated while she was DON at the facility, the facility's practice was to respond to grievances either in person or via phone unless a written response was requested.	F 585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 585	<p>Continued From page 6</p> <p>3. Review of the following written grievances filed by the family of Resident #143 revealed that the facility provided a verbal response in lieu of a written explanation for how these grievances were resolved:</p> <p>A grievance dated 9/26/18 documented the family was dissatisfied with care that Resident #143 had received over the past weekend. There was no resolution documented as provided to the family.</p> <p>A grievance dated 10/29/18 documented the family was concerned about care for Resident #143 and equipment not working properly. There was no resolution documented as provided to the family.</p> <p>A grievance dated 11/4/18 documented the family was concerned about the lifts not working properly. The resolution was documented as provided via telephone call to the family.</p> <p>During an interview on 11/14/18 at 1:30 PM, the administrator stated that she was the grievance officer for the facility and that the facility currently did not provide written responses to grievances filed by residents/families. The administrator further stated that a written response to grievances was only provided to residents/families upon request. The interview also revealed that this was the current practice and had been the facility's practice since she began as the administrator in August 2018.</p> <p>During an interview on 11/15/18 at 8:14 AM, the family stated that they had been provided verbal</p>	F 585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 585	Continued From page 7 responses when visiting at the facility and follow up via telephone call but no written responses were provided to the family.	F 585			
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)  §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed	F 636		12/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 636	<p>Continued From page 8</p> <p>on the care areas triggered by the completion of the Minimum Data Set (MDS).</p> <p>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to nutrition for 2 of 5 sampled residents at nutritional risk (Residents #18 and #84).</p> <p>The findings included:</p> <p>1. Resident #84 was admitted to the facility on 09/24/18 with diagnoses which included dementia, type 2 diabetes mellitus and severe</p>	F 636	<p>F636</p> <p>Corrective action has been accomplished for the alleged deficient practice in regards to conducting a comprehensive assessment to identify and analyze how conditions affected the functioning and quality of life for residents related to nutrition. On 12/13/18 resident #84 and resident #18 CAA (Care Area Assessment) was reassessed to reflect contributing factors/ risk factors and diagnosis.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 636	<p>Continued From page 9 protein calorie malnutrition.</p> <p>Review of Resident #84's admission history and physical dated 09/26/18 revealed the physician documented a diagnosis of anorexia with continued administration of Megace (a medication used to treat anorexia) twice daily and monitoring.</p> <p>Review of Resident #84's admission Minimum Data Set (MDS) dated 10/01/18 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #84 required set up and physical assistance with eating with functional impairment of one arm. The MDS indicated nutritional status among the areas that triggered for further analysis.</p> <p>Review of Resident #84's Nutritional Status Care Area Assessment (CAA) dated 10/04/18 revealed no documentation of findings with a description of the problem, contributing factors and risk factors related to nutrition. The CAA indicated receipt of a mechanical soft diet and decreased appetite. There was no documentation of input from Resident #84's family and/or representative. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.</p> <p>Interview with the Dietary Manager on 11/16/18 at 1:57 PM revealed she did not realize documented descriptions, contributing factors, risk factors and analysis of findings were required on the CAA.</p> <p>Interview with the Administrator on 11/16/18 at 2:19 PM revealed she expected staff to follow the Resident Assessment Instrument process. The Administrator reported the CAA should contain</p>	F 636	<p>Residents currently residing in the facility with nutritional status concerns have the potential to be affected by the same alleged deficient practice. Resident with nutritional status concerns have been identified by MDS and an audit will be conducted on all dietary CAAs with nutritional conditions that affect function and quality of life completed within the last 3 months by MDS. Nurse to identify comprehensive CAA completion by 12/18/18. Any negative findings will be corrected and reassess per the RAI manual.</p> <p>Measures put into place to ensure that alleged deficient practice does not recur included: in-service education with IDT (interdisciplinary team that is not limited to the Dietary Manager, MDS, Social Services, Activities) on how to appropriate complete a CAA on 11/30/18 by the MDS Consultant.</p> <p>MDS consultant/ MDS nurse will audit nutritional CAA for completion of comprehensive assessment to identify and analyze how conditions may affect function and quality of life of the resident and the decision to proceed or not proceed to the care plan monthly for 3 months then quarterly thereafter.</p> <p>MDS Coordinator will bring results of the audit data to QAPI meeting monthly x 3 months. The QI committee will review the findings identification of trends, actions taken, and to determine the need for and/</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 636	<p>Continued From page 10</p> <p>documentation of descriptions, contributing factors, risk factors and analysis of findings.</p> <p>2. Resident #18 was readmitted to the facility on 08/04/18 with diagnoses which included cerebral infarction and lung mass. Resident #18 was readmitted under hospice care with a pureed diet and nectar thick liquids.</p> <p>Review of Resident #18's significant change Minimum Data Set (MDS) dated 08/11/18 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #18 required the physical assistance of one person with eating.</p> <p>Review of Resident #18's Nutritional Status Care Area Assessment (CAA) dated 08/25/18 revealed no documentation of findings with a description of the problem, contributing factors and risk factors related to nutrition. There was no documentation of input from Resident #84's family and/or representative. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.</p> <p>Interview with the Dietary Manager on 11/16/18 at 1:57 PM revealed Resident #18's CAA was conducted by another staff member who was not available for interview. The Dietary Manager reported she did not realize documented descriptions, contributing factors, risk factors and analysis of findings were required on the CAA.</p> <p>Interview with the Administrator on 11/16/18 at 2:19 PM revealed she expected staff to follow the Resident Assessment Instrument process. The Administrator reported the CAA should contain documentation of descriptions, contributing</p>	F 636	<p>or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The DON or the MDS Nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendation and oversight. QAPI will evaluate the results for effectiveness and continued compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 636	Continued From page 11	F 636			
F 641	Accuracy of Assessments	F 641		12/15/18	
SS=D	CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to code that a Hospice resident was terminally ill for 1 of 2 sampled residents receiving Hospice services (Resident #199).  The findings included:  Resident #199 was admitted to the facility on 08/03/18 with diagnoses that included degeneration of the brain and late onset Alzheimer's disease. A Hospice contract dated 08/03/18 certified that Resident #199 was admitted under the care and services of Hospice for end of life.  The Minimum Data Set (MDS) dated 08/10/18 specified the resident's cognition was severely impaired and she was receiving Hospice services but did not have less than 6 months to live.  On 09/03/18 Resident #199 died in the facility.  MDS Nurse #2 was responsible for completing Resident #199's MDS but she was not able to be reached for an interview.  On 11/16/18 at 10:29 AM MDS Nurse #1 was interviewed and reported that section J1400 of the MDS was coded yes that a resident had less	F641 Corrective action has been accomplished for he alleged deficient practice in regards to end of life coding for Hospice residents. Resident #18's MDS (minimum data set) was modified and submitted to the state on 11/30/18 to include terminal illness.  Residents resident in the facility who receive Hospice services have the potential to be affected by this same alleged deficient practice. MDS Nurse completed an audit of all residents receiving services Hospice services on 11/30/18. The audit revealed that one of five needed modification and theses assessments were corrected and re-submitted to the state on 11/30/18  Measures put in place to ensure that the alleged deficient practice does not recur include: In-service education with MDS nurse by RN Consultant on 11/30/18 regarding coding for Hospice residents of terminal illness.  Administrator/ DON or designated staff member will conduct an audit of Hospice resident MDS for accuracy in coding			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 641	Continued From page 12 than 6 months live if there was a signed form by the physician stating the resident was terminally ill.  On 11/16/18 at 10:34 AM during the same interview with MDS Nurse #1, the Corporate MDS Nurse added that section J1400 should be coded yes when a resident was on Hospice and stated Resident #199's MDS needed to be modified.	F 641	monthly x 3 months and data collected will be brought to QAPI for analysis of effectiveness and continued compliance. The QI committee will review the findings identification of trends, actions taken, and to determine the need for and/ or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The DON and MDS Nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendation and oversight.		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff and hospice nurse interviews and record review, the facility failed to coordinate the care plan with hospice for 1 of 3 sampled residents who received hospice care (Resident #18).  The findings included:  Review of the facility's agreement with hospice dated 10/26/15 revealed a plan of care would be	F 684	Corrective action has been accomplished for the alleged deficient practice in regards to the collaboration with hospice staff to develop and implement a coordinated plan of care. On November 28, 2018 the hospice provider for Resident #18 and the resident's family were contacted by the social worker and invited to attend a care plan meeting. A care plan meeting conducted on 12/6/18.	12/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 684	<p>Continued From page 13</p> <p>jointly established, maintained, reviewed and modified as necessary at regular intervals with the participation of the facility and hospice interdisciplinary team members.</p> <p>Resident #18 was readmitted to the facility under hospice care on 08/04/18 with diagnoses which included cerebral infarction and lung mass.</p> <p>Review of Resident #18's significant change Minimum Data Set (MDS) dated 08/11/18 revealed an assessment of moderately impaired cognition and receipt of hospice care.</p> <p>Review of Resident #18's care plan dated 08/23/18 revealed Resident #18 received "palliative/hospice care due to disease process: late affect CVA (cerebral vascular accident)." The care plan did not indicate which services from hospice Resident #18 received. The care plan listed interventions of assistance with fluids, provision of medications and physician notification of changes.</p> <p>Review of Resident #18's hospice notes revealed documentation of hospice visits with a facility staff member signature. The hospice notes indicated Resident #18's medication administration records were reviewed.</p> <p>Interview with Nurse #1 on 11/15/18 at 1:00 PM revealed Resident #18 received a skilled nurse visit weekly from the hospice nurse. Nurse #1 reported Resident #18 also received care twice weekly from a hospice nurse aide. Nurse #1 explained the facility staff coordinated orally with the hospice staff with each visit.</p> <p>Telephone interview with Resident #18's hospice</p>	F 684	<p>Resident #18's care plan was developed/reviewed and was agreed upon by those present.</p> <p>Residents currently residing in the facility receiving hospice services have the potential to be affected by the same alleged deficient practice. Residents receiving hospice services have been identified and a record review for coordination of services / care planning was conducted by the Director of Nursing on November 27, 2018 to identify additional residents. No additional residents were identified. New residents or residents with new hospice services added, will be identified during review of new orders by nursing administration during monitoring IDT meeting. This information will be communicated to the Social Services Department for follow-up.</p> <p>Measures put into place to ensure that the alleged deficient practice does not recur include: On 11/28/18 the administrator conducted a mandatory in-service. Beginning on 12/4/18 the DON (Director of Nursing) and the SDC ( staff Development Coordinator) in-serviced licensed nurses, and other designated facility staff members regarding the importance of utilizing and documenting the coordination of service for the hospice resident on the care plan. The care plan will indicate the services provided by the hospice for the resident. The social service department will be responsible for coordinating care for the resident with hospice provider. Compliance will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 684	Continued From page 14 nurse on 11/15/18 at 1:43 PM revealed Resident # 18's care was coordinated with the staff nurse on each visit by oral report. The hospice nurse explained facility staff used Resident #18's hospice care plan (a separate document) as reference.  Interview with Nurse #2, unit manager, on 11/15/18 at 2:46 PM revealed Resident #18's hospice nurse orally communicated changes required in the care plan.  Interview with MDS Coordinator #1 on 11/15/18 at 2:55 PM revealed the facility's social worker coordinated the care plan with hospice.  Interview with the social worker on 11/15/18 at 3:13 PM revealed hospice was not included on the facility care plan for Resident #18 but coordination occurred orally.  Interview with the Director of Nursing (DON) on 11/15/18 at 3:22 PM revealed the facility should involve and coordinate with hospice in the development and revisions of Resident #18's care plan.	F 684	discussed during the morning meeting, to assure that care for hospice residents is coordinated with the hospice. The Director of Nursing, MDS coordinator, Administrator or other designated individual will review care plans for hospice residents to assure coordination of care is documented, then weekly for 4 weeks and then monthly for 3 months. Continued monitoring will determined frequency based on compliance.  The DON/ADON or other assigned administrative nurse will review data related to the coordination of services with hospice providers, analyzing for patterns/trends and report in QAPI (Quality Assurance/ Performance Improvement) meeting monthly for 3 months. The QI committee will review the findings identification of trends, actions taken, and to determine the need for and/ or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The DON and MDS Nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendation and oversight.		
F 697 SS=D	Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 697		12/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 697	<p>Continued From page 15 and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interviews and record review, the facility failed to respond to a resident's complaint of pain for 1 of 3 sampled residents reviewed for pain management (Resident #97).</p> <p>The findings included:</p> <p>Resident #97 was readmitted to the facility on 10/18/18 with diagnoses that included abdominal pain, end stage renal disease and others.</p> <p>A physician's order dated 10/18/18 specified Resident #97 was to receive Oxycodone (pain medication) 10mg (milligrams) every 8 hours as needed for pain.</p> <p>The most recent Minimum Data Set (MDS) dated 10/25/18 specified the resident's cognition was intact, she had clear speech and could make her needs understood and understood others. The MDS also specified the resident received as needed pain medication for frequent pain.</p> <p>A care plan updated 10/25/18 identified interventions to address Resident #97's pain. The interventions included:</p> <ul style="list-style-type: none"> <li>- Listen to resident's concerns</li> <li>- Give as needed pain medication for breakthrough pain per the physician's orders and note the effectiveness</li> </ul> <p>A document titled "Grievance Form" dated 10/28/18 was reviewed and revealed Resident #97 reported that she requested pain medication from Nurse #1, but the nurse left the hall to take a</p>	F 697	<p>Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 97. Resident # 97 was offered ordered pain medication on 10/28/18 by the licensed nurse. The resident declined but did accept an over the counter medication. The resident continued to receive ordered pain management. The resident was assessed for pain by his/her physician on November 19, 2018 and no changes were made to the medication regime. The physician / physician extender will be notified of new or changes to the resident's pain and / the ineffectiveness of the pain regime. The resident will be assessed for pain prior to the administration of prn (as needed) pain medication and after the administration of prn pain medication to determine effectiveness. Complaints of pain and/or requests for pain medication will be addressed as soon as possible following the receipt of the complaint.</p> <p>Residents currently residing in the facility have the potential to be affected by the same alleged deficient practice. For residents that have a BIMS score of 9 or higher that currently have scheduled or prn pain medication orders will be interviewed by the licensed nurses to determine if appropriate response has been provided for expressed concerns of pain. The DON will review residents for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 697	<p>Continued From page 16 break.</p> <p>On 11/13/18 at 12:00 PM Resident #97 was interviewed in her room and when asked if her pain was effectively managed she stated, "No." Resident #97 described the incident on 10/28/18 stating that around 10 AM she experienced breakthrough pain rated as "6 or 7" out of 10 (being the worst). Resident #97 added that as Nurse #1 walked by the room, she called out and told Nurse #1 she needed a pain pill. Resident #97 stated that Nurse #1 replied that she was on her way to a break and would be back later. Resident #97 stated she feared that if she didn't get a pain pill soon her pain would reach an "unbearable" level. She added that she waited about 20 minutes and when the nurse arrived in the room, she had dispensed the wrong amount of pain medication. Resident #97 reported that she declined the pain medication because the Nurse had dispensed the wrong amount and she "didn't trust the nurse." The resident also stated that her pain did not worsen as result of having to wait for pain medication.</p> <p>On 11/15/18 at 10:23 AM Nurse #1 was interviewed and explained that on 10/28/18 she was assigned to Resident #97 and the resident requested a pain pill as the nurse was on her way to break. Nurse #1 explained that she told Resident #97 she would be back and went on break. While on the break, she was interrupted by another nurse to tell her Resident #97 had been waiting 30 minutes for her pain medication. Nurse #1 added that she left the breakroom and dispensed the pain medication for Resident #97 and the resident had not been waiting 30 minutes. Nurse #1 stated that she "wasn't sure" what the procedure was for handling a resident's</p>	F 697	<p>concerns regarding pain management during morning clinical meeting. The review will include the timeliness of interventions, including non-pharmacologic interventions for complaints of pain</p> <p>Measures put into place to ensure that the alleged deficient practice does not recur include: Beginning on 12/3/18 a mandatory in-service for the licensed nurses, certified nursing assistants and other designated staff members to be provided by the DON, Staff Development Coordinator (SDC) or other designated staff member(s) regarding the importance of ensuring that prompt and appropriate response for pain management is provided to residents who require those services. Residents will be assessed/ evaluated for pain, minimally on admission / readmission, with reports of pain or observation of potential pain by others, following the administration of medication for pain, quarterly and with significant change. The Unit Managers, Supervisors or other licensed nurse will review the 24-hour report in the morning IDT meeting to identify pain concerns and will follow –up as needed. The Interdisciplinary Team will review concerns on pain management, including appropriate and timely response to complaints of pain.</p> <p>The DON/ADON or other assigned administrative nurse will review data related to pain management, analyzing for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 697	Continued From page 17 request for pain medication when a nurse was going on break. The nurse stated that she was supposed to report to another nurse when she left the hall but could not recall if she notified anyone on 10/28/18. The nurse also stated that she could have notified another nurse of Resident #97's request for pain medication. The nurse reported that she felt weak that day and made mistake by not addressing Resident #97's request for pain medication before going on break. She also stated she forgot to assess Resident #97's pain and did not document the effectiveness of the pain medication.  On 11/16/18 at 9:34 AM the Director of Nursing (DON) was interviewed and reported she was not working when the incident on 10/28/18 occurred. The DON stated that the "best case scenario would be for the nurse to stop, go back to the cart and give the resident what they need."  On 11/16/18 at 12:18 PM the Administrator was interviewed and stated she would expect the nurse to address the resident's pain before leaving on break.	F 697	patterns/trends and report in QAPI (Quality Assurance/ Performance Improvement) meeting monthly for 3 months. . The QI committee will review the findings identification of trends, actions taken, and to determine the need for and/ or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The DON and MDS Nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendation and oversight.		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)  §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		12/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 732	<p>Continued From page 18</p> <p>(A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post accurate nurse staffing information for the facility in an area visible to residents and visitors for 3 out of 5 days during the recertification survey conducted 11/13/18 through 11/17/18.</p> <p>Findings included:</p> <p>An observation was made on entry into the facility, adjacent from the lobby area, on 11/13/18</p>	F 732	<p>Corrective action has been accomplished for the alleged deficient practice in regards to the posting of nursing staffing. Nursing staffing was posted on November 16, 2018. One to one education was provided for the nursing scheduler on 11/28/18 by the facility's Administrator.</p> <p>Residents residing in the facility and visitors have the potential to be affected by the same alleged deficient practice.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 732	<p>Continued From page 19</p> <p>at 9:31 AM which revealed the nurse staffing information posted was dated 11/10/18.</p> <p>An observation was made on 11/14/18 at 8:37 AM which revealed the nurse staffing information posted was dated 11/13/18.</p> <p>A follow up observation was made on 11/14/18 at 12:45 PM and 3:28 PM which revealed the nurse staffing information was not available. No signage was posted.</p> <p>An observation was made on 11/15/18 at 8:45 AM which revealed no nurse staffing information was posted.</p> <p>An interview was conducted on 11/16/18 at 9:03 AM with the staffing coordinator which revealed she was responsible for posting the nurse staffing information Monday through Friday. The staffing coordinator stated the nurses or the manager on duty were responsible for changing out staffing sheets on the weekends or holidays. The staffing coordinator verbalized she had to rely on other administrative staff for census information prior to completing the nurse staffing information due to not having computer access. The staffing coordinator further explained she was pulled in a lot of different directions and forgot to post the nurse staffing information.</p> <p>An interview was conducted on 11/16/18 at 9:12 AM with the Administrator. The Administrator stated she expected the nurse staffing information to be posted daily. On the weekends, the Administrator further stated she expected her weekend staff to post the nurse staffing information.</p>	F 732	<p>Members of the facility's administrative team including but not limited to; the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers (UM), Social Services, Activity Director, Nursing Supervisors, Dietary Manger, Business Office Manager and other designated individuals will observe and report in morning meeting during normal business hours, posting of the nursing staffing presence for the day. Off hours and weekend licensed nurses or other assigned staff will check the front lobby for the posting.</p> <p>Measures put into place to ensure that the alleged deficient practice does not recur include: mandatory in-service beginning 12/4/18 for the nursing scheduler, licensed nurses and other designated facility staff members to be provided by the Administrator, DON, Staff Development Coordinator (SDC) or other designated staff member(s) regarding the importance of the posting of nursing staffing in a clear and readable format; and the process for updating the posting when changes occur Newly hired staff, if hired for a role that is responsible for the posting, will be provided training during the orientation process. Administrative staff including: Administrator, Director of Nurses, Staff Development Coordinator, Social Worker and Unit Mangers will monitor for compliance during normal business hours. A review of the previous postings will be conducted by the Administrator, Director of Nursing, Assistant Director of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 732	Continued From page 20 An interview was conducted on 11/16/18 at 9:34 AM with the Director of Nursing (DON). The DON stated the staffing coordinator would be responsible for ensuring nurse staffing information was posted. The DON further stated she expected the staffing coordinator to have the nurse staffing information posted for the day at the beginning of the shift. The DON also stated she expected the weekend supervisory staff to post the nurse staffing information throughout the weekend.	F 732	Nursing or other designated staff during the morning IDT meeting for one week, then weekly for 4 weeks and then evaluated for future monitoring frequency based on compliance. The scheduler will responsible for maintaining the posting records.  The DON/ADON or other assigned administrative nurse will review data related to nursing staffing posting, analyzing for patterns/trends and report in QAPI (Quality Assurance/ Performance Improvement) meeting monthly for 3 months. The QI committee will review the findings for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The DON or the MDS Nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)  §483.75(g) Quality assessment and assurance.  §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility ' s Quality Assessment and Assurance	F 867	QAPI /QAA Improvement Activities	12/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 867	<p>Continued From page 21</p> <p>Committee failed to maintain implemented procedures and monitor interventions that the committee put into place in February, 2018. These were for deficiencies cited during the facility's recertification and complaint investigation survey conducted on 01/12/18, F 636 and F 641. The deficiencies were in the areas of Resident Assessments. The continued failure of the facility to sustain compliance, during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>The findings included:</p> <p>This tag is cross referred to:</p> <p>F 636: Resident Assessments. Based on staff interviews and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to nutrition for 2 of 5 sampled residents at nutritional risk (Residents #18 and #84).</p> <p>The facility was recited for failure to conduct a comprehensive assessment regarding nutrition. The F 636 was originally cited during a recertification and complaint investigation survey on 01/12/18 for failure to conduct a comprehensive assessment regarding activities.</p> <p>F 641: Resident Assessments. Based on record review and staff interview the facility failed to code that a Hospice resident was terminally ill for 1 of 3 sampled residents receiving Hospice services (Resident #199).</p> <p>The facility was recited for failure to accurately</p>	F 867	<p>The facility's quality assurance and performance improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the 1/13/18 recertification survey in the areas of: Comprehensive Assessments and Timing (F636) and Assessment Accuracy (F641),. These two (2) deficiencies were cited again on the current recertification survey completed on 12/17/18. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance (QAA) program.</p> <p>On 12/13/18, the corporate facility consultant in-serviced the facility administrator related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies related to the areas of Comprehensive Assessments and Timing (F636) and Assessment Accuracy (F641). The facility QAPI Committee is comprised of the: medical director, administrator, director of nursing, minimum data set (MDS) nurses, quality improvement/infection control nurse, admissions director, wound nurse, nursing unit managers, social services director, activities director, dietary manager, environmental services director, maintenance director, payroll, bookkeeping, a staff nurse, nursing assistant, pharmacy consultant.</p> <p>On 12/13/18, the corporate facility consultant in-serviced the QAPI</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 867	Continued From page 22 code the Minimum Data Set (MDS) regarding prognosis for life. The F 641 was originally cited during a recertification and complaint investigation survey on 01/12/18 for failure to accurately code the MDS regarding prognosis of life and active diagnoses.  Interview with the Administrator on 11/16/18 at 4:16 PM revealed recent staff changes in the MDS department were a possible reason for the inaccurate coding. The Administrator explained audits conducted did not identify inaccuracies or lack of comprehensive assessments.	F 867	committee and reviewed the purpose and function of QAA/QAPI committee and reviewed on-going compliance issues. The quarterly QAPI committee will hold a meeting in December 2018 to review the deficiencies from the 12/17/18 survey and go over the approved plan of correction (PoC) with the medical director and pharmacy consultant. On 12/12/18, the administrator completed in-servicing with the department heads on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies in the areas of Comprehensive Assessments and Timing (F636) and Assessment Accuracy (F641). After the facility consultant in-service on 12/13/18, the facility QAPI Committee began identifying other areas of quality concern through the quality improvement (QI) review process during the daily interdisciplinary team (IDT) meetings and monthly QI committee meetings, for example: review of rounds tools, review of Point Click Care (Electronic Medical Record), review of pharmacy reports, and review of regional facility consultant recommendations. The QI committee will meet at a minimum of monthly and QAPI committee meets a minimum of quarterly to identify issues related to quality assessment and assurance activities and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns in the areas of:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 867	Continued From page 23	F 867			
F 925 SS=E	<p>Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)</p> <p>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of facility records, the facility failed to maintain an effective pest control program as evidenced by flying insects in two of the facility hallways, the main dining room, the kitchen's dry storage room, the activity room and conference room.</p> <p>The findings include:</p> <p>Review of the facility's Pest Sighting Sheet dated 9/11/18 revealed no identified flying insects in the facility at the time of the service visit.</p> <p>An observation in the main dining room (Rose dining room) on 11/13/18 at 12:46 PM revealed flying insects in the dining area where residents were eating lunch.</p> <p>An observation on 11/13/18 between 12:50 PM to 12:55 PM revealed flying insects in the hallway adjacent to the kitchen and the 300 Hallway where residents and staff were present.</p> <p>On 11/13/18 at 1:00 PM and 4:20 PM, flying</p>	F 925	<p>Comprehensive Assessments and Timing (F636) and Assessment Accuracy (F641),. The facility administrator is responsible for implementing an effective QAPI/QAA program.</p> <p>Corrective action has been accomplished for the alleged deficient practice of maintaining an effective pest control program. On 11/1/18 exterminator was contacted and affected areas were addressed.</p> <p>Residents residing in the facility have a potential of being affected by this same alleged deficient practice. Dining Service staff was in serviced on 11/23/18 by the Dietary Manager regarding storage of bananas and reporting of pest. Department heads were in-serviced on 12/10/18 by the Administrator to report all pest concerns immediately to maintenance. All staff will be in-serviced by 12/14/ 2018 by the Staff development Coordinator regarding reporting any concerns with pest to maintenance immediately. New hires and agency staff will be in-serviced during their orientation to the facility by the Staff Development Coordinator.</p>	12/15/18	

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

PRINTED: 12/13/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 925	<p>Continued From page 24</p> <p>insects were observed in the conference room.</p> <p>On 11/13/18 from 4:24 PM to 4:30 PM, an observation of the kitchen's dry storage room revealed flying insects coming from a box of bananas with the removal of 18 ripe bananas. An interview with the dietary assistant manager during this time, the assistant manager reported she observed flying insects in the dry storage room after the removal of the ripe bananas. The assistant dietary manager reported she had not observed flying insects in the dry storage room prior to this observation. The assistant dietary manager stated any observation of pest activity should be reported to the maintenance director.</p> <p>During an interview with the maintenance director on 11/14/18 at 11:36 AM, the maintenance director stated the pest control company is contracted for quarterly visits to the facility. The maintenance director stated he has maintained a log of reported pest activity since his employment with the facility a year ago. The maintenance director stated he had no report of pest activity, including flying insects, during the month of November 2018.</p> <p>On 11/14/18 at 3:18 PM, flying insects were observed in the activity room during the Resident Council meeting.</p> <p>During an interview on 11/15/18 at 9:07 AM, the maintenance director reported the pest control company last visited on 9/11/18 and since that time he has not had a report of pest activity in the facility. The maintenance director stated when a report was made, the company would be contacted and would come to the facility the day of or the following day to provide service.</p>	F 925	<p>Measures put into place to ensure that the alleged deficient practice does not reoccur include: In-service education and dining service dry storage room temperature has been adjusted to 60 degrees. Temperature of dry storage will be monitored daily and TELS will be tracked by maintenance director for any reports of pest.</p> <p>The Maintenance Director or other assigned administrative staff will review data related to pest reporting, analyzing for patterns/trends and report in QAPI (Quality Assurance/ Performance Improvement) meeting monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance.</p>		

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

PRINTED: 12/13/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9200 GLENWATER DRIVE</b> <b>CHARLOTTE, NC 28262</b>		
(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 925	Continued From page 25  During an interview with the dietary manager on 11/15/18 at 12:05 PM, the dietary manager stated she had not been notified of flying insects in the kitchen's dry storage room. The director stated pest activity should be reported to the maintenance director for service by the pest control company.  During an interview with the administrator on 11/16/18 at 3:04 PM, the administrator stated she had not received a report of flying insects in the facility. The administrator stated her expectation was staff would report the presence of pests in the facility to the maintenance director. The administrator expected the maintenance director to contact the contracted pest control company for service.	F 925		