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

PRINTED: 07/22/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			1	C 24/2021
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9200 GLENWATER DRIVE CHARLOTTE, NC 28262	Ē	1 00/	2-7/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	conducted on 06/21/2 facility was found in crequirement CFR 483 Preparedness. Even	3.73, Emergency t ID #30S611.		000			
F 000	survey was conducte 06/24/21. There wer	complaint investigation of from 06/21/21 through e 59 complaint allegations was substantiated resulting	F	000			
F 812 SS=E	Food Procurement,S	tore/Prepare/Serve-Sanitary 2)	F 8	812			7/19/21
	§483.60(i)(1) - Procu approved or consider state or local authorit (i) This may include f from local producers, and local laws or reg (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision do	red satisfactory by federal, ies. ood items obtained directly subject to applicable State					
	serve food in accorda standards for food se This REQUIREMENT by:	prepare, distribute and ance with professional ervice safety. Γ is not met as evidenced ons and staff interviews, the		University Place Nursing and			
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE			(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed 07/15/2021

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

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		345142	B. WING			C	
NAME OF D	DOVIDED OD CUIDDUED	343142	D: Willo	CTREET ADDRESS CITY STATE ZID COR	•	6/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	'E		
UNIVERSI	TY PLACE NURSING	AND REHABILITATION CENTER		9200 GLENWATER DRIVE			
				CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 812	Continued From p	age 1	F 8	12			
F 812	facility failed to rer refrigerator in 1 of failed to label and for use in 3 of 4 nd. Findings included: 1. An observation the rehabilitation use in 3 of 4 nd. Conducted with the a. 15 expire milk cartons had a five milk cartons had a five milk cartons had some street of the conducted with the a. 15 expire milk cartons had a five milk cartons had some street of the conducted of 19/21. b. An undate of 17/21. d. An undate container of sliced e. An undate potato chips.	move expired items in the 4 nourishment rooms and date opened food items stored purishment rooms. a of the nourishment room on unit on 06/21/21 at 10:40 AM e wound nurse revealed: ad 8 ounce, cartons of milk; three an expiration date of 04/23/21, ad an expiration date of en milk cartons had expiration from 06/05/21 through and and unlabeled opened plastic ared and unlabeled opened bag of archeese that had expired on ared and unlabeled Styrofoam	F 8	Rehabilitation Center acknow receipt of the Statement of De and proposes this Plan of Co required by Federal and State and statutes applicable to lon providers. This plan does not an admission of liability on the facility, and such liability is he specifically denied. The submiplan does not constitute an authe facility that the surveyor conclusions are accurate, that constitute a deficiency, or the severity regarding any of the cited are correctly applied. Completion date is 07/19/202 F812 Corrective action has been and for the alleged deficient practifood procurement, store/prepare/serve-sanitary. 06/24/2021 the Director of Nu Assistant Director of Nursing full audit of 100% of nourishme throughout the building and dexpired items. On 06/24/202	eficiencies rrection as e regulations g term care t constitute e part of the ereby hission of this greement by s findings or t the findings scope or deficiencies e.1.		
	located on the Me AM with the Memo	n of the nourishment room mory unit on 06/21/21 at 11:00 ory Care Coordinator revealed: ted and unlabeled opened box of		Administrator conducted 1:1 i with Dietary Manager to inclu safety requirements for food pand food storage, preparatior	n-service de all food procurement		
	cheesecake. b. An undate container of Coolstoner of Cools	ted and unlabeled opened whip. ted and unlabeled opened plastic open liquid. ntainers of undated and		distribution, and serving. An was started on 06/24/2021 widepartment and Nursing Depregarding responsible roles for requirements. Education inclichecking ALL food items, inclifor expiration date and proper date received of opened and	in-service ith Dietary artment or food safety uded uding drinks r labeling of		

Facility ID: 923015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345142	B. WING _			1	24/2021	
NAME OF PE	ROVIDER OR SUPPLIER	!		STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	24/2021	
					00 GLENWATER DRIVE			
UNIVERSI	TY PLACE NURSING	AND REHABILITATION CENTER			HARLOTTE, NC 28262			
(V4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	1	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 812	Continued From pa	nge 2	F 8	12				
	not sure if the items belonged to residents or items and re		items and responsibility of removal of f items including drinks without a date or expired.					
		of the nourishment room						
		oretum unit on 06/21/21 at			Measures put into place to ensure that			
	10:30 AM with Nurse #1 revealed: a. An undated and unlabeled opened				alleged deficient practice does not recu include: In-service education was	ır		
	container of watern				conducted by Director of Nursing,			
		ed and unlabeled opened			Assistant Director of Nursing, and or			
	container of tea.	•			designee beginning on 06/24/2021 for	all		
	c. Three und	lated and unlabeled plastic			dietary and nursing staff covering			
	bags of food items.				responsible roles for food safety			
l l		e tea and watermelon			requirements including checking ALL for	ood		
	belonged to a resid	ent.			and drink items for expiration date and proper labeling of date received of ope	ned		
		cted with the Memory Care			and un-opened items and responsibility			
	_	06/22/21 at 11:50 AM			removal of food and drink items withou	t a		
		hment rooms were cleaned by			date or expired. Education will be	2001		
		the dietary staff discards			completed by 07/19/2021. Audits of 10			
	•	when they restock the stated many families bring			nourishment rooms have been comple 5 x□s weekly since 06/24/2021 by Die			
		esidents. The Nurse Manager			Manager, Director of Nursing, Assistan			
		taff are aware that they need			Director of Nursing, or designee. No			
		ny food items brought into the			issues have been noted. All newly hire	ed		
		embers, but there had been			dietary and nursing employees will be			
	many new agency	staff filling in since the			in-serviced on food safety requirement	s		
	pandemic began.				for food procurement and food storage			
					preparation, distribution and serving in			
		ne Housekeeping Supervisor 55 PM revealed someone from			orientation.			
	. •	assigned to the nourishment			Audits for nourishment rooms to check			
		ean the inside and outside of			for labeling, date, expiration and remov			
	•	She further stated the dietary			of expired food items will continue 5 x			
	department will rem labeled or dated.	nove any food that is not			weekly until 07/24/2021, then audits fo nourishment rooms will continue 3 x □s			
	iancieu oi ualeu.				weekly for 4 weeks, then weekly for 4			
	An interview with th	ne Dietary Manager on			weeks. The audits will be documented	on		
		PM revealed the dietary			the food procurement,			
		es expired food and beverages			store/prepare/serve-sanitary audit tool.			

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		345142	B. WING		C 06/24/2021
NAME OF P	ROVIDER OR SUPPLIER	0.0.12		STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF T	NOVIDEN ON SOIT LIEN			9200 GLENWATER DRIVE	
UNIVERSI	TY PLACE NURSING A	AND REHABILITATION CENTER			
				CHARLOTTE, NC 28262	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 812	Continued From pa	ge 3	F8	12	
	from the nourishment room refrigerators.			The Dietary Manager, Director	
	Administrator stated opened food items further stated any s	/23/21 at 04:20 PM. The If it was her expectation that the dated and labeled. She taff that observe an expired tor is responsible for		or Assistant Director of Nursing present the findings and recommendations at monthly G committee meeting. QAPI/QI or will evaluate for continued com 2 months.	QI ommittee