STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record reviews, resident, and staff interviews, the facility failed to provide the resident's preference of showers for 1 of 10 residents reviewed for activities of daily living (ADL) (Resident #49). The findings included: Resident #49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included asthma, cerebral vascular accident or stroke, right side hemiplegia, aphasia, and diabetes mellitus type II. Review of Resident #49's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and required total assistance with showering and bathing. The assessment also revealed Resident #49 had no rejection of care behaviors and according to the assessment, it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. An observation and interview with Resident #49 on 02/27/24 at 9:25 AM revealed her up in her wheelchair and dressed for the day. The resident's skin that was visible was dry and flakey. The resident stated she was not getting her showers two times a week as scheduled and stated she preferred to take showers because the hot water felt good to her body. Resident #49 further stated she had not refused any of her showers but had not been offered showers two times per week as scheduled. On 02/28/23 at 2:00 PM a Resident Council meeting was held and Resident #49 was in attendance and again complained during the meeting that she was not getting her showers two times a week as scheduled. Review of the shower schedule for the hall on which the resident resided revealed Resident #49 was scheduled for showers on Tuesday and Friday on 2nd shift (3:00 PM to 11:00 PM). Review of the documentation of showers in the electronic medical record for Resident #49 revealed for the month of February she had only received two showers on 02/13/24 and 02/16/24. On the other days she was scheduled for showers the following was documented: Friday 02/02/24 partial bed bath (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tuesday 02/06/24 partial bed bath Friday. 02/09/24 partial bed bath on 1st shift (7:00 AM to 3:00 PM) Tuesday, 02/20/24 partial bed bath on 1st shift Friday, 02/23/24 partial bed bath on 1st shift and on 2nd shift An interview on 02/28/24 at 2:29 PM with Nurse Aide (NA) #4 who was assigned to care for Resident #49 on 02/02/24, 02/06/24, 02/20/24 and 02/23/24 revealed on the days she had not provided the resident with a shower she had given her a partial bath and documented a partial bath. She stated the resident got up early in the morning and sometimes wanted to go back to bed early afternoon before it was time for her shower so she just washed her up in bed. NA #4 further stated she had not asked if Resident #49's showers could be changed to 1st shift because she had been told all B bed residents had their showers on 2nd shift but said she would probably benefit from having her shower time changed from 2nd shift to 1st shift. A telephone interview was attempted with NA #9 who was assigned to care for Resident #49 on 02/09/24 with voicemail message left for return call with no response from the NA. An interview on 02/29/24 at 2:09 PM with Nurse #6 who was assigned to care for Resident #49 revealed she was not aware of the resident refusing showers and said the NAs had not reported to her that she had refused showers so she had not documented a progress note regarding the resident refusing showers. An interview on 02/29/24 at 3:10 PM with Unit Manager #1 revealed she was not aware Resident #49 was not receiving her showers as scheduled and said no one had reported it to her. She stated if the 2nd shift shower were not working for Resident #49, they could certainly switch her to 1st shift showers. Unit Manager #1 stated the normal process for showers was if the resident refused their shower the NA had to go back again a little later and ask the resident if she/he was ready to take their shower and if the answer was no again, the NA was to report that to the nurse. She stated then the nurse was to ask the resident and if the resident refused to the nurse, she was supposed to write a progress note indicating the resident had refused his/her shower despite being asked three times. Unit Manager #1 further stated the NA should have reported the timing of Resident #49's shower not working for her and it could have been changed to accommodate the resident. An interview on 02/29/24 at 4:53 PM with the Director of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said it was a process they were currently working on with the NAs. She stated she expected residents to have their showers as scheduled and said if they did not receive their showers, she expected them to receive a complete bed bath not a partial bed bath and for it to be documented. The DON further stated if the resident refused their shower, she expected the nurse to document the refusal in their progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 6 residents (Resident #41, #102, #84) reviewed for Preadmission Screening and Resident Review (PASRR), and 1 of 3 residents (Resident #110) reviewed for restraints. Findings Include: 1. Resident #41 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, anxiety, and psychosis. Review of PASRR Level II determination letter from July 2021 revealed Resident #41 had met the requirements for a level II PASRR due to having mental illness diagnosis with specialized services required. The annual MDS assessment dated [DATE] indicated Resident #41 was cognitively intact and was not coded as having a level II PASRR. An interview with the MDS Coordinator on 02/29/24 at 3:28 PM revealed she had begun working at the facility in October 2023 and was not aware that Resident #41had a level II PASRR or that it had been coded on his MDS. She stated Resident #41's MDS did not reflect him having a level II PASRR assigned and that was an oversight based on human error and a correction would need to be made. An interview with the Administrator on 02/29/24 at 4:08 PM revealed she had just begun at the facility on Monday 02/26/24 and was not aware of Resident #41 PASRR level not being reflected on his MDS. She stated their process would be for the MDS to reflect current PASRR level and to be accurate. She felt it was just an oversight based on human error on the part of the MDS Coordinator. The Director of Nursing (DON) was interviewed on 02/29/24 at 4:45 PM revealed she was not aware of Resident #41 PASRR level was not reflected on his MDS and believed it was probably due to an oversight on the part of the MDS Coordinator. She stated MDS should reflect current PASRR level for all residents and a correction would need to be made. 2. Resident #102 was admitted to the facility on [DATE] with diagnoses that included dementia. Review of PASRR level II determination letter from May 2021 revealed Resident #102 met the requirements for a level II PASRR due to diagnosis of dementia. The annual MDS assessment dated [DATE] indicated Resident #102 was moderately cognitively impaired and was not coded as having a level II PASRR. An interview with the MDS Coordinator on 02/29/24 at 3:28 PM revealed she had begun working at the facility in October 2023 and was not aware that Resident #102 had a level II PASRR or that it had not been coded on her MDS. She stated she believed Resident #102's MDS not reflecting her having a level II PASRR assigned was an oversight based on human error by the previous MDS Coordinator and a correction would need to be made. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 02/29/24 at 4:08 PM revealed had just begun at the facility on Monday 02/26/24 and was not aware of Resident #102 PASRR level not being reflected on her MDS. She stated their process would be for the MDS to reflect current PASRR level and to be accurate and they felt it was just an oversight based on human error on the part of the MDS Coordinator. The Director of Nursing (DON) was interviewed on 02/29/24 at 4:45 PM revealed she was not aware of Resident #102 PASRR level was not reflected on her MDS and believed it was probably due to an oversight on the part of the MDS Coordinator. She stated MDS should reflect current PASRR level for all residents and a correction would need to be made. 45358 3. Resident #84 was admitted to the facility on [DATE] with diagnoses of dementia, schizophrenia, and anxiety. The most recent annual Minimum Data Set assessment dated [DATE] indicated Resident #84 was not currently considered by the state level II PASRR process to have serious mental illness. Review of Resident #84's electronic medical record revealed a Halted level II PASRR identification number noted in the demographic information. During an interview on 2/29/24 at 3:34 PM MDS Coordinator #1 indicated it was the responsibility of the MDS coordinator to enter PASRR information onto the MDS assessment at admission and annually. She further indicated she initially understood Resident #84's PASRR to be halted and therefore Resident #84 was not considered to have a level II PASRR determination. However, she realized the PASRR section of the MDS should have been marked as having a level II PASRR, since the Resident was admitted with a PASRR number and mental health diagnoses. The Director of Nursing (DON) was interviewed on 02/29/24 at 4:58 PM revealed she was not aware of Resident #84's PASRR level was not reflected on her MDS. She believed it was probably due to an oversight on the part of the MDS Coordinator staff changes. She stated her expectation was that MDS should reflect current PASRR levels for all residents. An interview with the Administrator on 02/29/24 at 5:10 PM revealed had just begun at the facility on Monday 02/26/24 and she expected the MDS to be reviewed and coded correctly. 48684 4. Resident #110 was admitted to the facility on [DATE]. The quarterly Minimum Data Sheet (MDS) assessment dated [DATE] indicated Resident #110 was coded for the use of a limb restraint less than daily. The previous annual MDS dated [DATE] indicated no use of restraints. Review of Resident #110's current care plans dated 12/1/23 revealed Resident #110 had no restraint care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with MDS Coordinator #1 and MDS Coordinator #2 on 2/29/24 at 3:56 PM. MDS Coordinator #1 explained Resident #110's MDS assessment dated [DATE] was completed by another MDS Coordinator who was no longer employed at the facility. The MDS Coordinator #2 confirmed Resident #110 did not use a limb restraint now and had not used one in the past. The MDS Coordinator #2 stated it was likely an entry issue and they would look into the entry. During an interview on 2/29/24 at 5:06 PM, the Administrator stated it was her expectation for MDS assessments to be completed accurately. The Administrator further stated that MDS entries should be checked before final submission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for resident with mental health diagnosis upon admission and residents with new mental health diagnoses for 3 of 6 residents (Resident# 141, #31, #49) reviewed for PASRR. The findings include: 1. Review of Resident #141's medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on [DATE]. The resident had been diagnosed with delusional disorder on 08/31/23 and dementia, severe, with psychotic disturbance as part of her admission. No PASRR level II had been completed per Resident #141 medical records. During an interview on 02/29/24 at 4:05 PM with the Social Worker (SW) revealed she had been employed as the facility SW over the past year and since that time had been responsible for completing PASRR upon a resident admission, when a change in condition or behavior had occurred, or when there had been a new diagnosis. She revealed she would review a resident's diagnosis once they were admitted seeing if they would require a level II PASRR to be completed and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition. The SW stated Resident #141 admission diagnosis and level of PASRR had simply been overlooked, however based on Resident #141 admission diagnosis of delusional disorder and dementia, severe, with psychotic disturbance and the preadmission PASRR level I, paperwork for a PASRR level II should have been completed. During an interview on 02/29/24 at 4:15 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #141 admission diagnosis of delusional disorder and dementia, severe, with psychotic disturbance a PASRR level II should have been completed. 2. Review of Resident #31's medical record revealed the resident had a PASRR level I completed prior to his admission and was admitted to the facility on [DATE]. The resident was diagnosed with dementia with mood disturbance disorder on 05/05/23. No PASRR level II had been completed per Resident #31 medical records. During an interview on 02/29/24 at 4:05 PM with the Social Worker (SW) revealed she had been employed as the facility SW over the past year and since that time had been responsible for completing PASRR upon a resident admission, when a change in condition or behavior had occurred, or when there had been a new diagnosis. She revealed she would review a resident's diagnosis once they were admitted seeing if they would require a level II PASRR to be completed and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition. The SW stated she had not been made aware of Resident #31's new mental health diagnosis of dementia with mood disturbance and felt it could have been an oversight, however based on his new diagnosis and the preadmission level I PASRR, paperwork for a PASRR level II should have been completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/29/24 at 4:15 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #31 newly added diagnosis of dementia with mood disturbance disorder a PASRR level II should have been completed. 3. Review of Resident #49's medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on [DATE]. The resident was diagnosed with major depressive disorder on 11/28/22. No PASRR level II had been completed per Resident #49 medical records. During an interview on 02/29/24 at 4:05 PM with the Social Worker (SW) revealed she had been employed as the facility SW over the past year and since that time had been responsible for completing PASRR upon a resident admission, when a change in condition or behavior had occurred, or when there had been a new diagnosis. She revealed she would review a resident's diagnosis once they were admitted seeing if they would require a level II PASRR to be completed and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition. The SW stated she was not aware of Resident #49 not having a level II PASRR, however based on her new diagnosis of major depressive disorder and the preadmission level I PASRR, paperwork for a PASRR level II should have been completed. During an interview on 02/29/24 at 4:15 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #49 newly added diagnosis of major depressive disorder a PASRR level II should have been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review, staff interviews, and observations the facility failed to revise a smoking care plan for Resident #75, resolve inactive care plans for Resident #51 and schedule quarterly care plan meetings (Resident #83) for 3 of 5 sampled residents. The findings included: 1. Resident #75 was admitted to the facility on [DATE] with hypertension. Review of Resident #75's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively impaired and was independent for most activities of daily living (ADL). Review of Resident #75's quarterly smoking assessments dated 01/27/24 revealed the resident was an unsafe smoker and required to be supervised. Review of Resident #75's care plan revised on 03/29/23 revealed on the resident's care guide that resident smoking status was an independent smoker and may smoke at time of own choice without supervision. A joint interview with the MDS coordinator #1 and MDS coordinator #2 on 02/29/24 at 3:30 PM revealed Resident #75 was an unsafe smoker, and the resident's care plan should have reflected that. An interview conducted with the Director of Nursing (DON) on 02/29/24 at 4:50 PM revealed Resident #75 was an unsafe smoker, and the resident's care guide should have reflected that. The DON further revealed staff review the resident's care guide for care areas. An interview conducted with the Administrator on 02/29/24 at 5:15 PM revealed residents who are considered unsafe smokers should have been care planned as an unsafe smoker. It was further revealed Resident #75's care guide on the care plan should have not stated the resident was a safe smoker. 48684 2. Resident # 51 was admitted to the facility on [DATE] with diagnoses including neurogenic bladder and a chronic autoimmune disorder that affects movement, sensation and bodily function. Review of Resident #51's current care plans initiated 3/4/21 and revised on 4/2/23 revealed a focus area for the resident being at risk for actual infection related to COVID 19 Virus. Will be free of signs and symptoms of infection through next review. Interventions Medications as ordered, treatment as ordered, encourage resident compliance with infection, encourage resident to report signs and symptoms of infection to the nurse, and isolation precautions. A care plan initiated on 3/28/22 and revised 4/2/23 stated at risk for actual infection r/t fungi candida, resident will receive appropriate treatment for infection with resolution through next review. Interventions medications as ordered by physician, and to educate care staff on performing personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51 had a quarterly Minimum Data Set (MDS) assessment completed on 1/17/24. An interview with the MDS Coordinator #1 on 2/29/24 at 3:56 PM revealed that care plans should be reviewed and revised with each MDS assessment and be made inactive when a problem is resolved. MDS Coordinator #1 stated she was not aware that some of the care plans had not been revised in over a year. Stated that the last MDS Nurse left about two months ago had completed Resident #51 quarterly MDS on 1/17/24. MDS Nurse #1 indicated they were still trying to review and update everything. An interview with the Director of Nursing (DON) on 2/29/24 at 4:46 PM revealed that expectations were that care plans were initiated, revised, or completed as the resident condition changed. An interview with the Administrator on 2/26/24 at 5:06 PM revealed she expected all care plans to be updated and revised in a timely manner. Stated that the Corporate MDS Consultant was scheduled to be in the building the following week to help the new MDS staff with training and job duties since they are both relatively new to the position. 48006 3. Resident #83 was admitted to the facility on [DATE] with diagnoses that include dementia, and cerebral vascular accident (CVA). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 had moderate cognitive impairment. Review of Resident 83's medical record revealed the last documented care plan meeting occurred on 11/08/2022. A phone interview was conducted with Resident #83's responsible party (RP) on 02/26/2024 at 1:13 PM. The RP revealed she had not attended a care plan meeting for Resident #83 in a very long time. She further stated that she believed there was no care plan meeting scheduled for Resident #83 for the entire 2023 calendar year. Social Worker (SW) #2 was interviewed 02/29/2024 at 8:37 AM. SW#2 confirmed Resident #83 had not had a care plan meeting since 11/08/2022. She stated she had only been in her position for 3 weeks and was currently working to get the care plan meetings caught up. She further stated that there were several residents who were long overdue for care plan meetings. She also revealed she expected care plan meetings to be scheduled quarterly. She also stated it would be the SW's responsibility to create and maintain the care plan meeting calendar, send out the care plan meeting invitations, and hold the care plan meeting. An interview was completed on 02/29/2024 at 9:06 AM with the Administrator. The Administrator stated that she realized the care plan meeting process was behind schedule and the facility was currently working to ensure care plan meetings were being held.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record review, and staff interviews, the facility failed to follow physician orders for 1 of 4 wounds (non-pressure of left knee) on 1 of 3 residents (Resident #128) reviewed for wound care and failed to administer medications as ordered by the physician for 2 of 16 residents reviewed for medication errors (Residents #28 and #110). The findings included: Resident #128 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included congestive heart failure, Alzheimer's disease, dementia, and osteoarthritis. Review of Resident #128's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was rarely/never understood and rarely/never understands and had no speech. The assessment also revealed she was severely impaired and was dependent on staff for assistance with all activities of daily living (ADL) and anticipation of her needs. The assessment additionally revealed she had two unhealed stage II pressure ulcers and had pressure reducing device for bed, nutrition, and hydration interventions to manage skin problems, pressure injury care, and application of medications and dressings. Review of Resident #128's Treatment Administration Record (TAR) dated 02/01/24 through 02/29/24 revealed the following orders for wound care: 1. Cleanse the left knee with wound cleanser, apply dermasyn hydrogel AG (antimicrobial silver wound gel that facilitates moist wound healing), cover with gauze and dry dressing every day shift (7:00 AM to 7:00 PM) for wound healing. 2. Cleanse the right outer ankle with wound cleanser, apply xeroform (petroleum-based fine mesh gauze that has antimicrobial properties used for wound healing), and cover with dry dressing every day shift (7:00 AM to 7:00 PM) for wound healing. An observation of wound care was made on Resident #128 on 02/28/24 at 9:13 AM with the Treatment Nurse. The Treatment Nurse gathered her supplies for the four wounds and began with the right outer ankle wound. She removed the old dressing, cleaned the wound with wound cleanser-soaked gauze and applied hydrogel AG-soaked gauze and covered it with a bordered gauze dressing. The Treatment Nurse then moved to the left knee, removed the old dressing, cleaned the wound with wound cleanser and applied xeroform gauze to the wound bed and covered it with a bordered gauze dressing. As she was completing the left knee dressing, the Treatment Nurse said, I think I mixed up my dressings. An interview on 02/29/24 at 9:59 PM with the Treatment Nurse revealed she realized while doing the left knee that she had mixed up the treatments on the right outer ankle and left knee and had applied the wrong treatments to the wounds. She stated she was nervous about being watched and had just mixed up the dressings for those two wounds even though she had labeled the treatments for each wound. An interview on 02/29/24 at 11:51 AM with the Director of Nursing (DON) revealed she expected the wound treatments to be done as prescribed by the physician. She stated she thought the Treatment Nurse was nervous about being watched during wound care and just got the two wound treatments mixed up. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	40476 2. Resident #28 was admitted to the facility on [DATE] with a diagnosis of anxiety and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact. The MDS revealed Resident #28 received an antipsychotic medication during the assessment period. The active physician's orders for December 2023 for Resident #28 included an order dated 11/09/23 for Seroquel 25 mg give 1 tablet by mouth two times a day for depression. A Medication Administration Record (MAR) dated December 2023 revealed the Seroquel 25 mg scheduled for 8:00 PM was not documented as given on 12/10/2023. 3. Resident #110 was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #110 was cognitively intact. The active physician's orders for December 2023 for Resident #110 included an order dated 12/04/23 for Amoxicillin 500 mg give 1 tablet by mouth two times a day for a bacterial infection for 10 days. A Medication Administration Record (MAR) dated December 2023 revealed the Amoxicillin 500 mg scheduled for 8:00 PM was not documented as given on 12/10/2023. A facility investigation summary dated 12/12/23 revealed the facility interdisciplinary team was reviewing the Medication Administration Audit report for the previous 48 hours and noted the medication errors and Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110 had not been administered their medication during the 7:00 PM to 11:00 PM shift. An investigation was then initiated, and the Medical Director was notified. The investigation was completed by the Regional Nurse Consultant who identified the cause of the incident was due to a nurse not reporting for the 7:00 PM to 11:00 PM shift. An interview conducted on 02/28/24 at 4:30 PM with the Director of Nursing (DON) revealed on 12/10/23 around 6:30 PM she was told by Unit Manager #1 that Nurse #2 had called out for the 7:00 PM to 11:00 PM shift. She stated Unit Manager #1 told her that Nurse #3, Nurse #4 and Nurse #5 were instructed to split the medication cart and had taken report on the residents. She stated she heard the next morning that some residents had not received their medication. The interview revealed residents including Resident #28 and Resident #110 did not receive any scheduled medication. She stated Nurse #5 told her she had completed her assigned half and thought someone else was going to administer the rest of the residents' medication. The DON stated it was a communication error between the nurses. She stated no adverse outcomes had occurred from the incident and no residents needed medical treatment due to not receiving their medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/29/24 at 11:20 AM an interview was conducted with the Medical Director. During the interview he stated he was notified by the facility that the residents had missed their medication on 12/10/23. The interview revealed he notified the Nurse Practitioner's that were in the facility of the incident and that nurses on the unit were monitoring the residents for any changes of condition. He stated no residents were having symptoms from not receiving their medication. The MD stated although medication such as anticoagulants, opioids, antipsychotics and insulin were significant, it would not be harmful to the residents to miss one dose. The interview revealed none of the residents identified to have missed their medication were sent to the hospital or experienced a change of condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record reviews, resident, and staff interviews, the facility failed to provide showers and hair washing to 1 of 10 residents (Resident #94) and failed to provide incontinence care as trained for 1 of 10 residents (Resident #51). These failures occurred for 2 of 10 residents reviewed for activities of daily living (ADL). The findings included: 1. Resident #94 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type II, vitamin deficiency, dementia, and anorexia. Review of Resident #94's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired and required total assistance with showering and bathing. The assessment also revealed Resident #94 had no rejection of care behaviors. Review of Resident #94's care plan revealed a focus area for activities of daily living/personal care deficit related to dementia. The interventions included personal hygiene with substantial/maximal assistance and showering/bathing dependent on staff. An observation and interview with Resident #94 on 02/26/24 at 11:42 AM revealed the resident sitting in her wheelchair in her room, dressed for the day. The resident's hair appeared greasy and disheveled and she stated she was not getting her showers as scheduled two times per week. Resident #94 further stated she preferred showers because she liked to get her hair washed when she was bathed. Review of the shower schedule for the hall on which the resident resided revealed Resident #94 was scheduled for showers on Tuesday and Friday on 1st shift (7:00 AM to 3:00 PM). Review of the documentation of showers in the electronic medical record for Resident #94 revealed for the month of February she had only received one shower on 02/27/24. On the other days she was scheduled for showers the following was documented: Tuesday 02/06/24 no indication or documentation Tuesday, 02/13/24 no indication or documentation Tuesday, 02/20/24 no shower or bed bath given Friday, 02/23/24 partial bed bath (not a complete bed bath) A telephone interview on 02/29/24 at 10:46 AM with NA #8 who was assigned to care for Resident #94 on 02/06/24 and 02/13/24 stated if she were assigned to a resident and did not have time to give them a shower, she would wash them up in bed and document it as a partial bath but said it was not a complete bed bath. NA #8 stated she could not recall why she had not given Resident #94 a shower on 02/06/24 or 02/13/24 but said it was most likely due to staffing issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/28/24 at 10:34 AM with NA #12 who was assigned to care for Resident #94 on 02/09/24 revealed if she was assigned to the resident and had given her a complete bed bath instead of a shower it was due to not having time to shower the resident. She stated they were short of help sometimes and it was less time-consuming to give residents a bed bath than shower. An interview on 02/29/24 at 1:45 PM with NA #7 who was assigned to care for Resident #94 on 02/23/24 revealed she could not recall why she had not given the resident a shower as scheduled. She stated there were days they worked short of help and that could have been one of those days when she did not have time to give the resident a shower and just bathed her in bed and documented it as a partial bath. NA #7 further stated when she showered residents, she tried to cut their nails and shave them as needed but did not always have time to do so due to staffing issues. An interview on 02/29/24 at 3:10 PM with Unit Manager #1 revealed she was not aware Resident #94 was not receiving her showers as scheduled and said no one had reported it to her. She stated the normal process for showers was if the resident refused their shower the NA had to go back again a little later and ask the resident if she/he was ready to take their shower and if the answer was no again, the NA was to report that to the nurse. Unit Manager #1 further stated that the nurse was to ask the resident and if the resident refused the nurse, she was supposed to write a progress note indicating the resident had refused her/his shower despite being asked three times. She indicated if the NAs were having difficulty completing their showers, they should have reported that to her so she could have provided them with additional staff to assist with showers. An interview on 02/29/24 at 4:53 PM with the Director of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said it was a process they were currently working on with the NAs. She stated she expected residents to have their showers as scheduled and said if they did not receive their showers, she expected them to receive a complete bed bath not a partial bed bath and for it to be documented. The DON further stated if the resident refused their shower, she expected the nurse to document the refusal in their progress notes. 48684 2. Resident # 51 was admitted to the facility on [DATE] with diagnoses including neurogenic bladder and a chronic autoimmune disorder that affects movement, sensation and bodily functions. Resident #51's care plan initiated 1/17/24 revealed a focus area for the resident having an activities of daily living (ADL) self-care deficit due to [chronic autoimmune disorder that affects movement, sensation and bodily functions] and neurogenic bladder. The interventions included assisting with activities of daily living (ADL), dressing, grooming, toileting, promote independence and dignity, and provide positive reinforcement for all activities. Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed total dependence for toilet and bathing. Impaired range of motion was noted to bilateral lower extremities. The resident was coded as always incontinent of bowel and for the presence of a supra pubic catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 02/28/24 at 1:40 PM of Resident #51 receiving incontinence care from NA #1. While providing incontinence care NA #1 was observed wiping the resident starting under the scrotum and wiping up towards his penis with wash cloth that had soap and water on it. NA#1 continued wiping several more times from under the scrotum up towards the resident's abdomen while using the same surface of the washcloth. When the resident turned on his side there was visible bowel movement on his left and right buttocks and anal area. NA #1 continued with the same washcloth and continued to wipe with downward motion and was observed wiping bowel movement from anal area towards the scrotum. The NA folded the washcloth to change surfaces when cleaning the resident. This process continued until all bowel movement was removed from the resident's skin. Interview on 02/28/24 at 1:50 PM with NA #1 revealed he believed he had done a good job providing incontinence care on Resident #51 and did not realize he had been wiping from lower perineal region to upper perineal area. Stated he was nervous and must not have been thinking. NA #1 stated that he should have started at the penis and wiped down toward the anal area, and from the anal area to the upper buttocks. NA #1 further stated he should have started on the upper perineal area and wiped down towards the scrotal area, and from the anal area to the upper buttocks. NA #1 stated he had been trained in how to provide incontinence care. Interview on 02/29/24 at 4:46 PM with the Director of Nursing (DON) revealed she would expect nursing staff to follow the care plans and facility policies. The DON stated that all employees have been trained in incontinence care and the appropriate process was to always be followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review, facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 4 of 5 residents reviewed for activities (Resident #17, 31, 35, and 110). The residents expressed not being able to leave the facility for over a year made them feel more dependent, less social, sad, and they missed getting out with the group to shop and socialize. The findings included: A review of the February 2024 activity calendar revealed activities for inside of the facility during the week and on the weekends. There were no activities scheduled for outside of the facility. Review of resident council minutes from February 2023 through February 2024 revealed grievances for scheduled group activities outside of facility were discussed each month during meetings and the response given from the previous Administrator was one of the facility vans was broken and unable to provide transportation for residents and the other facility van was only available for short distances to resident medical appointments. Observation on 02/26/24 at 9:30 AM revealed the facility was located within a business and residential complex that contained sidewalks, pedestrian crosswalks and was within walking distance to numerous local and commercial shops, grocery stores, local and commercial coffee shops, fast food, and sit-down restaurants. a. Resident #17 was admitted to the facility on [DATE]. An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #17 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #17 was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Actual harm Residents Affected - Some	An interview as conducted with Resident #17 on 2/28/24 at 2:00 PM during resident council meeting revealed there had not been a scheduled group activity outside of the facility in over a year and the resident council had requested one each month, made grievances, and met with the previous administrator about it and each time was told there was nothing they could do because the van was broken, and they had no other way to transport residents. She stated in her opinion group activities outside of the facility were important to the residents that were able to go and participate because it allowed them some lasting independence, socialization with the group and outside world, and helped with their mental and physical health, it made them feel normal and that they weren't just stuck in a facility. Resident #17 stated not being able to leave the facility in a year and participate in group activities outside the facility had sometimes made her feel as though she had lost some of her own independence and was having to rely on someone else to do her personal shopping instead of on her own. She revealed personally being able to do her own shopping and socializing with other people outside of the facility was very important to her. Resident #17 asked surveyor at the end of resident council meeting if she promised to share their concerns with administration about not being able to schedule activities outside of the facility over the past year and how important this matter was to all of them. b. Resident #31 was admitted to the facility on [DATE]. An Admission Minimum Data Set (MDS) dated [DATE] indicated Resident #31 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #31 was cognitively intact. An interview was conducted with Resident #31 on 2/28/24 at 2:00 PM during resident council meeting revealed he had been told for the past year that they were not allowed to schedule any group activities outside of the facility because they did not have resident transportation due to the van being broken. He stated he asked about alternate transportation that the residents could pay for if they wanted to and was also told no due to insurance reasons. He also stated that for the past year they have not been able to leave the facility for any outings other than to a doctor's appointment and after a while they get tired of looking at the inside of the facility. Resident #31 began shaking his head and looking down towards the floor and revealed that going out to eat at a restaurant and talking with the group or going into a store and being able to shop for your own personal belongings made you feel independent and normal, and he felt that not being able to do those things over the past year had made him less independent and more reliant on staff and not as social as he used to be and he would just like the opportunity to have those things again. c. Resident #35 was admitted to the facility on [DATE]. An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #35 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #35 was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Actual harm Residents Affected - Some	An interview was conducted with Resident #35 on 2/28/24 at 2:00 PM during resident council meeting revealed she knew for a fact that resident council had made numerous grievances to the Administrator about not being able to schedule group activities outside of the facility and each time was told that was not possible because the van was broken, and they had no way to transport residents. She revealed they were also told they would have to continue with activities inside of the building or on the grounds of the facility and there was never any discussion of finding a different way to help with transportation. Resident #35 stated being able to go outside of the facility for group activities was important to her because she enjoyed interaction with her friends, and it helped with her mental health and allowed her some independence. She revealed not being able to have group activities outside of the facility had made her sad at times and miss what the world outside the facility was like. d. Resident #110 was admitted to the facility on [DATE]. An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #110 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #110 was cognitively intact. An interview was conducted with Resident #110 on 2/28/24 at 2:00 PM during resident council meeting revealed she along with the other residents in the meeting had been asking to schedule group activities outside of the facility for the past year at least and were always told by the previous Administrator the van was broken and they had no other way to transport residents. Resident #110 revealed being at the facility day in and day out sometimes made her feel sad and like she was always reliant on staff for her needs, but being able to get out of the facility and go out into the community for group activities allowed her to be more independent, socialize with her friends and the community in a different setting and gave her a break from being inside the building all the time and made her feel good. An interview was conducted with the Activity Director (AD) on 02/28/24 at 2:30 PM revealed she had been working as the AD at the facility for the past 2 years and part of her responsibilities was scheduling and implementing resident activities inside and outside of the facility for each month. She stated prior to this past year, she would schedule monthly outings for the residents to attend outside of the facility such as going to eat at a restaurant, shopping, or the movies, but for the past year she had not been able to schedule any resident group activities outside of the facility due to transportation issues. She revealed one of the facility vans had been broken for over a year and she was told by the previous administrator the other facility van could only be used for medical appointments and residents would just have to participate in activities inside of the facility or on facility grounds. The AD stated she had brought the issue to Administration monthly of the residents requesting to schedule activities outside of the facility and each time was told no due to the transportation and alternate transportation for the residents was never discussed. She revealed she had been doing personal shopping for residents so they could continue to receive their preferences but understood that was not the same as the residents being able to leave the facility and shop for themselves or eat a meal together at a restaurant or watch a movie outside of the facility. She stated she felt like activities outside of the facility for those residents who could participate were important for their overall mental and physical well- being and allowed them some independence. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Actual harm Residents Affected - Some	During an interview conducted with the Administrator on 02/29/24 at 5:15 PM she revealed this was her first week of work at the facility and she was unaware of the facility vans needing repair and residents not having been to participate in activities outside of the facility over the past year. She stated she would investigate the issue and see what alternative transportation methods were available that could be used to assist with the residents being able to participate in activities outside of the facility until the situation with the vans could be resolved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record review, and staff interviews, the facility failed to follow physician orders for 1 of 4 wounds (pressure ulcer of right outer ankle) on 1 of 3 residents (Resident #128) reviewed for wound care. The findings included: Resident #128 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included congestive heart failure, Alzheimer's disease, dementia, and osteoarthritis. Review of Resident #128's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was rarely/never understood and rarely/never understands and had no speech. The assessment also revealed she was severely impaired and was dependent on staff for assistance with all activities of daily living (ADL) and anticipation of her needs. The assessment additionally revealed she had two unhealed stage II pressure ulcers and had pressure reducing device for bed, nutrition, and hydration interventions to manage skin problems, pressure injury care, and application of medications and dressings. Review of Resident #128's Treatment Administration Record (TAR) dated 02/01/24 through 02/29/24 revealed the following orders for wound care: 1. Cleanse the right outer ankle with wound cleanser, apply xeroform (petroleum-based fine mesh gauze that has antimicrobial properties used for wound healing), and cover with dry dressing every day shift (7:00 AM to 7:00 PM) for wound healing. 2. Cleanse the left knee with wound cleanser, apply dermasyn hydrogel AG (antimicrobial silver wound gel that facilitates moist wound healing), cover with gauze and dry dressing every day shift (7:00 AM to 7:00 PM) for wound healing. An observation of wound care was made on Resident #128 on 02/28/24 at 9:13 AM with the Treatment Nurse. The Treatment Nurse gathered her supplies for the four wounds and began with the right outer ankle wound. She removed the old dressing, cleaned the wound with wound cleanser-soaked gauze and applied hydrogel AG-soaked gauze and covered it with a bordered gauze dressing. The Treatment Nurse then moved to the left knee, removed the old dressing, cleaned the wound with wound cleanser and applied xeroform gauze to the wound bed and covered it with a bordered gauze dressing. As she was completing the left knee dressing, the Treatment Nurse said, I think I mixed up my dressings. An interview on 02/29/24 at 9:59 PM with the Treatment Nurse revealed she realized while doing the left knee that she had mixed up the treatments on the right outer ankle and left knee and had applied the wrong treatments to the wounds. She stated she was nervous about being watched and had just mixed up the dressings for those two wounds even though she had labeled the treatments for each wound. An interview on 02/29/24 at 11:51 AM with the Director of Nursing (DON) revealed she expected the wound treatments to be done as prescribed by the physician. She stated she thought the Treatment Nurse was nervous about being watched during wound care and just got the two wound treatments mixed up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review and staff interviews the facility failed to complete a quarterly smoking assessment 1 of 3 residents reviewd for smoking (Resident #75). The findings included: Resident #75 was admitted to the facility on [DATE] with hypertension. Review of Resident #75s quarterly Minimum Dat set (MDS) dated [DATE] revealed the resident was cognitively impaired and was independent for most activities of daily living (ADL). Review of Resident #75's care plan revised on 03/29/24 revealed the resident had problematic manner in which the resident acts characterized by use of tobacco. The goal was for resident #75 to smoke safely in designated areas with supervision through the next review. Interventions included to evaluate residents ' ability to smoke safely on a consistent and regular basis. Review of Resident #75's quarterly smoking assessments revealed the resident did not receive a quarterly smoking assessment from 09/27/23 until 01/27/24. A joint interview was conducted with the MDS coordinator #1 and MDS coordinator #2 on 02/29/24 at 3:30 PM revealed Resident #75 was an unsafe smoker, and an assessment should have been completed quarterly. It was further revealed Resident #75 did not receive a quarterly smoking assessment from 09/27/23 until 01/27/24 and could not recall why it was not updated in the quarterly time frame. An interview conducted with the Director of Nursing (DON) on 02/29/24 at 4:50 PM revealed Resident #75 should have had a quarterly smoking assessment completed due to being an unsafe smoker. It was further revealed by the DON she was not aware Resident #75 had a late completed assessment and it should have been completed prior to 01/27/24. An interview conducted with the Administrator on 02/29/24 at 5:15 PM revealed residents who are considered unsafe smokers should have a smoking assessment completed quarterly. The Administrator stated she expected assessments to be completed in a timely manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48684 Based on observations, record review, resident and staff interviews, the facility failed to provide sufficient nursing staff to ensure resident were administered medications per the physician orders for 8 of 16 residents reviewed for significant medication errors (Residents #7, #28, #47, #51, #73, #79, #88, and #110) and provide assistance with showers and hair washing for 1 of 10 residents reviewed for assistance with activities of daily living (Resident #94). The findings included: 1a. Resident #7 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was severely cognitively impaired. Resident #7 was coded as received insulin 7 times during the assessment period. The active physician's orders for December 2023 for Resident #7 included an order dated 08/07/23 for Insulin Detemir solution 100 units per milliliter (ml), inject 13 units at bedtime for diabetes and an order dated 11/06/2023 for Novolog flex pen solution pen- injector 100 units/ml sliding scale insulin four times a day for diabetes. A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Detemir Solution 13 units, scheduled for 8:00 PM, was not documented as given on 12/10/2023 and the Novolog flex pen sliding scale insulin scheduled for 8:30 PM was not documented as given on 12/10/2023. b. Resident #28 was admitted to the facility on [DATE] with a diagnosis of hypertension, anxiety, diabetes mellitus and heart failure. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact. Resident #28 was noted to have received insulin 5 times during the assessment period. The MDS revealed Resident #28 received an antipsychotic medication during the assessment period. The active physician's orders for December 2023 for Resident #28 included an order dated 11/10/23 for Lantus Solostar pen-injector 100 units/ml, inject 10 units at bedtime for diabetes, an order dated 11/09/2023 for Carvedilol oral tablet 6.25 mg 1 tablet by mouth two times a day for heart failure and an order dated 11/09/23 for Seroquel 25 mg give 1 tablet by mouth two times a day for depression. A Medication Administration Record (MAR) dated December 2023 revealed the Lantus Solostar pen-injector 100 units/ml 10 units, Carvedilol oral tablet 6.25 mg and Seroquel 25 mg scheduled for 8:00 PM, were not documented as given on 12/10/2023. c. Resident #47 was admitted to the facility on [DATE] with a diagnosis of depression and schizophrenia and anxiety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was severely cognitively impaired. Resident #47 was coded as receiving antipsychotic medication, antianxiety medication, antidepressant medication and opioids. The active physician's orders for December 2023 for Resident #47 included an order dated 02/19/22 for Seroquel 200 mg give 1 tablet by mouth at bedtime for mood, an order dated 03/10/22 for Lorazepam 1 mg by mouth two times a day for agitation, an order dated 08/25/22 for Trazodone 125 mg by mouth at bedtime for insomnia and an order dated 04/07/23 for Percocet oral tablet 10-325mg give 1 tablet by mouth three times a day for severe pain. A Medication Administration Record (MAR) dated December 2023 revealed the Seroquel 200 mg, Trazodone 125 mg, Lorazepam 1 mg and Percocet oral tablet 10-325mg scheduled for 8:00 PM were not documented as given on 12/10/2023. d. Resident #51 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus and atrial fibrillation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was moderately cognitively impaired. Resident #51 was coded as receiving insulin on 7 days during the assessment period. The MDS revealed Resident #51 had received an anticoagulant during the assessment period. The active physician's orders for December 2023 for Resident #51 included an order dated 11/15/22 Insulin Glargine solution 100 units/ml inject 12 units at bedtime for diabetes, an order dated 11/15/22 for Eliquis tablet 5 mg by mouth two times a day for anticoagulant therapy and an order dated 7/16/23 for Metformin 500 mg 1 tablet by mouth two times a day for diabetes. A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Glargine solution 100 units/ml 12 units, Eliquis tablet 5 mg and Metformin 500 mg scheduled for 9:00 PM were not documented as given on 12/10/2023. e. Resident #73 was admitted to the facility on [DATE] with a diagnosis of depression. An annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 was cognitively intact. Resident #73 was coded as received an antidepressant during the assessment period. The active physician's orders for December 2023 for Resident #73 included an order dated 06/20/23 for Trazodone 50 mg 1 tablet by mouth at bedtime for insomnia. A Medication Administration Record (MAR) dated December 2023 revealed the Trazodone 50 mg scheduled for 8:00 PM was not documented as given on 12/10/2023. f. Resident #79 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 was moderately cognitively impaired. Resident #79 was coded as received insulin on 7 days during the assessment period. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The active physician's orders for December 2023 for Resident #79 included an order dated 11/14/23 for Insulin Glargine solution 100 units/ml inject 2 units at bedtime for diabetes. A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Glargine solution 100 unit/ml 2 units scheduled for 9:00 PM was not documented as given on 12/10/2023. g. Resident #88 was admitted to the facility on [DATE] with a diagnosis of hypertension, heart failure and coronary artery disease (CAD). A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was severely cognitively impaired. The active physician's orders for December 2023 for Resident #88 included an order dated 03/31/22 for Metoprolol Tartrate 25 mg give 0.5 tablet by mouth two times a day for heart failure. A Medication Administration Record (MAR) dated December 2023 revealed the Metoprolol Tartrate 12.5 mg scheduled for 9:00 PM was not documented as given on 12/10/2023. h. Resident #110 was admitted to the facility on [DATE] with a diagnosis of hypertension and atrial fibrillation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #110 was cognitively intact. The active physician's orders for December 2023 for Resident #110 included an order dated 1/10/23 for Carvedilol 3.125mg 1 tablet by mouth two times a day for hypertension and an order dated 12/04/23 for Amoxicillin 500 mg give 1 tablet by mouth two times a day for a bacterial infection for 10 days. A Medication Administration Record (MAR) dated December 2023 revealed the Amoxicillin 500 mg and Carvedilol 3.125 mg scheduled for 8:00 PM were not documented as given on 12/10/2023. An interview was conducted on 02/28/24 at 4:00 PM with Nurse #1. She stated on 12/10/23 she was working the 7:00 AM to 7:00 PM shift assigned to Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88, and Resident #110. The interview revealed Nurse #2 had contacted her after 12:00 PM stating she would not be coming into work for the 7:00 PM to 11:00 PM shift to take over the resident assignment. She stated she told Nurse #2 she would need to contact management and let them know. The interview revealed she then told Unit Manager #1 that she did not think Nurse #2 would be coming into the facility for her assigned shift. She stated report on the residents was given to Nurse #3, Nurse #4 and Nurse #5 who were told by the Unit Manager #1 to split the medication cart. The interview revealed she had offered to stay over to cover the shift from 7:00 PM to 11:00 PM but was told it was necessary by the scheduler. She stated she left the facility at 7:00 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted on 02/28/24 at 3:36 PM with Unit Manager #1 revealed on 12/10/23 she was notified later in the day by Nurse #1 that Nurse #2 was not going to come in for the scheduled 7:00 PM to 11:00 PM shift. She stated she called the scheduler who no longer works in the facility and Director of Nursing (DON) to let them know they were going to be a nurse short. The interview revealed the scheduler could not get in touch with Nurse #2 so Unit Manger #1 then notified Nurse #3, Nurse #4 and Nurse #5 they would need to split the medication cart for the 7:00 PM to 11:00 PM shift. She stated Nurse #4 told her she needed to get some food and would look at the medication cart when she returned, and Nurse #5 stated the medication cart had too many residents to split. She stated she then left the facility at 7:00 PM and did not know until 12/12/23 that the residents had never received their scheduled medication on the evening of 12/10/23. An interview was attempted with Nurse #2 on 02/28/24 and on 02/29/24 with no return phone call received. An interview was attempted with Nurse #3, Nurse #4 and Nurse #5 on 02/29/24 with no return phone call received. An interview conducted on 02/28/24 at 4:30 PM with the Director of Nursing (DON) revealed on 12/10/23 around 6:30 PM she was told by Unit Manager #1 that Nurse #2 had called out for the 7:00 PM to 11:00 PM shift. She stated Unit Manager #1 told her that Nurse #3, Nurse #4 and Nurse #5 were instructed to split the medication cart and had taken report on the residents. She stated she heard the next morning that some residents had not received their medication. The interview revealed that Nurse #5 had given half of the assigned residents their medication, but the other 8 residents Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110 did not receive any scheduled medication. She stated Nurse #5 told her she had completed her assigned half and thought someone else was going to administer the rest of the residents' medication. The DON stated it was a communication error between the nurses. The interview revealed the residents' vital signs were obtained on 12/11/23 along with blood glucose levels for the diabetic residents. She stated no adverse outcomes had occurred from the incident and no residents needed medical treatment due to not receiving their medication. 2. Resident #94 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type II, vitamin deficiency, dementia, and anorexia. Review of Resident #94's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired and required total assistance with showering and bathing. The assessment also revealed Resident #94 had no rejection of care behaviors. Review of Resident #94's care plan revealed a focus area for activities of daily living/personal care deficit related to dementia. The interventions included personal hygiene with substantial/maximal assistance and showering/bathing dependent on staff. An observation and interview with Resident #94 on 02/26/24 at 11:42 AM revealed the resident sitting in her wheelchair in her room, dressed for the day. The resident's hair appeared greasy and disheveled, and she stated she was not getting her showers as scheduled two times per week. Resident #94 further stated she preferred showers because she liked to get her hair washed when she was bathed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower schedule for the hall on which the resident resided revealed Resident #94 was scheduled for showers on Tuesday and Friday on 1st shift (7:00 AM to 3:00 PM). Review of the documentation of showers in the electronic medical record for Resident #94 revealed for the month of February she had only received one shower on 02/27/24. On the other days she was scheduled for showers the following was documented: Tuesday 02/06/24 no indication or documentation Tuesday, 02/13/24 no indication or documentation Tuesday, 02/20/24 no shower or bed bath given Friday, 02/23/24 partial bed bath (not a complete bed bath) A telephone interview on 02/29/24 at 10:46 AM with Nurse Aide (NA) #8 who was assigned to care for Resident #94 on 02/06/24 and 02/13/24 stated if she were assigned to a resident and did not have time to give them a shower, she would wash them up in bed and document it as a partial bath but said it was not a complete bed bath. NA #8 stated she could not recall why she had not given Resident #94 a shower on 02/06/24 or 02/13/24 but said it was most likely due to staffing issues. An interview on 02/28/24 at 10:34 AM with NA #12 who was assigned to care for Resident #94 on 02/09/24 revealed if she was assigned to the resident and had given her a complete bed bath instead of a shower it was due to not having time to shower the resident. She stated they were short of help sometimes and it was less time-consuming to give residents a bed bath than shower. An interview on 02/29/24 at 1:45 PM with NA #7 who was assigned to care for Resident #94 on 02/23/24 revealed she could not recall why she had not given the resident a shower as scheduled. She stated there were days they worked short of help and that could have been one of those days when she did not have time to give the resident a shower and just bathed her in bed and documented it as a partial bath. NA #7 further stated when she showered residents, she tried to cut their nails and shave them as needed but did not always have time to do so due to staffing issues. An interview on 02/29/24 at 3:10 PM with Unit Manager #1 revealed she was not aware Resident #94 was not receiving her showers as scheduled and said no one had reported it to her. She indicated if the NAs were having difficulty completing their showers, they should have reported that to her so she could have provided them with additional staff to assist with showers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 2/29/23 at 12:30 PM with the Nursing Scheduler who has been in her position for the last two months. The Scheduler revealed that all call ins by nursing staff go to the Director of Nursing (DON) who then tells her what needs to be filled. The Nursing Scheduler stated she filled out the schedules in advance, so staff can pick up extra hours and staff were good about picking open shifts. She explained the problem was the call ins and trying to find someone to fill the opening. The scheduler further stated she was not on call and worked Monday through Friday 8:00 AM to 5:00 PM so after hours and on the weekends, it falls on nurse management to fill open positions. The scheduler stated she was not aware of a situation where there was not a nurse for a cart when other nurses did not step up and take care of the cart. The Nursing Scheduler indicated the following were the staffing levels she was expected to maintain. The Scheduler went on to say that it was hard to keep those levels of staffing in the building, but she tried hard to get positions filled so staff were not short, but that it happens at times and there is nothing that can be done about it. 1. 7:00 AM-3:00 PM shift 10-12 Nurse Aides (NAs) and 3 NAs on memory care. 2. 7:00 AM-3:00 PM shift 6 Nurses and 2 nurses on memory care. 3. 3:00 PM-11:00 PM shift 10-12 NAs and 2-3 NAs on memory care 4. 3:00 PM-11:00 PM shift 5 Nurses and 2 nurses on memory care 5. Memory care works 7:00 AM - 7:00 PM so this covers the third shift. 6. 11:00 PM -7:00 AM shift 9-10 NAs and 2-3 on memory care Interview on 02/29/24 at 4:46 PM with the Director of Nursing (DON) revealed she would expect nursing staff to communicate in a timely manner when they are not going to report to work so that the facility has time to try and fill the open position. They have been posting open positions on their website and have recently started using a staffing agency to assist with staffing levels. An interview on 02/29/24 at 4:53 PM with the Director of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said it was a process they were currently working on with the NAs. She stated she expected residents to have their showers as scheduled and said if they did not receive their showers, she expected them to receive a complete bed bath not a partial bed bath and for it to be documented. The DON further stated if the resident refused their shower, she expected the nurse to document the refusal in their progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 Based on record reviews, family member and staff interviews, the facility failed to provide effective orientation to a new nurse when Nurse #8 failed to supervise Nurse #9 during medication administration resulting in a resident receiving the wrong medications. This deficient practice affected 1 of 1 resident reviewed for medication administration. (Resident #83). The findings included: Resident #83 was admitted to the facility on [DATE] with diagnoses including cerebral vascular accident (CVA), high blood pressure, dementia, and diabetes mellitus (DM). Review of the December 2023 physician orders for Resident #83 revealed the following medications: -Sertraline (antidepressant) 150 milligrams (mg) 1 tablet by mouth one time a day for depression. -Vimpat Oral Solution (anti-seizure) 250mg by mouth two times a day for seizures. -Divalproex Sodium (anti-seizure) delayed release 250 mg 3 tablets by mouth twice a day for neurological disorder. -Xarelto (anticoagulant) 20 mg 1 tablet by mouth one time a day for deep vein thrombosis prevention. -Amlodipine Besylate 10 mg 1 tablet by mouth daily for high blood pressure. Resident #30 was admitted to the facility on [DATE]. A review of the physician orders dated December 2023 revealed Resident #30 had orders for: -Diltiazem (cardiac medication) 120mg extended release 1 capsule by mouth one time a day for atrial fibrillation. -Citalopram Hydrobromide 10 mg one tablet by mouth daily for depression. -Lasix (diuretic/fluid pill) 20 mg by mouth one time day for fluid. -Seroquel (antipsychotic) 25 mg by mouth three times a day for schizoaffective disorder -Ativan (anti-anxiety) 0.5 mg by mouth twice a day for anxiety. Review of an incident report dated 12/27/2023 at 1:30 PM written by Nurse #8 revealed Resident #83 had received Resident #30's medications which included: Lasix 20 mg, Ativan 0.5 mg, Seroquel 25 mg, Celexa 10 mg, and Diltiazem 120 mg. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 02/26/2024 at 13:20 PM with Resident #83's RP. The RP stated the facility reported to her that a medication error had occurred. She further stated that a new nurse who was still being oriented gave Resident #83's the wrong medications. She also stated that the nurse in training should not have been allowed to administer medications without another staff member being present. Multiple unsuccessful attempts were made to contact Nurse #8, and Nurse #9 (nurse in training) for interview. An interview was conducted on 02/28/2024 at 11:40 AM with the Director of Nursing (DON). The DON revealed that during a medication pass, Resident #83 was given the incorrect medications. Nurse #9 was being oriented by Nurse #8. Nurse #8 was standing at the medication cart and Nurse #9 went into the room to administer the medications. Nurse #9 got confused about the room numbers and got bed A and bed B mixed up. Nurse #8 went into the room when she saw Nurse #9 at Resident #83's bedside. Nurse #9 had already given Resident #30's medications to Resident #83. The DON also stated Nurse #8 and Nurse #9 were no longer employed by the facility. She further stated Nurse #8 should have stayed with Nurse #9 throughout the entire medication pass especially when actually administering the medications at the bedside. She stated nursing staff should have provided the correct medication to the correct resident. The DON also revealed Nurse #8 and Nurse #9 completed the facility nursing orientation which included a review of the Six Rights of Medication Administration (a method used during medication administration to safeguard residents before giving the medications).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 Based on record reviews, and family member, staff, and Medical Director interviews, the facility failed to prevent significant medication errors when Nurse #9 administered medications to Resident #83 prescribed for Resident #30 which included Lasix (fluid pill), Ativan (a medication used to treat anxiety, Seroquel (an antipsychotic), Celexa (an antidepressant), and Diltiazem (used to treat cardiac disorders). The facility also failed to prevent significant medication errors when medications were not administered as ordered by the physician. This deficient practice affected 9 of 16 residents reviewed for significant medication errors (Resident # 83, #7, #28, #47, #51, #73, #79, #88, and #110.) . The findings: 1. Resident #83 was admitted to the facility on [DATE] with diagnoses including cerebral vascular accident (CVA), high blood pressure, dementia, and diabetes mellitus (DM). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 had moderate cognitive impairment. The MDS revealed Resident #83 was not receiving diuretics, anti-anxiety, or anti-psychotics. Review of the December 2023 physician orders for Resident #83 revealed the following medications: -Sertraline (antidepressant) 150 milligrams (mg) 1 tablet by mouth one time a day for depression. -Vimpat Oral Solution (anti-seizure) 250 mg by mouth two times a day for seizures. -Divalproex Sodium (anti-seizure) delayed release 250 mg 3 tablets by mouth twice a day for neurological disorder. -Xarelto (anticoagulant) 20 mg 1 tablet by mouth one time a day for deep vein thrombosis prevention. -Amlodipine Besylate 10 mg 1 tablet by mouth daily for high blood pressure. Resident #30 was admitted to the facility on [DATE]. A review of the physician orders dated December 2023 revealed Resident #30 had orders for: -Diltiazem (cardiac medication) 120 mg extended release 1 capsule by mouth one time a day for atrial fibrillation. -Citalopram Hydrobromide 10 mg one tablet by mouth daily for depression. -Lasix (diuretic/fluid pill) 20 mg by mouth one time day for fluid. -Seroquel (antipsychotic) 25 mg by mouth three times a day for schizoaffective disorder (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ativan (anti-anxiety) 0.5 mg by mouth twice a day for anxiety. An incident report dated 12/27/2023 written by Nurse #8 revealed Resident #83 had received Resident #30's medication which included: Lasix 20 mg, Ativan 0.5 mg, Seroquel 25 mg, Celexa 10 mg, and Diltiazem 120 mg at 10:00 AM in addition to her own morning medications. The incident was reported to the on-call provider at 1:20 PM after Nurse #8 realized Resident #83 had been given Resident #30's medications. Resident #83 was noted to be in no acute distress and at her baseline. Resident #83's responsible party (RP) was notified of the medication errors on 12/27/2023 at 1:35 PM. Resident #83's documented vital signs dated 12/27/2023 at 1:35 PM revealed the following: blood pressure123/74 (normal range systolic (top number) less than 120 and diastolic (bottom number) less than 80), temperature 97.2 (normal range 97 to 99), pulse 55 beats per minute (normal range 60-100), respirations 14 breaths per minute (normal range 12-20), oxygen saturation 94% (normal range 92% or greater) on room air. Review of the Nurse Practitioner (NP) acute visit note dated 12/27/2023 revealed Resident #83 was being seen due to a medication error. Resident #83 received Lasix, Ativan, Seroquel, Celexa, and Diltiazem in error. The NP visit note further revealed Resident #83 appeared at her baseline with stable vital signs and was awake and alert and offered no complaints. The NP's note also indicated Resident #83 was in no acute distress and no adverse reactions were noted. The provider ordered vital signs to be checked every shift for 24 hours and to closely monitor Resident #83 for low blood pressure and sedation. An interview was conducted on 02/26/2024 at 13:20 PM with Resident #83's RP. The RP stated the facility reported to her that a medication error had occurred. She further stated that a new nurse who was still being oriented gave Resident #83's the wrong medications. She also stated that the nurse in training should not have been allowed to administer medications without another staff member being present. She also indicated the facility contacted the pharmacy and Resident #83's doctor. Multiple unsuccessful attempts were made to contact Nurse #8 and Nurse #9 (the nurse in training). An interview was conducted on 03/05/2024 at 9:03 AM. The pharmacist stated there was no medication error report on file for Resident #83 for 12/27/2023. She further stated the concern with the Amlodipine and the Diltiazem would be for hypotension. She also stated hypotension would develop on the day of administration due to the short half-life of the drugs. An interview was conducted on 03/05/2024 at 09:36 with the Nurse Practitioner (NP) who evaluated Resident #83. The NP stated she was notified of the medication errors the morning of 12/27/2023 and she does not remember exactly what time she evaluated Resident #83, but she stated it was before 12:00 PM. She also indicated she was most concerned with the cardiac medications: Amlodipine and the Diltiazem and the potential for hypotension. She further added Resident #83 was stable during her evaluation and that she asked the nursing staff to monitor Resident #83 and notify her if the resident became hypotensive or had any other clinical concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 02/28/2024 at 11:40 AM with the Director of Nursing (DON). The DON revealed that during a medication pass, Resident #83 was given the incorrect medications. Nurse #9 (nurse in training) was being oriented by Nurse #8. Nurse #8 was standing at the medication cart and Nurse #9 went into the room to administer the medications. Nurse #9 got confused about the room numbers and got bed A and bed B mixed up. Nurse #8 went into the room when she saw Nurse #9 at Resident #83's bedside. Nurse #9 had already given Resident #30's medications to Resident #83. The DON also stated Nurse #8 and Nurse #9 were no longer employed by the facility. The DON further revealed Nurse #8 had immediately notified the physician, assessed the resident, and notified the RP following the incident. The DON stated the staff did everything they should have after the incident occurred. She further stated Nurse #8 should have stayed with the nurse in training throughout the entire medication pass especially when actually administering the medications at the bedside. She stated nursing staff should have provided the correct medication to the correct resident. 40476 2a. Resident #7 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was severely cognitively impaired. Resident #7 was coded as received insulin 7 times during the assessment period. The active physician's orders for December 2023 for Resident #7 included an order dated 08/07/23 for Insulin Detemir solution 100 units per milliliter (ml), inject 13 units at bedtime for diabetes and an order dated 11/06/2023 for Novolog flex pen solution pen- injector 100 units/ml sliding scale insulin four times a day for diabetes. A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Detemir Solution 13 units, scheduled for 8:00 PM, was not documented as given on 12/10/2023 and the Novolog flex pen sliding scale insulin scheduled for 8:30 PM was not documented as given on 12/10/2023. b. Resident #28 was admitted to the facility on [DATE] with a diagnosis of hypertension, anxiety, diabetes mellitus and heart failure. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact. Resident #28 was noted to have received insulin 5 times during the assessment period. The active physician's orders for December 2023 for Resident #28 included an order dated 11/10/23 for Lantus Solostar pen-injector 100 units/ml, inject 10 units at bedtime for diabetes, an order dated 11/09/2023 for Carvedilol oral tablet 6.25 mg 1 tablet by mouth two times a day for heart failure. A Medication Administration Record (MAR) dated December 2023 revealed the Lantus Solostar pen-injector 100 units/ml 10 units, Carvedilol oral tablet 6.25 mg and Seroquel 25 mg scheduled for 8:00 PM, were not documented as given on 12/10/2023. c. Resident #47 was admitted to the facility on [DATE] with a diagnosis of depression, schizophrenia, anxiety and bilateral chronic lymphedema with lower extremity pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was severely cognitively impaired. Resident #47 was coded as receiving antipsychotic medication, antianxiety medication, antidepressant medication and opioids. The active physician's orders for December 2023 for Resident #47 included an order dated 02/19/22 for Seroquel 200 mg give 1 tablet by mouth at bedtime for mood, an order dated 03/10/22 for Lorazepam 1 mg by mouth two times a day for agitation, an order dated 08/25/22 for Trazodone 125 mg by mouth at bedtime for insomnia and an order dated 04/07/23 for Percocet oral tablet 10-325mg give 1 tablet by mouth three times a day for severe pain. A Medication Administration Record (MAR) dated December 2023 revealed the Seroquel 200 mg, Trazodone 125 mg, Lorazepam 1 mg and Percocet oral tablet 10-325mg scheduled for 8:00 PM were not documented as given on 12/10/2023. d. Resident #51 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus and atrial fibrillation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was moderately cognitively impaired. Resident #51 was coded as receiving insulin on 7 days during the assessment period. The MDS revealed Resident #51 had received an anticoagulant during the assessment period. The active physician's orders for December 2023 for Resident #51 included an order dated 11/15/22 Insulin Glargine solution 100 units/ml inject 12 units at bedtime for diabetes, an order dated 11/15/22 for Eliquis tablet 5 mg by mouth two times a day for anticoagulant therapy and an order dated 7/16/23 for Metformin 500 mg 1 tablet by mouth two times a day for diabetes. A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Glargine solution 100 units/ml 12 units, Eliquis tablet 5 mg and Metformin 500 mg scheduled for 9:00 PM were not documented as given on 12/10/2023. e. Resident #73 was admitted to the facility on [DATE] with a diagnosis of depression. An annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 was cognitively intact. Resident #73 was coded as received an antidepressant during the assessment period. The active physician's orders for December 2023 for Resident #73 included an order dated 06/20/23 for Trazodone 50 mg 1 tablet by mouth at bedtime for insomnia. A Medication Administration Record (MAR) dated December 2023 revealed the Trazodone 50 mg scheduled for 8:00 PM was not documented as given on 12/10/2023. f. Resident #79 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 was moderately cognitively impaired. Resident #79 was coded as received insulin on 7 days during the assessment period. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The active physician's orders for December 2023 for Resident #79 included an order dated 11/14/23 for Insulin Glargine solution 100 units/ml inject 2 units at bedtime for diabetes. A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Glargine solution 100 unit/ml 2 units scheduled for 9:00 PM was not documented as given on 12/10/2023. g. Resident #88 was admitted to the facility on [DATE] with a diagnosis of hypertension, heart failure and coronary artery disease (CAD). A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was severely cognitively impaired. The active physician's orders for December 2023 for Resident #88 included an order dated 03/31/22 for Metoprolol Tartrate 25 mg give 0.5 tablet by mouth two times a day for heart failure. A Medication Administration Record (MAR) dated December 2023 revealed the Metoprolol Tartrate 12.5 mg scheduled for 9:00 PM was not documented as given on 12/10/2023. h. Resident #110 was admitted to the facility on [DATE] with a diagnosis of hypertension and atrial fibrillation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #110 was cognitively intact. The active physician's orders for December 2023 for Resident #110 included an order dated 1/10/23 for Carvedilol 3.125mg 1 tablet by mouth two times a day for hypertension and an order dated 12/04/23. A Medication Administration Record (MAR) dated December 2023 revealed the Amoxicillin 500 mg and Carvedilol 3.125 mg scheduled for 8:00 PM were not documented as given on 12/10/2023. A facility investigation summary dated 12/12/23 revealed the facility interdisciplinary team was reviewing the Medication Administration Audit report for the previous 48 hours and noted the medication errors and Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110 had not been administered their medication during the 7:00 PM to 11:00 PM shift. An investigation was then initiated, and the Medical Director was notified. The investigation was completed by the Regional Nurse Consultant who identified the cause of the incident was due to a nurse not reporting for the 7:00 PM to 11:00 PM shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 02/28/24 at 4:00 PM with Nurse #1. She stated on 12/10/23 she was working the 7:00 AM to 7:00 PM shift assigned to Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110. The interview revealed Nurse #2 had contacted her after 12:00 PM stating she would not be coming into work for the 7:00 PM to 11:00 PM shift to take over the resident assignment. She stated she told Nurse #2 she would need to contact management and let them know. The interview revealed she then told Unit Manager #1 that she did not think Nurse #2 would be coming into the facility for her assigned shift. She stated report on the residents was given to Nurse #3, Nurse #4 and Nurse #5 who were told by the Unit Manager #1 to split the medication cart. The interview revealed she had offered to stay over to cover the shift from 7:00 PM to 11:00 PM but was told it was necessary by the scheduler. She stated she left the facility at 7:00 PM. An interview conducted on 02/28/24 at 3:36 PM with Unit Manager #1 revealed on 12/10/23 she was notified later in the day by Nurse #1 that Nurse #2 was not going to come in for the scheduled 7:00 PM to 11:00 PM shift. She stated she called the scheduler who no longer works in the facility and Director of Nursing (DON) to let them know they were going to be a nurse short. The interview revealed the scheduler could not get in touch with Nurse #2 so Unit Manger #1 then notified Nurse #3, Nurse #4 and Nurse #5 they would need to split the medication cart for the 7:00 PM to 11:00 PM shift. She stated Nurse #4 told her she needed to get some food and would look at the medication cart when she returned, and Nurse #5 stated the medication cart had too many residents to split. She stated she then left the facility at 7:00 PM and did not know until 12/12/23 that the residents had never received their scheduled medication on the evening of 12/10/23. An interview was attempted with Nurse #2 on 02/28/24 and on 02/29/24 with no return phone call received. An interview was attempted with Nurse #3, Nurse #4 and Nurse #5 on 02/29/24 with no return phone call received. An interview conducted on 02/28/24 at 4:30 PM with the Director of Nursing (DON) revealed on 12/10/23 around 6:30 PM she was told by Unit Manager #1 that Nurse #2 had called out for the 7:00 PM to 11:00 PM shift. She stated Unit Manager #1 told her that Nurse #3, Nurse #4 and Nurse #5 were instructed to split the medication cart and had taken report on the residents. She stated she heard the next morning that some residents had not received their medication. The interview revealed that Nurse #5 had given half of the assigned residents their medication, but the other 8 residents Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110 did not receive any scheduled medication. She stated Nurse #5 told her she had completed her assigned half and thought someone else was going to administer the rest of the residents' medication. The DON stated it was a communication error between the nurses. The interview revealed the residents' vital signs were obtained on 12/11/23 along with blood glucose levels for the diabetic residents. She stated no adverse outcomes had occurred from the incident and no residents needed medical treatment due to not receiving their medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/29/24 at 11:20 AM an interview was conducted with the Medical Director. During the interview he stated he was notified by the facility that the residents had missed their medication on 12/10/23. The interview revealed he notified the Nurse Practitioner's that were in the facility of the incident and that nurses on the unit were monitoring the residents for any changes of condition. He stated no residents were having symptoms from not receiving their medication. The MD stated although medication such as anticoagulants, opioids, antipsychotics and insulin were significant, it would not be harmful to the residents to miss one dose. The interview revealed none of the residents identified to have missed their medication were sent to the hospital or experienced a change of condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48006 Based on observations, staff interviews, and record review the facility failed to record an open date on multi-dose insulin pens, failed to discard an expired insulin pen and failed to store unopened insulin pens in the refrigerator for 2 of 4 medication carts (Garden City Cart #1 and Arboretum Cart #2) which were reviewed for medication storage. The findings: Review of the manufacturer's package insert for Glargine stated to store unopened Glargine insulin pens in a refrigerator and in-use (opened) insulin pens at room temperature for 28 days. 1a. An observation of the Garden City medication cart #1 was conducted on 02/28/2024 at 11:11 AM with Nurse #6 and the Director of Nursing. The observation revealed an opened Glargine insulin pen and an opened Novolin insulin pen that were not dated. The medication cart observation also revealed an opened insulin pen with an open date of 12/08/2023 which had passed the 28-day expiration date of 01/05/2024. An interview was conducted with Nurse #6 on 02/28/2024 at 11:26 AM who stated she thought 3rd shift (11:0 PM to 7:00 AM) nursing staff were responsible for checking the medications carts for expired medications and she did not realize the insulin pens were not dated and that one was expired. 1b. An observation of the Arboretum Cart #2 was conducted on 02/28/2024 at 12:03 PM with Nurse #7 and the Director of Nursing. The observation revealed 2 unopened insulin pens were stored in the medication cart and were labeled as refrigerate until opened and one Glargine insulin pen with an open date that was illegible. The ink had smeared, and the opening date was unidentifiable. An interview was conducted with Nurse #7 on 02/28/2024 at 12:24 PM who stated she did not realize there was no open date on the insulin pens, and she thought the pharmacy placed the open date on the insulin pens. She also stated she did not know the unopen insulin pens required refrigeration and she did know how long the insulin pens had been in the medication cart. She also added she did not realize the insulin pen open date was not legible. She further stated she did not know who was responsible for checking the medication carts. An interview was conducted with the Director of Nursing (DON) on 02/28/2024 at 1:12 PM. The DON revealed all insulin pens should have been labeled when opened for use with a 28-day expiration date sticker. She also indicated that all nurses were responsible for putting the date of opening on the insulin pens and checking all medications in the medication carts. She further stated that she expected all insulin pens to be labeled when opened and discarded 28 days after opening. She also stated that all unopened insulin pens should be stored in the refrigerator until ready for use and that no expired medications should be available for use in the medication carts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on observation and staff interviews, the facility failed to remove expired food items and unlabeled items which belonged to staff for 1 of 3 resident's nourishment rooms. These practices had the potential to affect food served to residents. Findings included: An observation and interview was conducted with Nurse Aide (NA) #5 on [DATE] at 10:15 AM revealed an 8 oz. fat free milk with the best by date of [DATE] and three separate lunch bags not labeled in the memory care unit nourishment room. NA #5 indicated nursing staff on the memory care unit had stored their personal items in the nourishment room because the nursing staff break room was on the other side of the facility. NA #5 stated nursing staff had been educated to not store personal items in the nourishment room and to discard any expired items. An interview conducted with the Dietary Manager (DM) on [DATE] at 10:30 AM revealed dietary aides check nourishment rooms daily but could not recall if any staff had checked them over the weekend. It was further revealed nursing staff had been educated not to store personal items in the nourishment rooms refrigerators and to also throw away any expired items that were found. An interview conducted with the Director of Nursing (DON) on [DATE] at 4:55 PM revealed nursing staff were educated not to store personal belongings in the nourishment rooms because there was a staff break room available with a refrigerator. The DON further stated she was unaware staff had stored items in the memory care nourishment room refrigerator. The DON indicated dietary aides were responsible for checking nourishment rooms, but nursing staff was also responsible for throwing out items if found that needed to be discarded. An interview conducted with the Administrator on [DATE] at 5:10 PM revealed she expected staff to check nourishment rooms daily and to discard any expired or unlabeled items. The Administrator further revealed it was not appropriate for nursing staff to store personal items in the nourishment room refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the focused infection control survey that occurred on [DATE], the recertification and complaint investigation surveys that occurred on [DATE] and [DATE]. This failure was for three deficiencies that were originally cited in the areas of Accuracy of Assessments (F641), Food Procurement, Store/Prepare/Serve Food Under Sanitary Conditions (F812) and Infection Prevention and Control (F880) and were subsequently recited on the current recertification and complaint investigation survey of [DATE]. The repeat deficiencies during multiple surveys of record show a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F641: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 6 residents (Resident #41, #102, #84) reviewed for Preadmission Screening and Resident Review (PASRR), and 1 of 3 residents (Resident #110) reviewed for restraints. During the recertification and complaint investigation survey conducted [DATE] the facility failed to accurately code the Minimum Data Set (MDS) assessment related to tobacco use for residents reviewed for smoking. F812: Based on observation and staff interviews, the facility failed to remove expired food items and unlabeled items which belonged to staff for 1 of 3 resident's nourishment rooms. These practices had the potential to affect food served to residents. During the recertification and complaint investigation survey conducted [DATE], the facility failed to remove expired food items in the refrigerator in 1 of 4 nourishments rooms and failed to label and date opened food items stored for use in 3 of 4 nourishment rooms. During the recertification and complaint investigation survey conducted [DATE], the facility failed to discard produce with signs of spoilage, remove expired food items and date leftover food stored ready for use in the walk-in cooler. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F880: Based on observations, record reviews, and staff interviews, the facility failed to ensure staff implemented their handwashing/hygiene policy as part of their infection control policy when the Treatment Nurse did not perform hand hygiene and don clean gloves after cleaning two wounds with wound cleanser and one wound with normal saline and before applying treatment to the wounds for two residents (Resident #128 and Resident #43) and did not doff gloves, sanitize hands and don clean gloves after wound care and prior to touching the resident's (Resident #128) pillows and bedding. The Treatment Nurse was also observed during wound care on another resident (Resident #126) with Methicillin-Resistant Staphylococcus Aureus (MRSA) and Carbapenem-Resistant Enterobacterales (CRE) in the wound and she did not doff gloves, sanitize hands and don clean gloves after cleaning the wound which had brown colored drainage and before applying the treatment to the wound and with the same gloves on the Treatment Nurse used to clean the drainage from the wound was observed touching the bed controls to lower the resident's bed and touching the trash bag on the resident's bed. In addition, another staff member (Nurse Aide (NA) #1) was observed providing incontinence care of bowel movement to a resident (Resident #51), and with the same gloves on that he had cleaned the resident with touching the resident's closet door, bedside drawer and over bed table. These failures occurred for 3 of 3 residents reviewed for wound care and 1 of 3 residents reviewed for incontinence care. During the focused infection control survey conducted [DATE] the facility failed to ensure dietary staff implemented the facility's infection control measures when 2 staff members failed to wear a facemask covering their mouth and nose while working in the kitchen. During an interview on [DATE] at 5:19 PM with the Administrator she revealed the QAPI committee meets monthly with department heads, administrative staff, the Medical Director, and at least quarterly the Pharmacist and Registered Dietician attend and monthly attend by phone. She reported they currently had Process Improvement Plans (PIPs) addressing some of the issues she and the corporate advisors had identified at the facility. Some of the PIPs currently being addressed included grievances, care plan meetings, resident weights, and physician visits. She also reported they would be putting PIPs into place to address the current concerns addressed during the current recertification and complaint survey. The Administrator stated the PIPs would be ongoing and monitored to ensure ongoing and future compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record reviews, and staff interviews, the facility failed to ensure staff implemented their handwashing/hygiene policy as part of their infection control policy when the Treatment Nurse did not perform hand hygiene and don clean gloves after cleaning two wounds with wound cleanser and one wound with normal saline and before applying treatment to the wounds for two residents (Resident #128 and Resident #43) and did not doff gloves, sanitize hands and don clean gloves after wound care and prior to touching the resident's (Resident #128) pillows and bedding. The Treatment Nurse was also observed during wound care on another resident (Resident #126) with Methicillin-Resistant Staphylococcus Aureus (MRSA) and Carbapenem-Resistant Enterobacterales (CRE) in the wound and she did not doff gloves, sanitize hands and don clean gloves after cleaning the wound which had brown colored drainage and before applying the treatment to the wound and with the same gloves on the Treatment Nurse used to clean the drainage from the wound was observed touching the bed controls to lower the resident's bed and touching the trash bag on the resident's bed. In addition, another staff member (Nurse Aide (NA) #1 was observed providing incontinence care of bowel movement to a resident (Resident #51), and did not remove his gloves and perform hand hygiene before touching the resident's closet door, bedside table drawer and other surfaces. These failures occurred for 3 of 3 residents reviewed for wound care (Resident #128, #43, and #126) and 1 of 3 residents reviewed for incontinence care (Resident #51). The findings included: The facility's policy entitled Handwashing Policy which is part of the Infection Control Policies and Procedures last revised on 04/2023 read in part: Personnel are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by acceptable standards of practice. An alcohol-based hand sanitizer may be used for handwashing unless the hands are visibly soiled. The hands should be free of dirt and organic material when using an alcohol hand sanitizer. The hands should be washed with soap and water after exposure to blood or body fluids. Personnel should wash their hands: After contact with blood, body fluids, secretions, excretions and equipment or articles contaminated by them. After removing gloves and before performing procedures in which a normally sterile part of the body is entered. Before and after touching wounds. After situations during which microbial contamination of hands is likely to occur. After touching inanimate sources that are likely to be contaminated with virulent or epidemiologically significant microorganisms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Between resident contacts. When otherwise indicated to avoid transfer of microorganisms to other residents and environments. When indicated between tasks and procedures to prevent cross contamination of different body sites. When hands are visibly and obviously soiled. 1. a. A wound observation was made on 02/28/24 at 9:13AM on Resident #128 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. The Treatment Nurse washed her hands with soap and water and donned clean gloves to remove the resident's dressing from her right ankle which had a small amount of drainage on the old dressing. She doffed her gloves after removing the dressing, sanitized her hands, donned clean gloves, and cleansed the wound with wound cleanser-soaked gauze. The Treatment Nurse then proceeded without doffing her gloves, sanitizing her hands, and donning clean gloves, and applied the hydrogel gauze and ankle dressing and reapplied her boot. The Treatment Nurse then moved to the wound on the left knee and doffed her gloves, sanitized her hands, donned new gloves, and proceeded to clean the left knee with wound cleanser-soaked gauze and without doffing her gloves, sanitizing her hands and donning clean gloves applied xeroform gauze to the knee and covered with a border gauze dressing. The Treatment Nurse then moved to the wound (a skin tear) on the left arm and removed the dressing and cleansed the wound with normal saline and without doffing her gloves, sanitizing her hands, and donning new gloves applied xeroform gauze to the wound and covered with a border gauze dressing. With the same gloves on the Treatment Nurse adjusted the resident's bed with the controls, positioned her in bed with pillow between her legs, gathered her trash, doffed her gloves, left the room, and sanitized her hands in the hallway after discarding the trash. b. A wound observation was made on 02/29/24 at 9:30 AM on Resident #43 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. The Treatment Nurse cleaned the wound with anasept (antimicrobial skin and wound cleaner)-soaked gauze and without doffing her gloves, sanitizing her hands, and donning new gloves she applied the treatment of hydrocolloid dressing to the wound. With the same gloves on, she re-attached the resident's brief and adjusted the resident's bed with the controls, repositioned the pillow under her head. The Treatment Nurse then threw away her trash, washed her hands with soap and water, brought out the trash bag, discarded it and sanitized her hands. An interview on 02/29/24 at 9:59 AM with the Treatment Nurse revealed she did not realize she had not doffed her gloves after cleaning the wounds, sanitized her hands and donned clean gloves before applying treatment and dressings to the wounds. She stated she was just nervous about someone watching her and forgot to do the correct procedure. An interview on 02/29/24 at 11:51 AM with the Infection Preventionist (IP) revealed they had done several in-services on handwashing, donning, and doffing personal protective equipment (PPE) but said she would do one-on-one education with the Treatment Nurse. The IP stated any time nurses went from a dirty procedure (cleaning a wound bed) to a clean procedure (applying treatment to wounds) they should doff their gloves, sanitize their hands, and don clean gloves and especially if they are touching objects in the resident's room that the resident may later touch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) on 02/29/24 at 12:00 PM revealed the Treatment Nurse had shared with them her errors during treatments for Resident's #128 and #43. The DON stated she thought the Treatment Nurse was nervous having someone watching her and she and the IP would re-educate her on proper hand hygiene procedures and would be monitoring her during some of her treatments. 40476 2. A wound observation was made on 02/28/24 at 10:34 AM on Resident #126 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. She stated Resident #126 was on enhanced barrier precautions due to Methicillin-Resistant Staphylococcus Aureus (MRSA) and Carbapenem-Resistant Enterobacterales (CRE) in the wound. The Treatment Nurse washed her hands with soap and water and donned clean gloves to remove the resident's dressing from her right ankle which had a small amount of drainage on the old dressing. She doffed her gloves after removing the dressing, sanitized her hands, donned clean gloves, and cleansed the wound with wound cleanser-soaked gauze. The Treatment Nurse then doffed her gloves, sanitized her hands and donned clean gloves. She then lifted Resident #126's left foot and began cleaning the wound again with brown colored drainage observed on the gauze. The Treatment Nurse then proceeded without doffing her gloves, sanitizing her hands, and donning clean gloves, and applied the dermacol collagen and calcium alginate with silver and covered the wound with kerlix. With the same gloves on the Treatment Nurse adjusted the resident's bed with the controls, positioned her in bed with pillow between her legs, gathered her trash, doffed her gloves, left the room, and sanitized her hands in the hallway after discarding the trash. An interview on 02/29/24 at 11:51 AM with the Infection Preventionist (IP) revealed they had done several in-services on handwashing, donning, and doffing personal protective equipment (PPE) but said she would do one-on-one education with the Treatment Nurse. The IP stated any time nurses went from a dirty procedure (cleaning a wound bed) to a clean procedure (applying treatment to wounds) they should doff their gloves, sanitize their hands, and don clean gloves and especially if they are touching objects in the resident's room that the resident may later touch. An interview with the Director of Nursing (DON) on 02/29/24 at 12:00 PM revealed the Treatment Nurse had shared with them her errors during treatments for Resident #126. The DON stated she thought the Treatment Nurse was nervous having someone watching her and she and the IP would re-educate her on proper hand hygiene procedures and would be monitoring her during some of her treatments. 48684 3. Resident # 51 was admitted to the facility on [DATE] with diagnoses including neurogenic bladder and a chronic autoimmune disorder that affects movement, sensation and bodily functions. Resident #51's care plan initiated 1/17/24 revealed a focus area for the resident having an activities of daily living (ADL) self-care deficit due to [chronic autoimmune disorder that effects movement, sensation, and bodily functions] and neurogenic bladder. The interventions included assisting with activities of daily living (ADL), dressing, grooming, toileting, promote independence and dignity, and provide positive reinforcement for all activities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	9200 Glenwater Drive Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed total dependence for toilet and bathing. Impaired range of motion was noted to bilateral lower extremities. The resident was coded as always incontinent of bowel and for the presence of a suprapubic catheter. An observation was conducted on 02/28/24 at 1:40 PM of Resident #51 receiving incontinence care. NA #1 was observed washing his hands and applied gloves. NA #1 was observed cleaning bowel movement from Resident #51's right and left buttocks using a wet washcloth and soap. After the bowel movement was cleaned up the NA went to the closet to get a clean adult brief without removing his dirty gloves. He returned to bedside and opened the drawer of the bedside table to retrieve the barrier cream, opened it, and applied the cream to the resident's buttocks. NA#1 proceeded to apply the adult brief and change bed linens and was still wearing dirty gloves. NA #1 was also observed touching his uniform. After NA #1 had completed the incontinence care and changed the bed linens, he removed his gloves and washed his hands. After washing his hands NA #1 was observed picking up the barrier cream, placing the cap back on the tube and putting the barrier cream back into the beside table. Then NA #1 picked up the trash and dirty linen bags, opened the resident door and continued down the hallway and placed the trash and soiled linens into barrels. NA#1 then sanitized his hands using hand sanitizer. Interview on 02/28/24 at 1:50 PM with NA #1 revealed he believed he had done a good job providing incontinence care on Resident #51 and did not realize he had to remove dirty gloves and perform hand hygiene immediately after care was completed and before touching surfaces in the room. NA #1 stated he thought since his gloves were not visibly dirty that he was okay to continue care but stated he had washed his hands before and after care. Interview on 02/29/24 at 4:46 PM with the Director of Nursing (DON) revealed she would expect nursing staff to follow the policy for hand hygiene and glove policy and procedures. The DON stated that all employees had been trained in hand hygiene and glove policy and procedures and the appropriate process was to always be followed.