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 _____	C 08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of complaint investigation. Event ID: 588C11.	F 000	University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. University Place Nursing and Rehabilitation Centers response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, University Place Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	07/14/2011
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to use siderails to treat a medical symptom for one of one sampled resident (Resident #60). The findings are: Resident #60 was admitted to the facility with diagnoses including dysphagia, depression, obesity, hypertension, congestive heart failure and right sided weakness. The significant change Minimum Data Set (MDS) dated 1/19/11 and quarterly MDS dated 4/13/11 coded him as cognitively intact, requiring extensive assistance with bed mobility and transfers and requiring human assistance to balance when moving from surface to surface. This assessment did not indicate restraints were used. The current care plan which addressed Resident #60's ability to move about in bed with assistance included that siderails were utilized to aid in	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James A Kuff — TITLE: Administrator — (X6) DATE: 7-13-11

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

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F 221	Continued From page 1 turning and positioning. Resident #60 was observed in bed with three fourths siderails upright, covered with pipe foam padding on 6/21/11 at 1:40 PM and 4:08 PM and on 6/22/11 at 8:05 AM and at 8:49 AM. At 8:55 AM he activated his call light and requested to get out of bed. Resident #60 remained in bed with both siderails upright until 9:49 AM. On 6/21/11 at 9:49 AM, Nurse Aide #2 stated Resident #60 was able to sit up by himself. Resident #60 stated at this time that staff would lower the siderails. Following a bed bath, on 6/21/11 at 10:04 AM, NA #2 lowered the siderail and Resident #60 independently got up into a sitting position on the side of the bed. Then with a gait belt and hands on assist, he stood and transferred to the wheelchair. NA #2 stated that she did not know why the siderails were used but that staff always raised them whenever Resident #60 was in bed. Again Resident #60 was observed in bed with both three fourths length siderails in the upright position on 6/22/11 at 11:35 AM. At 6/22/11 at 12:15 PM Licensed Nurse (LN) #2 stated she was aware that Resident #60 was able to sit up independently on the side of the bed. She further stated that the siderails were used as a fall precaution. The resident was observed in bed with three fourths siderails upright on 6/22/11 at 12:24 PM and at 1:11 PM. On 6/22/11 at 2:20 PM, the MDS coordinator #1 stated Resident #60 used his siderails to turn and reposition in bed. She further stated that when his feeding tube was placed, his bed was	F 221	F221 **Criteria One:** Resident #60 was assessed for use of side rails and side rails were removed on 06/23/2011 to include updating the plan of care on 06/27/2011. **Criteria Two:** A 100% audit was completed by 06/27/2011. Residents whose assessment did not indicate use of side rails had their side rails removed on 06/27/2011 and care plan updated as appropriate. **Criteria Three:** Licensed nurses, nursing assistants and therapy staff were in-serviced by the Registered Nurse-Staff Development Director on 07/13/2011 regarding the use of side rails. The Registered Nurse supervisors will audit side rails to ensure residents are assessed and provided with the proper assistive devices for bed mobility one time weekly for four weeks then one time monthly for (3) three months utilizing the Quality Monitoring Side Rail screening tool. The Director of Nursing will review the completed audits (1) one time weekly and monthly for (3) three months. **Criteria Four:** The Director of Nursing or Administrator will review the completed audits with the Quality Assurance and Assessment Team monthly for further follow-up and recommendations as indicated.	07/14/2011

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F 221	Continued From page 2 changed so the head of the bed could be elevated. The bed came with three fourths length siderails. She stated he was not safe to transfer alone as he is compulsive and moves too fast. She further stated that she had never seen him sit upright alone, however that he may be able to transfer alone depending on his mood. She stated she never considered the siderails as a restraint. On 6/22/11 at 2:31 PM, NA #4 stated Resident #60 was able to sit up at edge of bed by himself when railing was down and he required limited assistance to transfer by holding on to his arms. She further stated that when he is ready to go to bed he will throw himself into bed. On 6/22/11 at 2:38 PM Licensed Nurse (LN) #3 stated Resident #60 was capable of getting out of bed on his own and he used the siderails for turning and positioning. On 6/22/11 at 3:00 PM the Assistant Director of Nursing (ADON) stated Resident #60 only needed supervision to get up and she was not sure why the three fourths siderails were utilized. On 6/22/11 at 6:01 PM LN #4 stated siderails were used for Resident #60's safety awareness and to turn. She further stated he would try to get out of bed by himself if staff were not fast enough. On 6/22/11 at 6:04 PM, Resident #60 stated that when he requested, staff put the siderails down when he requested to get up.	F 221		07/14/2011
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		

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F 272	Continued From page 3 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**F272** **Criteria One:** Resident #60 was assessed for use of side rails and side rails were removed on 06/23/2011 to include updating the plan of care on 06/27/2011. **Criteria Two:** A 100% audit was completed by 06/27/2011. Residents whose assessment did not indicate use of side rails had their side rails removed on 06/27/2011 and care plan updated as appropriate. **Criteria Three:** Licensed nurses, nursing assistants and therapy staff were in-serviced by the Registered Nurse-Staff Development Director on 07/12/2011 regarding the use of side rails. The Registered Nurse supervisors will audit side rails to ensure residents are assessed and provided with the proper assistive devices for bed mobility one time weekly for four weeks then one time monthly for (3) three months utilizing the Quality Monitoring Side Rail screening tool. The Director of Nursing will review the completed audits one time weekly and monthly for (3) three months to ensure compliance is achieved. **Criteria Four:** The Director of Nursing or Administrator will review the completed audits with the Quality Assurance and Assessment Team monthly for further follow-up and recommendations as indicated.	07/14/2011

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F 272	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, facility record review and staff interview, the facility failed to assess siderails as a restraint for one (1) of sixteen (16) sampled residents. (Resident #60). The findings are: Resident #60 was admitted to the facility with diagnoses including dysphagia, depression, obesity, hypertension, congestive heart failure and right sided weakness. The significant change Minimum Data Set (MDS) dated 1/19/11 and quarterly MDS dated 4/13/11 coded him as cognitively intact, requiring extensive assistance with bed mobility and transfers and requiring human assistance to balance when moving from surface to surface. This assessment did not indicate restraints were used. There was no restraint assessment. The current care plan which addressed Resident #60's ability to move about in bed with assistance included that siderails were utilized to aid in turning and positioning. Resident #60 was observed in bed with three fourths siderails upright, covered with pipe foam padding on 6/21/11 at 1:40 PM and 4:08 PM and on 6/22/11 at 8:05 AM and at 8:49 AM. On 6/21/11 at 9:49 AM, Nurse Aide #2 stated Resident #60 was able to sit up by himself. Resident #60 stated at this time that staff would lower the siderails. Following a bed bath, on	F 272		07/14/2011

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F 272	Continued From page 5 6/21/11 at 10:04 AM, NA #2 lowered the siderail and Resident #60 independently got up into a sitting position on the side of the bed. Then with a gait belt and hands on assist, he stood and transferred to the wheelchair. NA #2 stated that she did not know why the siderails were used but that staff always raised them whenever Resident #60 was in bed. Again Resident #60 was observed in bed with both three fourths length siderails in the upright position on 6/22/11 at 11:35 AM. At 6/22/11 at 12:15 PM Licensed Nurse (LN) #2 stated she was aware that Resident #60 was able to sit up independently on the side of the bed. She further stated that the siderails were used as a fall precaution. The resident was observed in bed with three fourths siderails upright on 6/22/11 at 12:24 PM and at 1:11 PM. On 6/22/11 at 2:20 PM, the MDS coordinator #1 stated Resident #60 used his siderails to turn and reposition in bed. She further stated that when his feeding tube was placed, his bed was changed so the head of the bed could be elevated. The bed came with three fourths length siderails. She stated he was not safe to transfer alone as he is compulsive and moves too fast. She further stated that she had never seen him sit upright alone, however that he may be able to transfer alone depending on his mood. She stated she never considered the siderails as a restraint.	F 272		07/14/2011
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 322		

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F 322	Continued From page 6 who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to elevate the head of the bed during medication administration via gastrostomy tube for one (1) of one (1) resident. (Resident #128) The findings include: A review of the undated policy and procedure related to "Gastrostomy Tube Feeding" provided by the facility included that the G-Tube (Gastrostomy Tube) fed residents had to be in semi-Fowler position (the head of bed at 35-40 degrees elevated) while feeding or during medication administration. Resident #128 was admitted to the facility on 6/23/2009. Resident #128's diagnoses included Dysphagia, Seizure disorder, Aphasia and Dementia. Observation during the medication pass on 6/21/2011 at 4:10 PM revealed Resident #128 lying in bed with the bed elevated about 15 degrees. Cinder blocks were placed on the floor under the bed, but were not placed to elevate the head of bed. Licensed Nurse (LN #1) checked the placement of the tube, administered the	F 322	**F322** **Criteria One:** Resident #128 had the head of bed repositioned at 45 degrees on 06/22/2011. **Criteria Two:** A 100% audit of all residents with gastrostomy tubes was completed on 06/22/2011 by the Registered Nurse Supervisors to ensure residents head of bed was positioned appropriately. **Criteria Three:** Licensed nurses, nursing assistants were re-educated by the Registered Nurse-Staff Development Director regarding the head of bed position for residents that receive gastrostomy tubes on 06/30/2011. The Registered Nurse Supervisors will audit utilizing the Quality Monitoring Tube Feeding Audit one time weekly for four weeks and one time monthly for (3) months. The Administrator or Director of Nursing will review the completed audits to ensure compliance with position of the head of bed for residents receiving gastrostomy tubes weekly for four weeks and monthly for (3) months. **Criteria Four:** The Director of Nursing or Administrator will review the completed audits with the Quality Assurance and Assessment Team monthly for further follow-up and recommendations as indicated	07/14/2011

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F 322	Continued From page 7 medication and flushed with 200 ml water without making any attempt to elevate the head of bed beyond the 15 degree angle. An interview with LN #1 on 6/21/2011 at 4:15 PM revealed that she was aware the head of bed had to be 35 degrees or more. The nurse stated that she did not realize that the cinder block had been removed and she had been previously administering medications with the head of bed at the same elevation. An interview with the Administrator on 6/22/2011 at 8:25 AM confirmed that all residents receiving G-tube feedings had to be in a semi-fowler's position for medications and feedings and all nurses were aware of this information.	F 322		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, facility record review, and staff interview, the facility failed to monitor use by dates for mighty shakes and buttermilk. The findings are:	F 371	**F 371** **Criteria One:** The Butter Milk and Mighty Shakes were removed during the survey. **Criteria Two:** The walk in freezer and refrigerator was inspected the Administrator and Dietary manager and no other items were found past the "use by date" on 06/22/2011. **Criteria Three:** The Dietary Staff was re-educated on "dating and disposal of items past "use by" dates on 06/21/2011. The Dietary Cooks will utilize the Quality Monitoring Sanitation audit for the walk in refrigerator and freezer daily to ensure use by dates are within compliance. These audits will be reviewed by the Dietary Supervisor weekly for four weeks and monthly for (3) months to ensure compliance. **Criteria Four:** The Dietary Supervisor or Administrator will review the completed audit tool results with the Quality Assurance and Assessment Team monthly for further recommendation and follow-up as indicated.	07/14/2011

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F 371	Continued From page 8 1. According to the Mighty Shakes Code Dating Explanation, with a revised date of 1/9/08, the shelf life of refrigerated mighty shakes was 14 days thawed. On 6/19/11 beginning at 3:00 PM, the refrigerator in the kitchen was observed with dietary staff #1. At this time, dietary staff #1 stated that when cases of frozen mighty shakes were moved from the freezer into the refrigerator, a date was placed on the case to indicate the date they were pulled from the freezer. She further stated that the shakes were to be used within ten (10) days of when moved from the freezer. There were 2 cases of vanilla shakes and one (1) case of strawberry shakes which had no date indicating when they were moved from the freezer into the refrigerator. In addition, there were plastic crates located in the refrigerator which contained cartons of milks, juices and mighty shakes. There were twelve (12) mighty shake cartons in one crate and eleven (11) in another crate. Neither the crate nor the individual mighty shake cartons were labeled or dated to indicate when they were moved from the freezer to the refrigerator. Dietary staff #1 could not give an explanation as to why the mighty shakes were not dated. 2. On 6/19/11 beginning at 3:00 PM, the refrigerator in the kitchen was observed with dietary staff #1. At this time, one quart of buttermilk with a sell by date of 5/31/11 was observed opened with a handwritten date of 6/11/11 on the front. There were also five (5) unopened quarts of buttermilk with the sell by date of 5/31/11 on the shelf. Dietary staff #1	F 371		07/14/2011

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F 371	Continued From page 9 indicated that the handwritten date of 6/11/11 was the date the buttermilk was opened. Dietary staff #1 further stated that buttermilk can be used thirty (30) days past the sell by date. On 6/21/11 at 4:37 PM the Clinical Dietary Manager (CDM) stated the facility goes by used by dates as the expiration date. The CDM also stated the cases and crates of mighty shakes in the refrigerator should have been labeled with the date the shakes came from the freezer. On 6/21/11 at 6:37 PM interview with Dietary staff #1 revealed the expired buttermilk was used for the cornbread served on Monday 6/20/11 and that cornbread and muffins were the only things in which buttermilk was used. On 6/22/11 at 11:21 AM interview with the Administrator indicated there was no policy but the standard of practice was that the buttermilk should be used within 14 days of when it is opened or by the sell by date, whichever is first.	F 371		07/14/2011
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 10 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and facility record review the facility staff failed wash their hands while providing incontinence care for one (1) of two (2) residents (Resident #205) and failed to perform proper hand hygiene for one (1) of five (5) dining observations (Resident #18). The findings are: The facility's policy for hand washing revised 11/23/09 stated that hand washing should occur	F 441	**F441** **Criteria One:** Staff will provide appropriate infection control practices while providing care. Staff members who provided observed care for resident # 205 and #18 were re-educated by the Registered Nurse-Staff Development Coordinator on proper infection control procedures on 06/29/2011. **Criteria Two:** The corrective action for other residents was to re-educate the licensed nurses and certified nursing assistants on proper infection control procedures on 06/29/2011. **Criteria Three:** Licensed nurses and certified nursing assistants were re educated on infection control procedures on 06/27/2011. The Registered Nurse Supervisors will complete a Quality Monitoring control observation audit weekly for four weeks and monthly for (3) months with nursing staff to ensure the infection control procedures are being followed. The Administrator or Director of Nursing will review the completed audits weekly for four weeks and monthly for three months to ensure compliance. **Criteria Four:** The Director of Nursing or Administrator will review with the Quality Assurance and Assessment Team Committee monthly the outcome of the observation audits for further recommendation and follow-up as indicated.	07/14/2011

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UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

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F 441	Continued From page 11 before and after contact with residents and after handling contaminated items (soiled incontinent briefs, linens, trash, etc.) 1. During observation on 06/21/11 at 2:15 p.m., Nurse Aide (NA) #1 performed incontinence care for Resident #205. NA #1 washed her hands, donned gloves and closed the privacy curtain. NA #1 lifted the resident to a standing position using a mechanical lift and washed the resident's scrotum and peri-anal area then placed a clean brief on the resident. After the resident's care was completed, NA #1 grabbed the handles on the mechanical lift while still wearing the gloves used to provide incontinence care and moved the lift to the other side of the room. After moving the lift across the room, NA #1 removed her gloves, washed her hands then grabbed the lift handles again and moved the lift out into the hallway. During an interview on 6/21/11 at 2:30 p.m., NA #1 stated she knew to wash her hands after removing gloves and after she had provided incontinence care but could not recall whether she had specific training regarding hand washing or removing gloves before touching items regarding cross contamination. During this interview observations revealed an office staff member came down the hallway and grabbed the handles of the mechanical lift and moved it closer to the wall. During an interview on 6/22/11 at 11:20 a.m., the Staff Development Coordinator (SDC) stated all staff including NA #1 were inserviced regarding infection control which included cross contamination when first hired and again annually. The SDC stated she expected all staff	F 441		07/14/2011

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 _____	C 06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 12 (who have performed resident care) to remove gloves and wash their hands before touching any items in the resident's rooms. 2. On 6/19/11 at 7:02 PM, in the Carnation dining room, Nurse Aide (NA) #3 stacked used utensils, cups and trash inside two used dinner trays. Without washing or sanitizing his hands, NA #3 sat at 7:03 PM and began to feed Resident #18. At 7:06 PM NA #3 picked up a plastic cup by placing one finger inside the rim and a thumb outside the rim and poured water in it. On 6/19/11 at 7:39 PM, NA #3 was interviewed. NA #3 stated he was trained to wash his hands between residents and after he touched a resident. He further stated he should have washed his hands after touching the used trays and before feeding Resident #18. He also stated he did not recall touching the inside of the plastic cup before filling it with water. On 6/22/11 at 2:45 PM interview with the Assistant Director of Nursing (ADON) revealed that staff are taught to wash or sanitize their hands before serving trays, between residents when feeding and after gathering dirty trays. She further stated that cups should not be handled by the rim. On 6/22/11 at 3:44 PM, the Administrator stated that staff should wash their hands after handling soiled trays and before feeding residents.	F 441		07/14/2011