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 08/14/2015

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 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews, the facility failed to provide assistance with pericare to 1 of 1 sampled dependent resident who requested care. (Resident #2). The findings included: Resident #2 was admitted to the facility on 04/22/15. His diagnoses included neurogenic bladder. The admission Minimum Data Set (MDS) dated 04/29/15 coded him with intact cognition, requiring total assistance for transfers and extensive assistance with toileting and hygiene. He was coded as being nonambulatory, using an external catheter and always being incontinent of bladder. The Care Area Assessment dated 05/05/15 for activities of daily living skills (ADLs) revealed Resident #1 was always incontinent when the condom catheter was off and he required assistance. A care plan was developed on 05/06/15 for an altered pattern of urinary elimination with a	F 224	Resident #2 was assessed on 8/13/2015 by the Interim Director of Nursing and was provided care in a manner which prohibits neglect. All residents were reviewed on 8/13/2015 by the Interim Director of Nursing and Assistant Director of Nursing via facility rounds for potential neglect related issues. No other issues were identified during the rounds. The involved CNA was retrained on 8/14/2015 by the Interim Director of Nursing on responding to the residents' care in a timely manner. Nursing staff retraining was initiated on 8/14/2015 and completed on 8/31/2015 by the Staff Facilitator regarding responding to the residents' care in a timely manner. Any newly hired nursing staff will be trained on responding to residents' care in a timely manner during orientation. Seventy (70) audits will be conducted by the Administrative Nurses and Charge Nurses to ensure all residents' care is met in a	9/11/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 1 condom catheter. One goal was for Resident #2 to be clean, dry and free of odor or skin break down. Interventions included maintaining a closed drainage system with an unobstructed urine flow. Another care plan for urinary incontinence dated 05/06/15 included the interventions to provided pericare after each incontinent episode. The most recent quarterly MDS dated 07/22/15 also coded him with intact cognition and requiring extensive to total assistance with all activities of daily living skills, using an external catheter and being totally incontinent of urine. No changes were made to the existing care plan. On 08/13/15 at 11:21 AM, Resident #2 was observed in his room, in a gerichair and his catheter bag was empty. At this time he stated he was very frustrated due to his condom catheter had come off, he was wet, and he had been waiting for 3 hours to have care provided. At 11:36 AM, Nurse #1 entered with medication. In the presence of the surveyor, Nurse #1 told Resident #2 that staff was coming to give care. Resident #2 stated Nurse Aide (NA) #2 knew he needed care after breakfast. Nurse #1 told the resident that NA #1 was his assigned nurse aide and she had to finish another resident's care then NA #1 would get the lift and change him. Resident #2 again stated he told NA #2 at breakfast time he needed care. They began discussing the time frame of his request and wait period. Nurse #1 stated she told NA #1 just 30 minutes ago, when she became aware Resident #2 needed assistance. Resident #2 stated he had urinated 3 times since first letting staff know his condom catheter had come off. The nurse went to locate NA #1.	F 224	timely manner daily x 4 weeks, weekly x 4 weeks, and monthly x 3 months utilizing an audit tool. Any issues identified will be corrected immediately with further retraining and or other interventions as appropriate. Resident Council will be questioned regarding response to their care needs timely at the next 3 monthly meetings. Any issues reported will be forwarded to the Administrator for follow up. The results of the completed Audit Tools will be reviewed weekly by the Administrator and the Director of Nursing. The QA&A Committee will review the audits monthly x 3 months to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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F 224	Continued From page 2	F 224		

During interview on 08/13/15 at 11:44 AM, NA #1 stated she had not given Resident #2 care and she was supposed to go to lunch at 11:30 AM. NA #1 proceeded to tell Nurse #1 she was going to lunch, poked her head inside Resident #2's door and left the unit. Nurse #1 stated she would have expected NA #1 to provide Resident #2 care before going to lunch or ask another nurse aide to provide the care for her. Nurse #1 verified that she had told NA #1 Resident #2 was wet.

On 08/13/15 at 11:50 AM, NA #2 was interviewed about his morning interaction with Resident #2. NA #2 stated that around 10 AM Resident #2 told him his catheter had come off and he needed it put back on. NA #2 stated he passed NA #1 around 10:15 AM and told her Resident #2 needed care.

Care was observed on 08/13/15 at 11:52 AM. Resident #2 was transferred via mechanical lift into bed from his geri chair. Resident #2's lift pad, the pad he had been sitting on, and his pants were observed wet with urine, his condom catheter was off, and the incontinent brief he was wearing was heavy and soaked in urine. Pericare was provided. The catheter bag was empty of urine as it had not been on the resident.

Interview with the Administrator and interim Director of Nursing (DON) on 08/14/15 at 8:31 AM revealed they expected NA #1 to change Resident #2 prior to going for lunch. The Administrator and interim DON stated they did not think it was neglect as the resident's needs were taken care of by other staff.

Phone interview with NA #1 on 08/14/15 at 8:38

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F 224	Continued From page 3 AM, with the Administrator and surveyor on speaker phone, revealed that when NA #2 told her Resident #2 needed care, she was showering another resident. NA #1 stated NA #2 told her around 10 AM the resident's catheter had come off of him. NA #1 denied she was told he was wet. NA #2 then said she had to get another resident up for therapy after she completed the shower. NA #2 stated she told Resident #2 what she had to do before giving him are and he was fine with it. NA #2 stated that when his catheter comes off, he just gets a little wet. She further stated it was a very busy day. NA #1 again confirmed that she did what she normally would have done which was going to lunch before giving Resident #2 care.	F 224		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, record review and staff interview, the facility failed to promote the dignity of 1 of 1 sampled residents by providing personal care upon resident's request resulting in Resident #2 being saturated in urine. The findings included: Resident #2 was admitted to the facility on	F 241	Resident #2 was assessed on 8/13/2015 by the Interim Director of Nursing and was provided care in a manner in which enhances dignity and respect. All residents were reviewed on 8/13/2015 by the Interim Director of Nursing and Assistant Director of Nursing via facility rounds for potential dignity related issues. No other issues were identified during the rounds.	9/11/15

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F 241	Continued From page 4 04/22/15. His diagnoses included neurogenic bladder. The Care Area Assessment dated 05/05/15 for activities of daily living skills (ADLs) revealed Resident #1 was always incontinent when the condom catheter was off and he required assistance. A care plan was developed on 05/06/15 for an altered pattern of urinary elimination with a condom catheter. One goal was for Resident #2 to be clean, dry and free of odor or skin break down. Interventions included maintaining a closed drainage system with an unobstructed urine flow. Another care plan for urinary incontinence dated 05/06/15 included the interventions to provided pericare after each incontinent episode. The most recent quarterly MDS dated 07/22/15 coded him with intact cognition and requiring extensive to total assistance with all activities of daily living skills, using an external catheter and being totally incontinent of urine. No changes were made to the existing care plan. On 08/13/15 at 11:21 AM, Resident #2 was observed in his room, in a gerichair and his catheter bag was empty. At this time he stated he was very frustrated due to his condom catheter had come off, he was wet, and he had been waiting for 3 hours to have care provided. At 11:36 AM, Nurse #1 entered with medication. In the presence of the surveyor, Nurse #1 told Resident #2 that staff was coming to give care. Resident #2 stated Nurse Aide (NA) #2 knew he needed care after breakfast. Nurse #1 told the resident that NA #1 was his assigned nurse aide	F 241	The involved CNA was retrained on 8/14/2015 by the Interim Director of Nursing on responding to residents' care in a timely manner. Nursing staff retraining was initiated on 8/14/2015 and completed on 8/31/2015 by the Staff Facilitator regarding responding to residents' care in a timely manner. All newly hired nursing staff will be trained on responding to residents' care in a timely manner during orientation. Seventy (70) audits will be conducted by the Administrative Nurses and Charge Nurses to ensure residents' care is met in a timely manner daily x 4 weeks, weekly s 4 weeks and monthly x 3 months utilizing an audit tool. Any issues identified will be corrected immediately with further retraining and or other interventions as appropriate. Resident Council will be questioned regarding response to care at the next 3 monthly meetings. Any issues reported will be forwarded to the Administrator for follow up. The results of the completed Audit Tool will be reviewed weekly by the Administrator and the Director of Nursing. The QA&A Committee will review the audits monthly x 3 months to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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F 241	Continued From page 5	F 241		

and she had to finish another resident's care then NA #1 would get the lift and change him. Resident #2 again stated he told NA #2 at breakfast time he needed care. They began discussing the time frame of his request and wait period. Nurse #1 stated she told NA #1 just 30 minutes ago, when she became aware Resident #2 needed assistance. Resident #2 stated he had urinated 3 times since first letting staff know his condom catheter had come off. The nurse went to locate NA #1.

On 08/13/15 at 11:44 AM, NA #1 was located standing in the doorway of another resident's room. When the surveyor asked if she was going to give care to Resident #2, NA #1 stated she was supposed to go to lunch at 11:30 AM but could provide care if the surveyor wanted her to do it then. The surveyor stated that staff should do what she normally would do and NA #1 stated she would normally go to lunch. NA #1 then proceeded to tell Nurse #1 she was going to lunch, she poked her head inside Resident #2's door and left the unit. Nurse #1 stated to the surveyor, she would stop her medication pass and get another nurse aide to provide Resident #2 care. Nurse #1 stated she would have expected NA #1 to provide Resident #2 care before going to lunch or ask another nurse aide to cover for her and provide the resident care. Nurse #1 stated she had told NA #1 previously Resident #2 was wet. Nurse #1 immediately obtained a lift and the services of NA #2 and NA #3 at 11:50 AM. At this time, NA #2 was asked about his interaction with Resident #2. NA #2 stated that around 10 AM Resident #2 told him his catheter had come off and he needed it put back on. NA #2 stated he passed NA #1 around 10:15 AM and told her Resident #2 needed care.

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F 241	Continued From page 6 Care was observed on 08/13/15 at 11:52 AM. Resident #2 was transferred via total mechanical lift into bed from his geri chair. Resident #2's lift pad, the pad he had been sitting on, and his pants were observed wet with urine, his condom catheter was off, and the incontinent brief he was wearing was heavy and soaked in urine. Pericare was provided. The catheter bag was empty of urine as it had not been on the resident. On 08/13/15 at 1:19 PM, Resident #2 stated that it made him feel like staff don't care about him when they make him wait so long for care. Interview with the Administrator and interim Director of Nursing (DON) on 08/14/15 at 8:31 AM revealed they expected NA #1 to change Resident #2 prior to going for lunch. Phone interview with NA #1 on 08/14/15 at 8:38 AM, with the Administrator and surveyor on speaker phone, revealed that when NA #2 told her Resident #2 needed care, she was showering another resident. NA #1 stated NA #2 told her around 10 AM the resident's catheter had come off of him. NA #1 denied she was told he was wet. NA #1 then said she had to get another resident up for therapy after she completed the shower. NA #1 stated she told Resident #2 what she had to do before giving him are and he was fine with it. NA #1 stated that when his catheter comes off, he just gets a little wet. NA #1 again confirmed that she did what she normally would have done which was going to lunch before giving Resident #2 care.	F 241		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		9/11/15

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F 312	Continued From page 7 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews, the facility failed to reattach a condom catheter and provide incontinence care upon request to 1 of 1 resident sampled with a condom catheter. (Resident #2). The findings included: Resident #2 was admitted to the facility on 04/22/15. His diagnoses included neurogenic bladder. The admission Minimum Data Set (MDS) dated 04/29/15 coded him with intact cognition, requiring total assistance for transfers and extensive assistance with toileting and hygiene. He was coded as being nonambulatory, using an external catheter and always being incontinent of bladder. The Care Area Assessment dated 05/05/15 for activities of daily living skills (ADLs) revealed Resident #1 was always incontinent when the condom catheter was off and he required assistance. A care plan was developed on 05/06/15 for an altered pattern of urinary elimination with a condom catheter. One goal was for Resident #2 to be clean, dry and free of odor or skin break down. Interventions included maintaining a	F 312	Resident #2 was assessed on 8/13/2015 by the Interim Director of Nursing and was provided care for incontinence. All residents were reviewed on 8/13/2015 by the Interim Director of Nursing and Assistant Director of Nursing via facility rounds for potential need of assistance with ADLS. No other issues were identified during the rounds. The CNA involved was retrained on 8/14/2015 by the Interim Director of Nursing on responding to the residents' care in a timely manner. Nursing staff retraining was initiated on 8/14/2015 and completed on 8/31/2015 by the Staff Facilitator regarding responding to residents' care in a timely manner. All newly hired nursing staff will be trained on responding to residents' care in a timely manner during orientation. Seventy (70) audits will be conducted by the Administrative Nurses and Charge Nurses to ensure residents' care is met in a timely manner daily x 4 weeks, weekly x 4 weeks and monthly x 3 months utilizing an audit tool. Any issues identified will be corrected immediately with further	

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F 312	Continued From page 8 closed drainage system with an unobstructed urine flow. Another care plan for urinary incontinence dated 05/06/15 included the interventions to provided pericare after each incontinent episode. The most recent quarterly MDS dated 07/22/15 also coded him with intact cognition and requiring extensive to total assistance with all activities of daily living skills, using an external catheter and being totally incontinent of urine. No changes were made to the existing care plan. On 08/13/15 at 11:21 AM, Resident #2 was observed in his room, in a gerichair and his catheter bag was empty. At this time he stated he was very frustrated due to his condom catheter had come off, he was wet, and he had been waiting for 3 hours to have care provided. At 11:36 AM, Nurse #1 entered with medication. In the presence of the surveyor, Nurse #1 told Resident #2 that staff was coming to give care. Resident #2 stated Nurse Aide (NA) #2 knew he needed care after breakfast. Nurse #1 told the resident that NA #1 was his assigned nurse aide and she had to finish another resident's care then NA #1 would get the lift and change him. Resident #2 again stated he told NA #2 at breakfast time he needed care. They began discussing the time frame of his request and wait period. Nurse #1 stated she told NA #1 just 30 minutes ago, when she became aware Resident #2 needed assistance. Resident #2 stated he had urinated 3 times since first letting staff know his condom catheter had come off. The nurse went to locate NA #1. On 08/13/15 at 11:44 AM, NA #1 was located standing in the doorway of another resident's	F 312	retraining and or other interventions as appropriate. Resident Council will be questioned regarding response to residents' care at the next 3 monthly meetings. Any issues reported will be forwarded to the Administrator for follow up. The results of the completed Audit Tools will be reviewed weekly by the Administrator and the Director of Nursing. The QA&A Committee will review the audits monthly x 3 months to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried as agreed upon at that time.	

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F 312	Continued From page 9	F 312		

room. When the surveyor asked if she was going to give care to Resident #2, NA #1 stated she was was supposed to go to lunch at 11:30 AM but could provide care if the surveyor wanted her to do it then. The surveyor stated that staff should do what she normally would do and NA #1 stated she would normally go to lunch. NA #1 then proceeded to tell Nurse #1 she was going to lunch, she poked her head inside Resident #2's door and left the unit. Nurse #1 stated to the surveyor, she would stop her medication pass and get another nurse aide to provide Resident #2 care. Nurse #1 stated she would have expected NA #1 to provide Resident #2 care before going to lunch or ask another nurse aide to cover for her and provide the resident care. Nurse #1 stated she had told NA #1 previously Resident #2 was wet. Nurse #1 immediately obtained a lift and the services of NA #2 and NA #3 at 11:50 AM. At this time, NA #2 was asked about his interaction with Resident #2. NA #2 stated that around 10 AM Resident #2 told him his catheter had come off and he needed it put back on. NA #2 stated he passed NA #1 around 10:15 AM and told her Resident #2 needed care.

Care was observed on 08/13/15 at 11:52 AM. Resident #2 was transferred via mechanical lift into bed from his geri chair. Resident #2's lift pad, the pad he had been sitting on, and his pants were observed wet with urine, his condom catheter was off, and the incontinent brief he was wearing was heavy and soaked in urine. Pericare was provided. The catheter bag was empty of urine as it had not been on the resident.

Interview with the Administrator and interim Director of Nursing (DON) on 08/14/15 at 8:31 AM revealed they expected NA #1 to change

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F 312	Continued From page 10 Resident #2 prior to going for lunch. Phone interview with NA #1 on 08/14/15 at 8:38 AM, with the Administrator and surveyor on speaker phone, revealed that when NA #2 told her Resident #2 needed care, she was showering another resident. NA #1 stated NA #2 told her around 10 AM the resident's catheter had come off of him. NA #1 denied she was told he was wet. NA #1 then said she had to get another resident up for therapy after she completed the shower. NA #1 stated she told Resident #2 what she had to do before giving him are and he was fine with it. NA #1 stated that when his catheter comes off, he just gets a little wet. She further stated it was a very busy day. NA #1 again confirmed that she did what she normally would have done which was going to lunch before giving Resident #2 care.	F 312		