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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 11/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER RD CHARLOTTE, NC 28256

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 policy review, resident interview, staff interviews and record reviews, the facility staff failed to follow the abuse policy by reporting 1 of 3 sampled residents' allegation of abuse to the administration for investigation. (Resident #1). The findings included: Review of the facility's Resident Abuse policy, last revised 01/01/12, included under the section of Employee Obligation: 1. Any employee who witnesses or has knowledge of an act of abuse to a resident is obligated to report such information to the Clinical Nurse in charge, Director of Clinical Services (Director of Nursing), and the Executive Director (Administrator); and 2. An employee shall be deemed to have violated his obligations if he fails to report an incident of abuse witnessed by or known to him/her. Resident #1 was admitted to the facility on 11/01/12 and readmitted following a hospitalization on 10/18/13 for rotator cuff arthopathy. Her diagnoses included rotator cuff repair, urinary tract infection, chronic back pain, anemia, anxiety, atypical psychosis, and depression.	F 226	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident #1 was interviewed and a statement was taken. Resident number 1 was assessed for physical injury on 11/13/13. The employee named in the allegation was suspended pending the completion of the investigation. The 24hour report was sent into the state reporting agency to notify of the allegation. The investigation was completed by the Director of Clinical Services and the Executive Director and the allegation was unsubstantiated. The 5 day summary was completed and sent with the summary of the investigation on 11/15/13. 2. Nurse #1 and the Activity Director were disciplined for failure to report the allegation to the Executive Director or Director of Clinical Services. Education was conducted for all employees according to the abuse policy. The Executive Director and/or Director of Clinical Services interviewed facility staff members to determine if any other allegations had not been reported. Current alert and oriented residents were interviewed to determine if there were any unreported allegations of abuse. None were identified. Skin sweeps were performed on non-interview able residents and did not find any new areas that would indicate abuse occurred.	12/13/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawna Brown — TITLE: Executive Director — (X6) DATE: 11/27/13

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.

DHHR NC Black Mountain MRO Received DEC 09 2013 by: PAM

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F 226	Continued From page 1 Medical record review revealed she was under the care of a psychologist for mood and her last visit dated 09/18/13 noted she was seen for persecutory feelings and reduced self efficacy. The most recent Minimum Data Set, an annual dated 10/25/13, coded her with long and short term memory impairments, moderately impaired decision making skills, no behaviors and no moods. She also required limited assistance with most activities of daily living skills. Her cognitive Care Area Assessment dated 10/25/13 described Resident #1 with behaviors of removing her physician ordered sling, refusing to wear it, declining to wear her bi-pap machine, and a history of numerous documented cases of accusing others of stealing her belongings when in fact she forgot where she hid them. Resident #1 was currently care planned for difficulty recalling recent events (originating 11/08/13), exhibiting attention seeking behaviors (originating 11/30/12), wandering and taking other residents' belongings (originating 01/14/13) and claiming others are stealing from her (originating 05/01/13). On 11/13/13 at 11:14 AM, during interview, Nurse Aide (NA) #1 described different types of abuse including physical abuse. NA #1 stated she would report any allegations of abuse to the Administrator, Director of Nursing (DON), or immediate supervisor immediately. NA #1 stated Resident #1 told her a couple of days ago that a nurse aide (named a first name) pushed her. NA #1 stated she reported this accusation to the charge nurse, identified as Nurse #1, who stated	F 226	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 3. The ED/DCS/Nurse Managers will interview 5 staff members randomly on all three shifts 5 times per week for 4 weeks, and then 5 staff members randomly on all three shifts 3 times a week for 3 weeks, and then 5 staff member a week for a month to ask questions regarding abuse and who they need to report to. 4. The Executive Director will report the results of the QI monitoring completed by the Executive Director to the Quality Assurance/Performance Improvement (QA/PI) Committee Monthly Meeting for review and recommendations for the stated time frame to ensure substantial compliance is sustained. Re-education will be provided as needed based on the findings.	

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F 226	Continued From page 2 she was already aware of the accusation. On 11/13/13 at 12:40 PM Nurse #1 was interviewed. Nurse #1 stated she would report any allegations of abuse to the DON and the Unit Manager (UM) immediately. Nurse #1 stated last week a nurse aide reported to her that Resident #1 had told the nurse aide that a another nurse aide (named) hit her in the chest. Nurse #1 stated she talked to Resident #1 herself and reported this accusation to the DON and the UM who she identified as UM #1. Nurse #1 stated Resident #1 said it occurred on Wednesday night and made her black and blue. Nurse #1 stated upon assessment, there was no bruising noted. Nurse #1 stated that upon checking the schedule, the accused NA was not working Wednesday night. The first shift UM #1 was interviewed on 11/13/13 at 11:36 AM. She stated that she was unaware of any accusation of abuse made by Resident #1. She further stated Resident #1 was more confused lately and laboratory testing was being done to find the source of the confusion. She further stated Resident #1 has had recent hallucinations about family living in the room next door and that the police are coming to get her. The UM #1 also stated that she would immediately inform the administrator of any allegations of abuse. She again stated she did not recall ever being informed of Resident #1 accusing a nurse aide of abuse. On 11/13/13 at 12:47 PM, Resident #1 stated during interview that a "young lady" came into her room and caught the resident taking herself to the bathroom and proceeded to "beat" her up in the chair. She stated it happened on a Tuesday	F 226		

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night, the week after she returned from shoulder surgery at 3:00 AM. She referred to the young lady by two separate but similar first names (which did not match NA #1's interview) but stated she did not know the lady's last name. She stated the lady called her name, told her she was not supposed to be up, and "pounded" her in the chest. Resident #1 stated she told someone on Friday but could not recall who she told. When asked why she waiting so long to report this incident she stated that she was in emotional shock and went back to sleep. She then stated she and her son met with the DON on Monday. Resident #1 stated she expected the facility to at least move the accused person to work on the other side of the building.

The Activity Director (AD) was interviewed on 11/13/13 at 2:02 PM and stated that if he heard any allegations of abuse, he would report the concern to administration immediately. He further stated that since beginning employment in September, he had heard of only one allegation of abuse which involved Resident #1. He stated about 8 to 9 days ago, he reported an allegation of abuse to the administration. He could not recall who he told, but stated it was either the Administrator, DON or social worker (SW). He also stated he was told the issue was being handled. The AD described Resident #1 as confused but due to the severity of the allegation he told administration. He then stated he had heard Resident #1 telling other staff the same thing. Upon follow up interview on 11/1/3/13 at 2:52 PM, the AD stated Resident #1 told him someone pushed her and that no one believed her.

Interview with SW #1 on 11/13/13 at 2:54 PM

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F 226	Continued From page 4 revealed she heard nothing about any abuse allegations from anyone about Resident #1. She stated she met with Resident #1's son 11/11/13 after Resident #1 told him she was going home with a staff member. The son did not say anything about abuse allegations. On 11/13/13 at 3:06 PM, DON stated during interview she heard about Resident #1's allegation of abuse just this date from NA #1 and has sent the 24 hour report and began the investigation. Upon follow up interview with Nurse #1 on 11/13/13 at 3:15 PM, Nurse #1 stated Resident #1 was also telling her therapists and nurse aides about the alleged abuse. She then stated the DON was out of town and said she thought UM #1 was present and told her she had informed the Administrator. Upon follow up interview with UM #1 on 11/13/13 at 3:20 PM, UM stated she was not here Friday when Nurse #1 allegedly told her of Resident #1's allegation of abuse. This was confirmed with payroll review. During interview on 11/13/13 at 3:46 PM, the Administrator stated she just learned about the allegation of abuse regarding Resident #1 this date. She stated her expectation was for staff to inform her or the DON immediately either in person or via phone. The Administrator stated she started an investigation this date and so far determined through interviewing that staff who were aware of the allegation "assumed" administration was aware and doing something about it. She further stated that staff reported they had not seen the accused nurse aide and	F 226		

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F 226	Continued From page 5 assumed she was suspended when in fact the accused nurse aide had just been calling off work. The Administrator produced a written statement from AD, that she had him write out this date as she was beginning the investigation, which stated the AD told someone in administration, who exactly he could not recall, and he was of the opinion the accusation was being investigated. The signed written statement stated he did not tell the administrator or the DON. Interview on 11/13/13 at 4:09 PM with the physical therapy aide who worked with Resident #1 last week, revealed Resident #1 did not mention anything to her relating allegations of abuse. The second shift Unit Manager #2 stated on 11/13/13 at 4:14 PM during interview she was unaware of the allegation made by Resident #1 and would have reported it to the Administrator or DON immediately via in person or by phone. SW #2 stated on 11/13/13 at 4:17 PM during interview, she knew nothing about allegations of abuse relating to Resident #1 and would have informed the administrator or DON immediately.	F 226		