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 07/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD 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 000	INITIAL COMMENTS The Division of Health Service Regulation Nursing Home Licensure and Certification Section conducted a recertification and complaint investigation survey from 07/14/14 through 07/23/14. Immediate Jeopardy at Past Non-Compliance was identified in 483.13(b) which began on 09/05/13 and ended on 09/06/13.	F 000		
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to cease care for a combative resident which resulted in a left arm fracture for 1 of 3 sampled residents with allegations of abuse (Resident #33). The findings included: Resident #33 was admitted to the facility on 01/08/04 with diagnoses which included dementia with psychosis and behavioral disturbances. Review of Resident #33's Minimum Data Set (MDS) dated 07/23/13 revealed an assessment of short term and long term memory problems with verbal and physical behaviors directed	F 223	Past noncompliance: no plan of correction required.	8/15/14

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

Electronically Signed | 08/15/2014

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F 223	Continued From page 1	F 223		

toward others. The MDS indicated Resident #33 required the extensive assistance of one person with personal hygiene and the extensive assistance of 2 persons with transfers.

Review of the care plan with a review date of 08/07/13 revealed Resident #33 would refuse assistance with activities of daily living with verbal behaviors toward staff. Interventions included use of gentle touch with calm, slow verbal responses to Resident #33 and observation for any signs or symptoms of agitation of frustration.

Review of nursing notes dated 09/05/13 revealed Nurse Aide (NA) #1 and NA #2 reported Resident #33 complained of left arm pain after care. The physician received notification on 09/05/13 and ordered an x-ray.

Review of an x-ray report dated 09/05/13 revealed an acute proximal left humeral fracture.

Review of a written statement dated 09/05/13 by NA #1 revealed he entered Resident #33's room with NA #2 at approximately 6:45 AM. NA #1 wrote: "I held (Resident #33) arms while (NA#2) cleaned Resident. Resident said we broke his arm."

Review of an undated written statement by NA #2 revealed she requested assistance from NA #1 when Resident #33 became combative with care. NA #2 wrote: "(Resident #33) continued cursing, hitting at us, fighting, trying to bite and kick us so he said we broke his arm."

Review of a 24 hour report dated 09/06/13 and a 5 day working report to the North Carolina Health Care Personnel Registry dated 09/13/13 revealed

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F 223	Continued From page 2	F 223		

the facility conducted an investigation of the allegation of physical abuse. The facility's investigation substantiated the allegation and terminated NA #1 and NA #2 from employment.

Interview with NA #3 on 07/17/14 at 8:15 AM revealed Resident #33 became combative at times with care. NA #3 explained Resident #33 usually responded to verbal redirection but if that was unsuccessful, staff approached Resident #33 a later time when care was accepted.

Interview with NA #4 on 07/17/14 at 9:15 AM revealed nurse aides received direction in the care for Resident #33 from the nurses. NA #4 explained Resident #33's refusal of care would indicate staff to approach at a later time.

Interview with the Director of Nursing (DON) on 07/18/14 at 8:22 AM revealed NA #1 and NA #2 immediately reported holding Resident #33's wrists during care and Resident #33's complaint of arm pain. The DON explained she immediately suspended NA #1 and NA #2 and conducted an investigation of abuse with the Administrator.

Interview with the Administrator on 07/18/14 at 11:01 AM revealed the investigation concluded the fracture occurred directly as a result the incident on 09/05/13 as reported by NA #1 and NA #2. The Administrator reported she terminated NA #1 and NA #2 from employment. The Administrator reported the investigation included interviews of residents able to be interviewed, skin assessments of all residents in addition to staff interviews. There were no additional residents identified with concerns regarding abuse. The Administrator reported a

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F 223	Continued From page 3 corrective action was immediately implemented which included the following measures to ensure residents were safe from abuse and neglect with compliance effective 09/06/13 for the past non-compliance: · All nursing, dietary, and housekeeping staff received training regarding appropriate response to combative residents in addition to abuse and neglect policies and procedures on 09/05/13 and 09/06/13. · The facility's Quality Assurance (QA) committee met on 09/06/13 to review the allegation and began weekly audits regarding resident abuse and neglect. · The QA weekly audits began on 09/06/13 for 4 weeks and monthly thereafter. The audits included resident interviews and observations of resident and staff interactions with provision of care. Observations, resident and staff interviews, review of facility documentation during the 07/14/14 to 07/23/14 survey revealed the facility implemented theses corrective actions beginning on 09/05/13 and concluding on 09/06/13 to ensure residents were free from abuse and neglect. Interviews with alert and oriented residents revealed there were no current allegations of abuse or neglect. Staff interviews revealed the facility provided training on prevention and reporting of abuse and neglect. Review of personnel record revealed employees received background checks and training in abuse and neglect. Review of North Carolina Health Care Personnel Registry reports revealed the facility reported allegations of abuse and neglect according to state regulations.	F 223		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		8/22/14

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F 309 SS=G	Continued From page 4 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff, hospice nurse, family member and physician interviews, and record review, the facility failed to administer morphine sulfate (a narcotic analgesic) when nonverbal pain symptoms (facial grimaces, body tenseness, body rocking and moaning) occurred for 1 of 3 sampled residents who required pain management (Resident #133). The findings included: Resident #133 was admitted to the facility on 12/24/09 with diagnoses which included Alzheimer's Disease, cerebral vascular accident, and seizure disorder. Review of Resident #133's initial hospice evaluation revealed Resident #133 began hospice care on 04/21/14. Resident #133's physician orders dated 04/23/13 directed administration of Ultram 50 milligram (mg.) tablet three times daily for pain. Review of Resident #133's significant change Minimum Data Set (MDS) dated 04/25/14 revealed an assessment of short and long term	F 309	F 309 (G) 1. For Resident #133, the Physician was notified on 7/16/2014 and gave additional orders related to pain medications. The orders were to discontinue previous scheduled Morphine order and start Morphine Concentrate 20 milligrams per milliliter and give 10 milligrams by mouth sublingually every 6 hours scheduled. 2. Other residents residing in the facility exhibiting pain symptoms including nonverbal pain symptoms had the potential to be effected. Residents currently residing in the facility had pain assessments completed and orders reviewed on 7/16/2014 and 7/17/2014 by the Director of Clinical Services/Administrative Nurses/Licensed Nurses to ensure that anyone exhibiting pain symptoms were medicated per physician□s order. 3. Re-education was provided to the nursing staff by the Director of Clinical	

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F 309	Continued From page 5 memory problems with severely impaired decision making ability. Review of a telephone physician's orders dated 06/18/14 revealed an order received by Resident #133's hospice nurse for administration of morphine sulfate (a narcotic analgesic) 5 mg. in a liquid form orally or under the tongue on a scheduled basis every 6 hours. The physician also ordered the morphine sulfate to be given 5 mg. every hour as needed for mild pain, restlessness and/or shortness of breath, 10 mg. every hour as needed for moderate pain, restlessness and/or shortness of breath, and 20 mg. every hour as needed for severe pain, restlessness and/or shortness of breath. Review of a hospice nursing note dated 06/18/14 revealed documentation of a discussion with Resident #133's physician and family member regarding pain management and need for scheduled administration of morphine sulfate. The hospice nurse documented: "comfort directed care to "keep pt. (patient) calm and peaceful" with a report to the facility nurse (Nurse # 1). Review of Resident #133's care plan reviewed on 7/11/14 revealed Resident #133's problems included a potential for pain. Interventions included staff direction to report to hospice any signs or symptoms of nonverbal pain which included: changes in breathing, vocalizations of grunting, moaning, yelling out, silence, changes in behavior, facial expressions of sadness, crying, worried, clenched teeth and body tensing, rigid rocking or curling. Other interventions included hospice communication with family members about pain and options for pain management in	F 309	Services/Administrative Nurses regarding recognizing signs and symptoms of pain including nonverbal indications of pain which include but are not limited to facial grimaces, body tenseness, body rocking and moaning and administering pain medications per physician□s order. Observations will be conducted by the Director of Clinical Services/Administrative Nurses 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then weekly for 4 months to observe for signs and symptoms of pain as well as timely administration of medications by the Licensed Nurse per physician□s order and also the effectiveness of pain medication administered. Observations will include both verbal and nonverbal indicators of pain and may include but not be limited to facial grimaces, body tenseness, and body rocking and moaning. The Director of Clinical Services/Administrative Nurse(s) will conduct a review of physician□s orders for pain medications as well as effectiveness of administered pain medications for 5 residents per week for 6 months to ensure that pain medications ordered are effective in pain management. This review will also identify that if pain medications are not effective in pain management that the Licensed Nurse notified the Physician for additional orders to address the resident□s pain. 4. The observations and findings from the reviews will be discussed by the Executive Director/Director of Clinical Services/Administrative Nurse in the	

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F 309	Continued From page 6 addition to administration of pain medication. Review of Resident #133's July 2014 Medication Administration Record revealed Ultram 50 mg. scheduled to be administered at 6:00 AM, 2:00 PM and at 10:00 PM. The morphine sulfate 5 mg. was scheduled at 6:00 AM, 12:00 PM, 6:00 PM and at 12:00 AM. An observation on 07/15/14 at 9:02 AM revealed Nurse Aide (NA) #3 fed the breakfast meal to Resident #133. Resident #133 moaned and squeezed both eyes shut when addressed. NA #3 explained he reported Resident #133's moans and facial grimaces to Nurse #1. NA #3 reported Resident #133 moaned and grimaced throughout the breakfast meal. Observations on 07/15/14 at 9:06 AM, 9:24 AM, 9:27 AM and at 10:15 AM revealed Resident #133 moaned and grunted with his mouth open. The moaning and grunting could be heard in the hallway outside Resident #133's open door. Interview with Nurse #1 on 07/15/14 at 10:18 AM revealed Resident #133 received the regularly scheduled morphine sulfate at 6:00 AM and she just administered an additional dose of 10 mg. Nurse #1 explained Resident #133 received repositioning and incontinent care in addition to the pain medication. Nurse #1 reported NA #3 reported Resident #133's pain symptoms during the breakfast meal. Nurse #1 explained she could tell Resident #133 remained in pain due to his tense body position and moaning. Nurse #1 explained Resident #133 was not able to verbalize pain. Nurse #1 reported she would continue to administer the pain medication every hour until Resident #133 became comfortable.	F 309	monthly Quality Assurance Performance Improvement Committee Meeting for 6 months. Recommended revisions to the plan will be discussed by the committee to sustain substantial compliance. 5. 8/22/2014	

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Nurse #1 was not able to provide a reason for the delay in pain medication administration from 9:02 AM until 10:18 AM.

An observation on 07/15/14 at 11:23 AM revealed Resident #133 continued to moan with a facial grimace. Nurse #1 administered 20 mg. of morphine sulfate which she reported was for breakthrough pain.

An observation on 07/15/14 at 12:40 PM revealed Resident #133 moaned with both eyes closed, seated in a geriatric chair. Resident #133 rocked back and forth and squeezed both eyes tighter when addressed by voice.

An observation on 07/15/14 at 2:54 PM revealed Resident #133 asleep in the geriatric chair. Nurse #1 reported she administered an additional dose of 20 mg of morphine sulfate at 1:30 PM.

Interview with Nurse #1 on 07/17/14 at 8:29 AM revealed the additional doses of morphine sulfate she administered on 07/15/14 were not effective for approximately 4 hours. Nurse #1 reported hospice oversaw Resident #133's pain management and she intended to inform the hospice nurse on the next hospice visit which should be today (07/17/14).

Interview with the hospice nurse on 07/17/14 at 10:45 AM revealed Resident #133 should receive the as needed pain medication when pain symptoms occurred. The hospice nurse reported Resident #133 was placed on routine administration of the morphine in order to maintain comfort. The hospice nurse explained Resident #133 would build up a tolerance to the morphine sulfate and require a greater dose to

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achieve effective pain relief. The hospice nurse reported staff received education and direction that Resident #133's moaning and facial expressions were indications of pain. The hospice nurse explained it was difficult to assess Resident #133's pain but he should not continue moaning and grimacing if the pain medication was effective.

Interview with Nurse #2 on 07/17/14 at 11:30 AM revealed the hospice nurse received a physician's order to increase the morphine from 5 mg. to 10 mg. every 6 hours.

Interview with the Director of Nursing (DON) on 07/17/14 at 4:08 PM revealed she expected staff to administer pain medication when indicated.

Interview with Resident #133's physician on 07/17/14 at 4:58 PM revealed Resident #133 usually moaned and the moaning would not necessarily indicate pain. The physician explained Resident #133's pseudobulbar syndrome caused Resident #133 to continually moan which made pain assessment difficult. (Pseudobulbar syndrome is a medical condition characterized by uncontrollable episodes of verbal outbursts and facial movements.) The physician reported body movement would be an indicator of pain and Resident #133 should receive pain medication as ordered.

Telephone interview with Resident #133's family member on 07/18/14 at 3:36 PM revealed he discussed pain management on several occasions with the hospice nurse. Resident #133's family member reported he expected comfort measures to include the absence of frequent moaning, facial grimaces and

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F 309	Continued From page 9 restlessness.	F 309		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to offer fluids between meals for 1 of 3 sampled residents with physician ordered thickened liquids (Resident #77). The findings included: Resident #77 was admitted to the facility on 03/24/09 with diagnoses which included dementia and a history of dysphagia. Review of Resident #77's annual Minimum Data Set dated 06/12/14 revealed an assessment of moderately impaired cognition with the ability to understand and be understood by others. Resident #77 required the physical assistance and supervision of one person with eating. Review of Resident #77's monthly physician's orders dated 07/01/14 revealed direction to serve a mechanical soft with pureed dessert diet and nectar thick liquids. Review of Resident #77's care plan dated 07/02/14 revealed a risk for urinary tract infections with included the intervention of	F 327	F 327(D) 1. Resident #77 was provided with Nectar Thickened Liquids on 7/17/2014 by the Licensed Nurse. 2. Residents residing in the facility with physician□s orders for thickened liquids have the potential to be affected. A review of residents in the facility with physician□s orders for thickened liquids was completed by the Director of Clinical Services/Administrative Nurses on 7/17/2014 to ensure accuracy of physician□s orders for thickened liquids. Observations by designated department managers were conducted on room rounds on or before 8/22/2014 to ensure that residents with orders for thickened liquids have thickened liquids available in their room. A review of tray tickets was conducted on or before 8/22/2014 to ensure that residents with orders for thickened liquids had the appropriate order on the tray ticket. An observation of liquids provided at mealtimes has been conducted on or before 8/22/2014 by the	8/22/14

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F 327	Continued From page 10 encouragement of extra fluids between meals. Observation of Resident #77 on 07/14/14 at 10:50 AM revealed Resident #77 seated in a wheelchair with an empty lidded plastic glass on the over the bed table within reach. Interview with Resident #77 on 07/15/14 at 11:11 AM revealed she was thirsty and did not have independent access to obtain water. Observation of Resident #77's room revealed there were no fluids available in the room. Observation on 07/16/14 at 9:52 AM revealed Resident #77 seated in a wheelchair with an empty lidded plastic glass on the over the bed table within reach. There were no fluids available in the room. Interview on 07/16/14 at 11:17 AM with Resident #77 revealed she would like a drink of water but did not want to bother the nursing staff. Resident #77 explained she could not have water in her room but did not know the reason. Observation of delivery of the lunch meal by Nurse Aide (NA) #3 on 07/16/14 at 1:23 PM revealed Resident #77 received 4 ounces of nectar thick tea. Resident #77 consumed 100% of the tea which was the only beverage served with the lunch meal. Resident #77's dietary slip indicated nectar thick water was also to be served. Interview on 07/16/14 at 1:51 PM with NA #3 revealed Resident #77 received nectar thickened fluids on the meal trays. NA #3 explained all beverages were sent by dietary with the meals and residents could request fluids between	F 327	Dietary Manager/Administrative Nurse to ensure that liquids provided were consistent with what was documented on the tray ticket. Thickened Liquids are also available in the nourishment kitchens for nursing staff to have available to provide to residents as indicated. 3. Re-education has been provided by the Director of Clinical Services/Administrative Nurses to the nursing staff on or before 8/22/2014 regarding providing residents with sufficient fluid intake to maintain proper hydration and health. Education also included provision of fluids to residents between meals including residents with physician□s orders for thickened liquids. Other systemic changes include provision of a Hydration cart to come out three times per day between meals to include thickened liquids and to be offered to residents by nursing staff to begin on or before 8/22/2014. Observations will be conducted by the Director of Clinical Services /Executive Director/Administrative Nurses 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 months to ensure that residents are offered fluids/liquids between meals to include residents with orders for thickened liquids. Other systemic changes include coolers to be placed at the bedside of residents with physician□s orders for thickened liquids containing the appropriate physicians ordered liquid consistency to ensure that residents requiring thickened liquids have liquids	

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F 327	Continued From page 11 meals. NA #3 explained staff did not routinely offer fluids to Resident #77 since she could ask for her cup to be filled. NA # 3 did not notice the omission of water with Resident #77 ' s meal. Observation on 07/16/14 at 2:02 PM revealed Resident #77 returned to her room and an empty lidded plastic cup was on the over the bed table. There were no fluids available in the room. Observation on 07/16/14 at 4:23 PM revealed Resident #77 drinking thin water from a plastic lidded cup without difficulty. Resident #77 explained she filled the cup independently from the drinking fountain across the hall because she was thirsty. Resident #77 did not remember if thickened water was required. Interview on 07/17/14 at 4:24 PM with Nurse #4 revealed Resident #77 required nectar thick liquids and Nurse #4 obtained nectar thick water for Resident #77 after removal of the thin water. Nurse #4 reported Resident #77 received thickened liquids with meals and if requested. Interview on 07/16/14 at 4:30 PM with NA #6 revealed Resident #77 would be offered thickened liquids with the bedtime snack. NA #6 reported Resident #77 could request thickened fluids but none were kept in her room for independent access. Interview on 07/17/14 at 8:40 AM with Nurse #2 revealed nurse aides were to offer residents thickened liquids between meals from the kitchen. Nurse #2 explained the system of keeping thickened liquids in resident rooms changed recently so nurse aides needed to offer fluids. Nurse #2 explained the cup in Resident	F 327	available to them. Designated department managers will conduct room rounds three times per week for four weeks, then two times per week for four weeks, then weekly for 4 months to ensure that the liquid consistency provided is the appropriate physician□s ordered consistency. 4. Results of the reviews and observations will be discussed by the Director of Clinical Services/Administrative Nurse/Dietary Manager monthly at the Quality Assurance Performance Improvement Committee Meeting for six months. The Quality Assurance Performance Improvement Committee Meeting will recommend revisions to the plan to sustain substantial compliance. 5. 8/22/2014	

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 07/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 327	Continued From page 12	F 327		

#77's room should be filled with the nectar thick water.

Observation on 07/17/14 at 8:46 AM revealed the nursing unit's nourishment refrigerator contained one container of nectar thick water and one container of nectar thick cranberry juice.

Interview on 07/17/14 at 9:13 AM with NA #4 revealed residents who received thickened liquids received fluids with meals and upon request. NA #4 reported there were no specific directions to offer fluids routinely to residents with thickened fluids.

Interview on 07/17/14 at 10:14 AM with the dietary manager revealed nursing staff could request thickened liquids from the kitchen for distribution between meals. The dietary manager reported the kitchen sent thickened liquids to the nursing unit with the 8:00 PM delivery of bedtime snacks. The dietary manager explained the omission of nectar thick water on Resident #77's lunch tray was an error on the tray line.

Interview on 07/17/14 at 3:52 PM with the Director of Nursing (DON) revealed nurse aides were to offer fluids between meals on a regular basis to residents who required thickened liquids. The DON explained the nurse aides should offer these fluids when they pass the water and ice. The DON explained this was an unwritten general facility policy. The DON reported residents should be able to access thickened liquids when desired.