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 12/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		1/10/18

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

Electronically Signed | 12/29/2017

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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident/staff interviews and review of the medical record, the facility failed to promote the dignity of Resident #61 as evidenced by not providing him nail care prior to dining in the main dining room, attending an activity and ambulating in the hallway with therapy staff for 1 of 3 residents sampled for dignity. The findings included: Resident #61 was admitted to the facility on 8/20/16. Diagnoses included dementia, phthisis bulbi of the left eyelid (non-functional eye) and severe cervical spinal stenosis. A quarterly Minimum Data Set dated 10/18/17 assessed Resident #61 with clear speech, able to make himself understood/understand, moderately impaired vision, required the use of corrective lenses (glasses), moderately impaired cognition, required extensive staff assistance with activities of daily living (ADL) to include dressing and bathing and limited staff assistance with personal hygiene. A care plan, revised on 11/8/17 identified Resident #61 was at potential risk for injury and ADL self-care performance deficit due to dementia, poor safety awareness, confusion, and deconditioning. Interventions included that staff would assist Resident #61 with ADL. Resident #61 was observed in his room on 12/05/17 at 11:35 AM with the finger nails of both his right and left hands untrimmed and jagged.	F 550	On 12/22/2017, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure residents rights and dignity is maintained related to nail care. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #61, it was determined that the facility failed to monitor that nursing staff observed nails for length, smooth edges and cleanliness during scheduled showers and daily hygiene care for dependent residents to maintain dignity. On 12/8/17, Resident #61 nails were cleaned and trimmed and care plan updated to include weekly and as needed and/or requested nail care. Nail care to be provided by certified nurse aides (CNAs) while honoring resident choice and monitored by licensed nurses for compliance. On 12/11/2017, Director of Clinical Services (DCS) and / or designee completed a QA (quality assurance) monitoring of 100 current residents to ensure nails were cleaned, trimmed and	

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F 550	Continued From page 2 The fingernail to his right hand, fifth digit was observed to extend approximately 1-2 inches beyond the tip of the nail bed. Resident #61 stated during the observation "I need somebody to cut them (nails) down and trim them." Resident #61 was also observed with his fingernails the same on 12/6/17 at 2:00 PM in a group activity, 12/7/17 at 11:00 AM ambulating on the unit with occupational therapy staff while he passed other residents in the hallway, and 12/7/17 at 12:23 PM and 5:45 PM in the main dining room at a table with 3 other residents. An interview with Nurse Aide (NA) #2 occurred on 12/07/17 at 2:58 PM and revealed she assisted Resident #61 with a shower on the 7 AM to 3 PM shift that day, but that she "did not notice that anything was going on with his nails." NA #2 stated that she did not offer nail care to Resident #61 during the shower because she did not notice that he needed it. NA #2 stated she would report to the oncoming NA to trim his nails. A follow up interview occurred with Resident #61 on 12/07/17 at 3:20 PM. Resident #61 stated he received a shower earlier that day, but that his nails did not get trimmed. He further stated that he did not like being in public settings with untrimmed/jagged nails and when he was more independent with his care, he kept his finger nails trimmed/filed. A follow up interview with NA #2 occurred on 12/08/17 at 9:01 AM and revealed that she forgot to report to the oncoming NA that Resident #61 needed nail care. An interview with the Unit Manager (UM) on	F 550	free from jagged edges to promote and maintain dignity. Follow up/nail care completed based on findings By 1/5/2017, Director of Clinical Services (DCS) and / or designee provided education to nurse aides and licensed nurses on the policy for providing and monitoring routine resident nail hygiene and maintaining resident dignity. Nursing staff to observe residents□ nails for length, smooth edges and cleanliness during routine hygiene care and provide nail care as appropriate and per resident choice to maintain resident dignity. Nail care to be provided and documented per weekly bathing schedule and as needed and/or requested by the resident. The licensed nurse supervisor to monitor nail care by routine random observations and by review of shower documentation for compliance. Newly hired nurse aides and licensed nurses will be educated upon hire. The Director of Clinical Services or Licensed Nurse Supervisor to complete quality assurance monitoring of 5 random residents to ensure appropriate nail care to maintain dignity. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings.	

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F 550	Continued From page 3 12/08/17 at 9:07 AM revealed she had just observed the fingernails of Resident #61 and stated that his nails needed to be filed and trimmed. The UM further stated that she expected nail care to be offered/provided and that Resident #61 had one nail that was "really long" and that some of the other nails were jagged and should be filed. An interview with NA #3 on 12/08/17 at 9:33 AM revealed that she noticed that Resident #61 needed nail care, but that he was on his way to an activity so she told him she would come back later, but then stated that "I did not get back around to trimming his nails." An interview with the Director of Clinical Services on 12/08/17 at 1:26 PM revealed she expected nail care to be offered to any resident who needed it and that fingernails should be trimmed/clean to promote the dignity of all residents.	F 550	The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months .The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of	F 577		1/10/18

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F 577	Continued From page 4 the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to post the correct location of survey results. The findings included: Interview with Resident #53, resident council president, on 12/07/17 at 12:21 PM revealed she did not know if the facility's survey results were available. Observation on 12/08/17 at 11:52 AM revealed a sign posted on the main hallway which indicated the facility's results were located outside the administrator's office. Observation on 12/08/17 at 11:53 AM revealed there were no survey results or posted notice outside the administrator's office. Observation on 12/08/17 at 11:54 AM revealed a binder entitled "Facility Survey Result" in a plastic wall file on top of a two-drawer wood file cabinet in the front lobby.	F 577	On 12/22/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure survey results are available for viewing at the location posted. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings, it was determined that the facility failed to ensure that survey result signage is updated when the location of survey results are moved. Survey result posting is the responsibility of the Administrator and during times of management transition, may be delegated to the Regional Interim Administrator or Director of Clinical Services who will be	

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F 577	Continued From page 5 Interview with the receptionist on 12/08/17 at 11:56 AM revealed a previous administrator changed the facility survey result binder location approximately 2 to 3 weeks ago. Interview with the acting administrator on 12/08/17 at 12:42 PM revealed the facility should post the correct location of the survey results.	F 577	responsible for ensuring residents, family and visitors have access to the survey results of the facility. On 12/11/17, Executive Director updated the signage throughout the facility to indicate the location of the survey results in the front lobby. On 12/27/17, the facility held a Resident Council meeting to communicate the location of the facility survey results. During Mock Survey Rounds facility staff to inform residents of location of Survey results when location is changed. On 12/28//17, the Regional Director of Clinical Services provided education to the Administrator, Regional Interim Administrator and Director of Clinical Services on the residents right of access to survey results. Education included updating signage to reflect the accurate location of survey results and notification to residents and family through facility council meetings when changing survey results location. Newly hired Administrators, Interim Administrators and Directors of Clinical Services will be educated upon hire. The Administrator to ensure proper signage and communication to residents, family and guests regarding the location of the facilities survey results to maintain residents rights. During times of management transition, the Interim Administrator designee or Director of Clinical Services will assume responsibility. New residents to also	

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F 577	Continued From page 6	F 577	receive notification upon admission. The Director of Social Services or Activities to complete quality assurance monitoring of survey results location in front lobby per signage and of 5 random residents to ensure knowledge of survey result location. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months .The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this	

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F 577	Continued From page 7	F 577	plan. AOC date= 1/10/18	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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, resident/staff interviews and review of medical records, the facility failed to provide nail care to 2 of 5 sampled residents who were dependent on staff for assistance with activities of daily living (Residents #61 and #82). The findings included: 1. Resident #61 was admitted to the facility on 8/20/16. Diagnoses included dementia, phthisis bulbi of the left eyelid (non-functional eye) and severe cervical spinal stenosis. A quarterly Minimum Data Set dated 10/18/17 assessed Resident #61 with clear speech, able to make himself understood/understand, moderately impaired vision, required the use of corrective lenses (glasses), moderately impaired cognition, required extensive staff assistance with activities of daily living (ADL) to include dressing and bathing and limited staff assistance with personal hygiene. A care plan, revised on 11/8/17 identified Resident #61 was at potential risk for injury and ADL self-care performance deficit due to	F 677	On 12/22/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure residents dependent on assistance of staff with ADLs receive nail care per their plan of care. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #61 and #82, it was determined that the facility failed to monitor that nursing staff observed nails for length, smooth edges and cleanliness during scheduled showers and daily hygiene care for dependent residents. On 12/8/17, Resident #61and #82 nails were cleaned and trimmed per plan of care. Nail care will continue to be provided by certified nursing assistants and monitored	1/10/18

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F 677	Continued From page 8 dementia, poor safety awareness, confusion, and deconditioning. Interventions included that staff would assist Resident #61 with ADL. Resident #61 was observed in his room on 12/05/17 at 11:35 AM with the finger nails of both his right and left hands untrimmed and jagged. The fingernail to his right hand, fifth digit was observed to extend approximately 1-2 inches beyond the tip of the nail bed. Resident #61 stated during the observation "I need somebody to cut them (nails) down and trim them." Resident #61 was also observed with his fingernails the same on 12/6/17 at 2:00 PM, 12/7/17 at 11:00 AM, 11:21 AM, 12:23 PM, 3:20 PM and 5:45 PM and 12/8/17 at 8:35 AM. An interview with Nurse Aide (NA) #2 occurred on 12/07/17 at 2:58 PM and revealed she assisted Resident #61 with a shower on the 7 AM to 3 PM shift that day, but that she "did not notice that anything was going on with his nails." NA #2 stated that she did not offer nail care to Resident #61 during the shower because she did not notice that he needed it. NA #2 stated she would report to the oncoming NA to trim his nails. A follow up interview occurred with Resident #61 on 12/07/17 at 3:20 PM. Resident #61 stated he received a shower earlier that day, but that his nails did not get trimmed. A follow up interview with NA #2 occurred on 12/08/17 at 9:01 AM and revealed that she forgot to report to the oncoming NA that Resident #61 needed nail care. An interview with the Unit Manager (UM) on	F 677	by licensed nurses for compliance. On 12/11/17, Director of Clinical Services (DCS) and / or designee completed a QA (quality assurance) monitoring of 100 dependent residents to ensure nails were cleaned, trimmed and free from jagged edges per plan of care. Follow up/nail care provided as indicated by findings By 1/5/2017, Director of Clinical Services (DCS) and / or designee provided education to nurse aides and licensed nurses on the policy for providing and monitoring routine resident nail hygiene. Nursing staff to observe residents□ nails for length, smooth edges and cleanliness during routine hygiene care and provide nail care as appropriate or per resident choice. Nail care to be provided and documented per weekly bathing schedule and as needed and/or requested by the resident. The licensed nurse supervisor to monitor nail care by routine random observations and by review of shower documentation for compliance. Newly hired nurse aides and licensed nurses to be educated upon hire. The Director of Clinical Services or Licensed Nurse Supervisor to complete quality assurance monitoring of 5 random dependent residents to ensure appropriate nail care per plan of care or per resident choice. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance	

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F 677	Continued From page 9 12/08/17 at 9:07 AM revealed she had just observed the fingernails of Resident #61 and stated that his nails needed to be filed and trimmed. The UM further stated that she expected nail care to be offered/provided as part of ADL care and that it should be done without the resident having to ask. The UM stated that Resident #61 had one nail that was "really long" and that some of the other nails were jagged and should be filed. An interview with NA #3 on 12/08/17 at 9:33 AM revealed that she noticed that Resident #61 needed nail care, but that he was on his way to an activity so she told him she would come back later, but then stated that "I did not get back around to trimming his nails." An interview with the Director of Clinical Services on 12/08/17 at 1:26 PM revealed she expected nail care to be offered to any resident who needed it and that fingernails should be trimmed/clean. 2. Resident #82 was admitted to the facility on 3/21/14. Diagnoses included Parkinson's disease, osteoarthritis, hand contractures, and lack of coordination. A quarterly Minimum Data Set dated 11/3/17 assessed Resident #82 with clear speech, able to make himself understood/understand, impaired vision, required the use of corrective lenses (glasses), impaired cognition, required extensive staff assistance with activities of daily living (ADL) to include dressing, bathing and personal hygiene. A care plan, revised on 11/15/17 identified	F 677	Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan.	

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F 677	Continued From page 10	F 677		

Resident #82 was at potential risk for ADL self-care performance deficit due to limited range of motion, contractures and osteoarthritis. Interventions included that staff would assist Resident #82 with ADL.

Resident #82 was observed in his room on 12/05/17 at 12:38 PM with the fingernails to both his right/left hands untrimmed and jagged. Resident #82 stated "I need them trimmed, they do it, but not often enough; I have to ask when I want it done."

Resident #82 was observed again on 12/07/17 at 11:54 AM and 12/8/17 at 8:43 AM with his fingernails the same and confirmed that he still wanted his nails trimmed.

An interview occurred on 12/07/17 at 3:01 PM with NA #2 who stated that Resident #82 required total staff assistance with ADL. NA #2 stated that she gave Resident #82 a bed bath that morning but that she did not notice that his nails were jagged and that she did not offer nail care because it was not his shower day.

An interview with the Unit Manager (UM) on 12/08/17 at 9:07 AM revealed she had just observed the fingernails of Resident #82 and stated that his nails needed to be filed and trimmed. The UM further stated that she expected nail care to be offered/provided as part of ADL care and that it should be done without the resident having to ask.

A telephone interview occurred on 12/08/17 at 11:57 AM with NA #3 who stated that Resident #82 had limited range of motion in his hands due to arthritis. NA #3 stated that she asked the nurse

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	345388	A. BUILDING _____ B. WING _____	C 12/08/2017

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(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 677	Continued From page 11 for some clippers that week to trim resident's nails, but that she never got back to the nurse to get the clippers to provide nail care to residents she was assigned to. An interview with the Director of Clinical Services on 12/08/17 at 1:26 PM revealed she expected nail care to be offered to any resident who needed it and that fingernails should be trimmed/clean.	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on 2 dining observations, a resident interview, staff interviews and review of facility	F 692	On 12/22/17, a Quality Assurance Performance Improvement (QAPI)	1/10/18

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F 692	Continued From page 12 records, the facility failed to provide large portions per a physician order to a resident with a history of weight loss for 1 of 4 sampled residents reviewed for nutrition (Resident #61). The findings included: Resident #61 was admitted to the facility on 8/20/16. Diagnoses included dementia and diabetes mellitus type 2. Medical record review revealed a diet order communication dated 9/1/16 which recorded Resident #61 would receive large portions with his meals. A quarterly Minimum Data Set dated 10/18/17 assessed Resident #61 with clear speech, able to make himself understood/understand, moderately impaired cognition, required set up assistance and supervision from staff with meals, received a therapeutic diet, with no current significant weight changes. A care plan, revised on 11/8/17 identified Resident #61 was at potential risk for imbalanced nutrition/hydration as a result of the daily use of a diuretic for fluid imbalance, insulin for diabetes and a history of weight loss. Interventions included for staff to provide/serve his diet as ordered (carbohydrate controlled, no added salt, large portions diet), provide/serve his food preferences, evaluate his intake and make diet change recommendations as needed. Review of the December 2017 cumulative physician orders revealed Resident #61's order was for a regular texture, carbohydrate controlled, no added salt diet with large portions with meals.	F 692	meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure residents at risk for imbalanced nutrition receive nutrition as ordered. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #61, it was determined that the facility failed to ensure that nurse aides follow physician orders per meal ticket to maintain nutrition. On 12/11/17, the Director of Clinical Services provided 1:1 reeducation to NA (nurse aide) #1 and #5 on the importance of reviewing meal tickets against meal served to resident to adhere to physician orders and to maintain nutritional status. On 12/11/17, Dietary Manager completed a QA (quality assurance) monitoring of meal service to ensure residents receive nutrition as ordered and as reflected on corresponding meal ticket. By 1/5/17, Director of Clinical Services (DCS) and / or designee provided education to nurse aides on the importance of reviewing meal tickets against meal served to resident to adhere to physician orders and to maintain nutritional status. Education included but, not limited to providing attention to special	

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F 692	Continued From page 13 Resident #61 was observed on 12/07/17 at 12:23 PM in the main dining room. Review of his tray card revealed he should receive large portions with his meal. Nurse Aide (NA) #5 set up the lunch meal for Resident #61. The meal tray included two servings of beef stew (the 2nd serving was in a bowl with a lid), one serving of potatoes, one serving of fruit cocktail, one roll, eight ounces coffee and eight ounces iced tea. NA #5 removed the 2nd serving of beef stew (in a bowl with a lid) without offering it to Resident #61, she stated "They sent too much," and then walked away. Resident #61 ate 100% of his meal. An interview with Resident #61 occurred on 12/07/17 at 3:20 PM. He stated that large portions was added to his diet shortly after his admission to the facility because he was losing weight. Resident #61 confirmed that he did not receive large portions with his lunch meal that day, but that he would have eaten more if it were offered. Resident #61 was observed on 12/07/17 at 5:45 PM in the main dining room. Review of his tray card revealed he should receive large portions with his meal. NA #1 set up the supper meal for Resident #61. The meal tray included one serving of chicken pot pie, one serving of squash/zucchini, one roll, one cookie, and eight ounces of tea. Large portions were not provided. An interview with the District Dietary Manager (DDM) occurred on 12/07/17 at 5:50 PM and revealed a resident with a physician's order for large portions should receive two servings of the entrée from the dietary department without having to ask. The DDM observed the supper meal for	F 692	diet orders for double portions. Newly hired nurse aides to be educated upon hire. Residents nutrition orders to be printed on meal ticket and used to communicate nutritional needs. The nurse aide to ensure meal served matches meal ticket ordered to include attention to special nutritional needs, such as double entree provided as indicated to maintain residents nutritional status. The Dietary Manager or Licensed Nurse Supervisor to complete quality assurance monitoring of 5 random residents during meal service to ensure meal served matches nutritional orders. Monitoring to be completed at a frequency of 4 meals per week for 4 weeks then, 2 meals per week for 8 weeks, then one meal monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee based on Quality Monitoring findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months .The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant,	

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F 692	Continued From page 14 Resident #61 and confirmed he did not receive a large portion entrée. The DDM offered Resident #61 a second portion of the chicken pot pie which he accepted. Resident #61 ate 100% of his meal. NA #1 was interviewed on 12/07/17 at 6:02 PM and stated that she set up meals for Resident #61 before, but was not aware that his tray card recorded large portions. NA #1 stated "I have not noticed that before", but that she would get him more to eat if he asked. An interview with the Unit Manager (UM) occurred on 12/08/17 at 9:07 AM and revealed Resident #61 should receive large portions with his meals because of his history of weight loss; she expected staff to review the tray cards when providing set up assistance with meals to ensure the resident received the correct diet. An interview with the Director of Clinical Services (DCS) on 12/08/17 at 9:15 AM revealed Resident #61 had a history of weight loss and should receive large portions with his meals per the physician order. She stated that she expected all residents to receive their diets as ordered.	F 692	Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan.	
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident,	F 697	On 12/22/17, a Quality Assurance	1/10/18

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F 697	Continued From page 15 staff and medical doctor interviews, the facility failed to stop doing a dressing change, assess a resident for pain and administer pain medication as ordered by the physician for pain control for 1 of 3 residents (Resident #39) reviewed for wound care. The findings included: Resident #39 was admitted to the facility on 8/28/17 with diagnoses which included peripheral vascular disease, malignant prostate cancer and unstageable vascular ulcer of the left third toe. A review of the Significant Change Minimum Data Set (MDS) dated 10/09/17 revealed that Resident #39 had moderately impaired cognition with periods of confusion but was able to make needs known. The MDS also revealed Resident #39 had no behaviors, had a bladder catheter and was incontinent of stool. The MDS revealed Resident #39 received as needed (prn) pain medication for occasional moderate pain. A review of Resident #39's chart revealed an order written on 10/10/17 by the physician's assistant which read in part "Monitor for pain prior to, during and after wound care." A review of the Care Area Assessment (CAA) summary for dated 10/19/17 revealed Resident #39 did not trigger for pain at the time of the assessment but there was a care plan for pain. A review of Resident #39's chart revealed a wound care nurse's note dated 11/07/17 which read in part "Toe painful to touch." A review of the care plan for Resident #39 dated	F 697	Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure residents are monitored and provided care for pain prior to, during and after wound care as ordered and per residents plan of care. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #39, it was determined that the facility failed to ensure that licensed nurses were properly educated on the importance of assessing residents for pain prior to, during and after wound care treatments to control pain. On 12/11/17 , Director of Clinical Services (DCS) and / or designee completed a QA (quality assurance) monitoring of residents receiving wound care to ensure an appropriate plan of care is in place and followed to address the residents pain prior to, during and after wound care. Care plans updated by licensed nurse as appropriate. By 1/5/17, the Director of Clinical Services provided education and skills competency validation for licensed nurses on assessing for pain prior to, during and after wound care. Education inclusive of, but not limited to assessing and	

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F 697	Continued From page 16 11/29/17 revealed the resident was care planned for having alteration in pain/comfort due in part to left foot wound. The goals were for the resident not to have an interruption in normal activities due to pain through the review date of 02/28/18. Another goal was for the resident to display a decrease in behaviors of inadequate pain control (specify: irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning, crying) through the review date of 02/28/18. The interventions included "Monitor and report to Facility nurse any signs or symptoms of non-verbal pain: moans, yelling out, eyes shut, grimacing of face, rocking, curled up. Monitor pain characteristics frequently, every shift and as needed (prn). Monitor and report to nurse resident complaints of pain or requests for pain treatment. Administer analgesia as per orders and prior to treatments or care prn. Anticipate the resident's need for pain relief and respond to any complaint of pain." A review of Resident #39's current physician orders for December revealed an order for Percocet 5/Acetaminophen 325 milligrams (mg) 1 tablet by mouth every 4 to 6 hours as needed (prn) for pain. An observation of Resident #39's dressing change on 12/07/17 at 11:28 am revealed Nurse #3 accompanied by the Unit Manager for the North side had the dressing supplies laid out on the over bed table and Nurse #3 began the dressing change by cleaning the toe with wound cleanser. Once the nurse touched the resident's left third toe he retracted his leg and yelled "oh, oh that hurts, that hurts my toe" and his face was grimaced and eyes were clinched. The nurse continued with the dressing change and stated	F 697	medicating residents with ordered prn (as needed) pain medication as verbalized or anticipated to control pain; stopping wound care during care and assessing and administering pain medication if pain verbalized or indicated by non-verbal cues and after wound care to assess for pain and administer care per plan of care and meet the residents needs. Newly hired licensed nurses to be educated and skill competency validated upon hire and prior to providing patient care. Residents to be evaluated or observed during wound care for need for pain management interventions. Pain management interventions to be administered by licensed nurse as ordered prior to, during and after wound care for pain management. Pain evaluation/observation during wound care to be documented on MAR (Medication Administration Record) as appropriate. The Director of Clinical Services and/or Registered Nurse designee to complete quality assurance monitoring of 3 residents who receive wound care to ensure pain evaluation/observation is completed and pain management interventions provided as appropriate is provided for pain control. Monitoring to be completed at a frequency of 3 times per week for 4 weeks then, 2 times per week for 8 weeks, then once monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee based on quality monitoring findings to maintain compliance.	

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F 697	Continued From page 17 "let me just finish" and applied the dressing while the resident continued to yell in pain. The Unit Manager was standing beside Nurse #3 and did not stop the dressing change when the resident started yelling in pain. An interview with Resident #39 at 11:42 am, immediately following the dressing change revealed he had not been medicated for pain prior to the dressing change. Resident #39 stated it hurt so much when they touched his toe that he wished they would just cut it off. An interview with Nurse #3 on 12/07/17 at 11:48 am revealed the nurse stated she had offered the resident pain medication prior to the dressing change and he had declined the medication. The nurse stated she should have stopped the dressing change and medicated the resident for pain before she continued the dressing. An interview with the Unit Manager for the North side on 12/07/17 at 11:58 am revealed her expectation would have been for the nurse to administer pain medication to Resident #39 prior to the dressing change. She stated she should have stopped the dressing change and administered medication and continued with the dressing change once the medication had taken effect for the resident. An interview on 12/08/17 at 10:41 am with the Medical Director revealed her expectation would have been for the resident to receive pain medication prior to having his dressing change. An interview on 12/08/17 at 1:42 pm with the Director of Nursing revealed it was her expectation that residents receive pain	F 697	The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan.	

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F 697	Continued From page 18 medication as needed and ordered prior to their dressing change being done.	F 697		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews the facility failed to monitor a resident who was prescribed a blood thinner for side effects who had nose bleeds for 1 of 6 sampled residents reviewed for unnecessary medications (Resident #90). Findings included:	F 757	On 12/22/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure residents on anticoagulants are monitored for side effects per residents' plan of care and to prevent the use of unnecessary drugs.	1/10/18

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F 757	Continued From page 19 Resident #90 was admitted to the facility on 02/14/17 with diagnoses which included chronic obstructive pulmonary disease (COPD) and a history of venous thrombus (blood clots in the veins). Review of Resident #90's physician's orders dated 05/19/17 revealed an order for Xarelto (a blood thinner) 20 milligrams (mgs) take one tablet by mouth every day for mural thrombi (blood clots that adhere to the blood vessel wall). Review of Resident #90's quarterly Minimum Data Set (MDS) dated 11/10/17 revealed he had moderately impaired cognition, he could make himself understood and could understand others. The MDS also indicated Resident #90 received 7 days of anticoagulant (blood thinner) therapy in the look back period. Review of Resident #90's care plan dated 11/10/17 revealed Resident #90 was at risk for bleeding related to anticoagulation therapy. The goal was that Resident #90 would not experience excessive bleeding or bruising through the next review of 02/10/18. The interventions included vital signs as ordered, medications as ordered, monitor labs as ordered and notify physician of results and precautions during care to prevent injury to skin or risk of bleeding. During the Resident Council meeting on 12/06/17 at 2:00 PM Resident #90 reported he had a nose bleed in the early morning of Tuesday, December 05, 2017 and rang his call light for assistance. Resident #90 stated a male aide answered his call light and told him he would inform the nurse of his nose bleed but the nurse never came to assess him.	F 757	QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #90, it was determined that the facility failed to ensure that licensed nurses review residents' care plan for anticoagulant Xarelto medication use and that communication occurs between off-going and on-coming nurses to ensure care is provided to meet the needs of the resident. Resident #90 continues to be monitored for side effects for the use of Xarelto per residents' plan of care with no new adverse side effects reported. Nurse #1 received 1:1 education on the expectation of assessing residents with reported changes in condition to determine the immediacy of care and then if appropriate to delegate, to communicate to assigned licensed nurse timely via verbal report and written communication on the 24 hour report to ensure appropriate care of the resident. On 12/11/17, Director of Clinical Services (DCS) and / or designee completed a QA (quality assurance) monitoring of residents receiving anticoagulant medications to ensure side effects are being monitored per residents' plan of care. No adverse side effects observed or reported. By 1/5/17, the Director of Clinical Services	

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F 757	Continued From page 20 Review of Resident #90's nurses' notes revealed the last note documented was dated 11/30/17 at 4:12 PM which did not pertain to a nose bleed. Review of Resident #90's physician's orders dated 12/06/17 revealed in part an order for petroleum jelly to inside nares twice a day for nose bleeds. The order was hand written by the Nurse Practitioner (NP). During an interview on 12/08/17 at 8:57 AM the NP revealed Resident #90's family member called her 2 days prior (12/06/17) and reported Resident #90 had a nose bleed in the early morning of 12/05/17 but was not assessed by the nurse. The NP stated she asked the nursing staff on 12/06/17 about Resident #90's nose bleed but the nursing staff denied knowing anything about it. During an interview on 12/08/17 at 10:07 AM the third shift (11:00 PM to 7:00 AM) Nurse #1 stated he was informed by Nurse Aide (NA) #4 that Resident #90 had a nose bleed. Nurse #1 continued to state that it was the end of his shift and he was preparing to give report to the first shift (7:00 AM to 3:00 PM) Nurse #2 and he would report Resident #90's nose bleed to her for her to assess. Nurse #1 further stated he was not aware that Resident #90 was on a blood thinner or he would have assessed Resident #90's nose bleed. During an interview with NA #4 on 12/08/17 at 10:36 AM he revealed he answered Resident #90's call light in the early morning of Tuesday 05, 2017. NA #4 stated Resident #90 had a nose bleed and asked him to inform the nurse which	F 757	provided re- education to licensed nurses on monitoring of residents on anticoagulant medications for side effects. Education was inclusive of monitoring of labs results, precautions during care to prevent injury to skin or risk of bleeding, monitoring vitals as ordered and reporting changes to physician for intervention as necessary. Residents' receiving anticoagulant medications to be monitored for side effects by the licensed nurse and changes reported to the physician as indicated. The Director of Clinical Services and/or Registered Nurse designee to complete quality assurance monitoring of 3 residents who receive anticoagulant medications for appropriate monitoring of side effects per the plan of care. Monitoring to be completed at a frequency of 3 times per week for 4 weeks then, 2 times per week for 8 weeks, then once monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee based on findings to maintain compliance. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months.. The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members	

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HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

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F 757	Continued From page 21 he did so at that time. During an interview on 12/08/17 at 10:56 AM with Nurse #2 who was scheduled for first shift on 12/05/17 she denied Nurse #1 reporting Resident #90 having a nose bleed to her. Nurse #2 stated if she had known Resident #90 had a nose bleed she would have assessed him first thing after receiving report because she knew he was on a blood thinner. An interview conducted with Resident #90's Physician on 12/08/17 at 12:14 PM revealed she would have expected the nurses to assess Resident #90 to make sure he was not bleeding out and to inform his Physician if it was serious. During an interview with the Director of Nursing (DON) on 12/08/17 at 1:44 PM who stated she would have expected Nurse #1 to have assessed Resident #90's nose bleed especially since he was on a blood thinner.	F 757	consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan.	