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 08/31/2021

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
E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 08/23/21 through 08/31/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #2QK911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/23/21 through 08/31/21. 2 of the 36 complaint allegations were substantiated but did not result in a deficiency. 1 of the 36 complaint allegations was substantiated resulting in a deficiency. Event ID# 2QK911.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for decline (Resident #19).	F 637	1)Identified significant change assessment was completed and transmitted to Centers for Medicare & Medicaid Services (CMS) on 8/25/2021. 2)On 8/25/21 Regional Case Mix/MDS (Minimum Data Set) Coordinator audited	10/6/21

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

Electronically Signed | 09/24/2021

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F 637	Continued From page 1 Findings Included: Resident #19 was admitted to the facility on 11/14/2019 with a diagnosis of Parkinson's disease and respiratory failure. The Minimum Data Set (MDS) dated 7/6/21 revealed Resident #1 was not on hospice services. A record review revealed Resident #19 transitioned to hospice on 7/21/2021. A significant change MDS assessment was completed on 8/23/21 which indicated Resident #19 was receiving hospice services. An interview was completed with the MDS Nurse on 8/26/21 at 4:52 PM who stated that a significant change assessment should have been completed on the 14th day from which Resident #19 transitioned to hospice which would have been 8/4/21. The MDS Nurse stated that she was the traveling MDS Nurse and once she caught the error it was completed. She stated that it would be her expectation that these are done timely. An interview was completed with the Administrator on 8/27/21 at 3:19 PM who stated that it would be his expectation that the significant change assessment should be done in a timely manner.	F 637	all current Hospice residents as well as prior 3 months of payer changes to ensure Significant Change assessment had been completed timely after election of Hospice benefit. The results of the audit identified 0 other assessments needed a significant change. 3)On 8/31/21 Regional Case Mix/MDS Coordinator educated traveling MDS Nurse and facility Social Worker were educated on determination of need for Significant Change assessment after Hospice enrollment, change in Hospice services and revocation of Hospice. Effective 8/31/21, to ensure the alleged practice does not recur: In clinical meeting (Monday-Friday) the MDS nurse and clinical morning team to include: Director of Nursing, Assistant Director of Nursing, Unit Manager, and Social Worker will evaluate and compare current MDS to the previous MDS to determine if a significant change has occurred. The daily 24 hr report will be reviewed to determine if the assessment is necessary. 4)Regional Case Mix/MDS Coordinator will perform quality improvement monitoring for timeliness of significant change assessment after Hospice enrollment 2 X weekly for 4 weeks then 1 X weekly for 2 months then monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing or designee and or until substantial compliance is obtained. Corrective action will be completed by October 6, 2021.	

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F 641	Continued From page 2	F 641		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews, observations, and medical record reviews the facility failed to correctly code Minimum Data Sets (MDSs) for 4 of 9 residents reviewed for MDS accuracy. Resident # 77 was incorrectly coded for altered behaviors on an admission MDS dated 06/10/2021. Resident # 47 was not accurately coded for rejection of care on a quarterly MDS dated 07/19/2021. Resident # 2 had a quarterly MDS dated 05/20/2021 that was coded incorrectly for rejection of care. Resident # 58 was coded incorrectly for vision on both an annual MDS dated 04/26/2021 and a quarterly MDS dated 07/27/2021. Findings included: 1. Resident # 77 was admitted to the facility on 06/03/2021 with diagnoses of muscle weakness, neuropathy and sleep apnea. An admission MDS dated 06/10/2021 for Resident # 77 revealed that section E 0200 B verbal behaviors symptoms directed toward others was not coded as required by the RAI (Resident Assessment Manual) during the review period. A nurse note dated 06/09/2021 at 5:33 PM revealed in part that Resident # 77 cursed and yelled at staff.	F 641	1) All assessments identified with coding errors in the areas of Behavior Symptoms and Vision were modified and transmitted to Centers for Medicare & Medicaid Services (CMS) on 8/31/2021. 2) On 8/31/21 the Regional Case Mix/MDS (Minimum Data Set) Coordinator audited 78 most recent resident assessments for each area. All miscoded items were modified appropriately and transmitted to CMS upon completion. 3) On 8/31/21 the Regional Case Mix/MDS Coordinator educated traveling MDS Nurse and facility Social Worker on appropriate MDS coding for the areas of Section E0200- Behavioral Symptoms and E0800- Rejection of care. Traveling MDSC Nurse was also educated on appropriate coding for the area B1000- Vision. 4) Regional Case Mix/MDS Coordinator will perform quality improvement monitoring for these MDS areas to ensure coding accuracy in E0200- Behavioral Symptoms, 0800- Rejection of care and B1000- Vision 2 X weekly for 4 weeks then 1 X weekly for 2 months then monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing or	10/6/21

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F 641	Continued From page 3 Review of a nurse note on 06/09/2021 at 6: 25 PM revealed in part that Resident # 77 was verbally abusive and screamed at staff. On 08/25/2021 at 10:45 AM an interview was conducted with the facility social worker (SW). The SW explained that he was responsible to complete sections C, D, E and Q on all resident MDS assessments. The SW revealed that he had not reviewed other documentation in resident's medical records by any other care providers because he thought he was only to code what he observed and documented. The SW revealed that he was not familiar with the RAI (Resident Assessment Manual) that he could use as a coding guide for the MDS. An interview with the MDS nurse conducted on 08/26/2021 at 1:47 PM revealed that she was only a temporary MDS nurse at the facility and was not aware of how the SW coded his required MDS sections. The nursing home Administrator was interviewed on 08/26/2021 at 3:22 PM. The Administrator stated that he expected all MDS assessments be completed timely and coded accurately as directed per the RAI manual. 2. Resident # 47 was readmitted to the facility on 05/12/2021 with diagnosis that included cerebral infarct, depression, anxiety, symbolic dysfunction, tracheostomy and pain. Review of a quarterly MDS dated 07/19/2021 for Resident #47 revealed that section E 0800 rejection of care was not marked.	F 641	designee and or until substantial compliance is obtained. Corrective action will be completed by October 6, 2021.	

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F 641	Continued From page 4	F 641		

Review of nurse medication note dated 07/14/2021 at 6:46 PM included that Resident # 47 refused to be suctioned every 4 hours and as needed for increased secretions.

A nurse medication note dated 07/17/2021 at 4:10 PM included in part that Resident # 47 refused to be suctioned every 4 hours and as needed for increased secretions.

A nurse medication note dated 07/18/2021 at 6:39 PM included that Resident # 47 refused to be suctioned every 4 hours and as needed for increased secretions.

A nurse note dated 07/19/2021 at 7:24 PM included in part that Resident # 47 refused to be suctioned every 4 hours and as needed for increased secretions.

On 08/25/2021 at 10:45 AM an interview was conducted with the facility social worker (SW). The SW explained that he was responsible to complete sections C, D, E and Q on all resident MDS assessments. The SW revealed that he had not reviewed other documentation in resident's medical records by any other care providers because he thought he was only to code what he observed and documented. The SW revealed that he was not familiar with the RAI (Resident Assessment Manual) that he could use as a coding guide for the MDS.

An interview with the MDS nurse conducted on 08/26/2021 at 1:47 PM revealed that she was only a temporary MDS nurse at the facility and was not aware of how the SW coded his required MDS sections.

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F 641	Continued From page 5	F 641		

The nursing home Administrator was interviewed on 08/26/2021 at 3:22 PM. The Administrator stated that he expected all MDS assessments be completed timely and coded accurately as directed per the RAI manual.

3. Resident # 2 was readmitted to the facility on 11/27/2019 with diagnoses that included anxiety, depression, cervical spinal cord fracture and noncompliance with medical treatment.

Review of a quarterly MDS dated 05/20/2021 for Resident # 2 revealed that section E 0800 rejection of care was not marked.

Review of nurse medication note dated 05/14/2021 at 10:03 AM recorded that Resident # 2 refused to have his temperature and pulse oximetry taken every shift as ordered by the physician (MD).

Review of nurse medication note dated 05/15/2021 at 7:19 AM recorded that Resident # 2 refused to have his temperature and pulse oximetry taken every shift as ordered by the MD.

Review of nurse medication note dated 05/16/2021 at 12:49 PM recorded that Resident # 2 refused to have his temperature and pulse oximetry taken every shift as ordered by the MD.

Review of nurse medication note dated 05/17/2021 at 9:42 PM recorded that Resident # 2 refused to have his temperature taken every shift as ordered by the MD.

Review of nurse medication note dated 05/18/2021 at 9:10 PM recorded that Resident # 2 refused to have his temperature taken every

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F 641	Continued From page 6	F 641		

shift as ordered by the MD.

Review of nurse medication note dated 05/19/2021 at 3:48 AM recorded that Resident # 2 refused to have his temperature taken every shift as ordered by the MD.

On 08/25/2021 at 10:45 AM an interview was conducted with the facility social worker (SW). The SW explained that he was responsible to complete sections C, D, E and Q on all resident MDS assessments. The SW revealed that he had not reviewed other documentation in resident's medical records by any other care providers because he thought he was only to code what he observed and documented. The SW revealed that he was not familiar with the RAI (Resident Assessment Manual) that he could use as a coding guide for the MDS.

An interview with the MDS nurse conducted on 08/26/2021 at 1:47 PM revealed that she was only a temporary MDS nurse at the facility and was not aware of how the SW coded his required MDS sections.

The nursing home Administrator was interviewed on 08/26/2021 at 3:22 PM. The Administrator stated that he expected all MDS assessments be completed timely and coded accurately as directed per the RAI manual.

4. Resident #58 was admitted to the facility on 09/23/09 with diagnosis of vision loss in both eyes.

Review of Resident #58's medical chart revealed he had been legally blind since 11/01/17.

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F 641	Continued From page 7 Review the annual Minimum Data Set (MDS) dated 04/26/21 and the quarterly MDS dated 07/27/21 revealed Resident #58 was coded with adequate vision. During an interview on 08/23/21 at 11:57 AM, Resident #58 stated he had severe vision problems and was legally blind. During an interview on 08/24/21 at 2:08 PM Nurse #1 revealed Resident #58 was legally blind and it was important to tell Resident #58 the exact placement of his personal belongings and place the items at the same location consistently. During an interview on 08/25/21 at 3:33 PM the MDS Coordinator stated she had just been working at the facility for 10 days. She acknowledged that Resident #58 was legally blind and the coding the MDS dated 04/26/21 and 07/27/21 were incorrect. She explained the MDS Coordinator who had finalized the coding was no longer working in the facility and she did not know how the incorrect coding occurred. She added she would correct the errors and re-submit both MDS as soon as possible. During an interview on 08/26/21 at 10:05 AM the Director of Nursing stated it was her expectation for all the MDS assessments to be coded accurately. During a phone interview on 08/27/21 at 11:49 AM the Administrator stated he expected all the MDS assessments to be coded accurately.	F 641		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		10/6/21

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F 732	Continued From page 8	F 732		

§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:

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F 732	Continued From page 9 Based on observation, record review, and staff interviews, the facility failed to post accurate nurse staffing information in an area visible to residents and visitors for 1 of 7 days. Additionally, the facility failed to retain posted nurse staffing information for 9 of 30 days reviewed for staffing. The findings included: On 08/24/21 at 7:45 AM an initial morning tour of the facility revealed posted nurse staffing information dated 08/23/21 posted in the lobby. On 08/24/21 at 1:45 PM an afternoon tour of the facility revealed posted nurse staffing information dated 08/23/21 posted in the lobby. On 08/26/21 at 9:30 AM posted nurse staffing information was reviewed from 07/23/21 through 08/24/21. There was no posted nurse staffing information available for review for the following dates: 08/01/21 08/07/21 08/08/21 08/12/21 08/15/21 08/16/21 08/17/21 08/21/21 08/22/21 An interview with Receptionist #1 on 08/26/21 at 1:01 PM was completed. She revealed posted nurse staffing information was posted in the lobby, on a table adjacent to the reception desk. The posted nurse staffing information included a	F 732	F732 Posted Nurse Staffing Info 1) Receptionist #1, was reeducated by the Administrator on 9/24/21 regarding posting accurate daily nurse staffing information in an area visible to residents and staff. The education also included the facility must maintain the posted daily nurse staffing information for a minimum of 18 months. Receptionist #1 immediately posted Daily Nursing Staffing Form to reflect Staff Assignment Sheets in the lobby of the facility for 8/24/21. 2) On 9/20/21 the Assistant Business Office Manager completed audit back 30 days Daily Nursing Staffing Forms to Staff Assignments sheets to ensure accurate staffing information is being posted, correct any discrepancies. 3) The Administrator will provide education to Receptionist #2, Receptionist #3, Receptionist #4 and the Interdisciplinary Team to include: Director of Nursing, Assistant Director of Nursing, Unit Manager, Business Office Manager, Assistant Business Office Manager, Social Worker, Human Resource Coordinator, Therapy Manager, Activities Director, and Admissions Director by 10/6/21 on posting accurate daily nurse staffing information in an area visible to residents and staff, which will be the lobby. The education also will include how to complete and adjust the Daily Nursing Staffing Form (Example: if there's call outs or if someone goes home early) and that the facility must maintain the posted daily nurse staffing information for a minimum of 18 months Receptionist #1 will be responsible for posting the daily	

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F 732	Continued From page 10 breakdown of nurses and nurse assistants scheduled by number and hours worked per shift. Receptionist #1 revealed that she completed the posted nurse staffing information upon arrival to the facility. The Receptionist expressed that on 08/24/21 she arrived to work later due to a traffic accident. She stated she completed the posted nurse staffing information as soon as she came into the facility and placed the posted nurse staffing information for 08/24/21 on the lobby table. She explained it was possible that she documented the incorrect date on the sheet. A follow-up interview with Receptionist #1 on 08/26/21 at 1:18 PM was completed. Receptionist #1 expressed the weekend staff completed the posted nurse staffing information on the weekends. Receptionist #1 and the Business Office Manager could not locate the posted nurse staffing information for the above dates. A telephone interview with Receptionist #2 was completed on 08/27/21 at 11:15 AM. Receptionist #2 revealed she worked Monday through Friday from 4:30 PM to 8:00 PM and every other weekend. She stated she worked on 08/21/21 and 08/22/21. She stated she completed the posted nurse staffing information on the weekends when she worked first shift (7:00 AM to 3:00 PM). Receptionist #2 recalled completing the posted nurse staffing information on the dates she was scheduled to work. She stated the completed posted nurse staffing information should have been placed in a folder on the receptionist desk. A telephone interview with Receptionist #3 was completed on 08/27/21 at 3:09 PM. Receptionist #3 revealed she worked as needed. She	F 732	nurse staffing information Monday-Friday. Receptionist #2, Receptionist #3, and Receptionist #4 will be responsible for posting on the weekends. The Assistant Business Office Manager will serve as a back-up. Additionally the Daily Nursing Staffing Forms and Staff Assignment Sheets will be filed in a binder and will be reviewed during Stand-Up meeting. All new employees will receive education as part of orientation. Current staff will receive education on their next scheduled shift. 4) The Administrator or designee will perform Quality Improvement Monitoring of 3 Daily Nursing Staffing Forms to ensure accurate staffing information is being posted 2 X weekly for 4 weeks then 1 X weekly for 2 months then monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Administrator or designee for 6 months and/or until substantial compliance is obtained. Corrective action will be completed by October 6, 2021.	

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F 732	Continued From page 11 confirmed that she worked on 08/14/21 and 08/15/21. Receptionist #3 stated she remembered completing the posted nurse staffing information on 08/14/21 and 08/15/21. She stated she was unsure where the posted nurse staffing information she completed were located. A telephone interview with Receptionist #4 on 08/27/21 at 3:19 PM revealed she worked every other weekend. Receptionist #4 confirmed she worked 08/08/21. She communicated she completed the posted nurse staffing information on 08/08/21. Receptionist #4 voiced the completed posted nurse staffing information should have been placed in the folder on the receptionist desk. An interview with the Director of Nursing (DON) on 08/26/21 at 12:23 PM revealed posted nurse staffing information was completed daily, at the beginning of the shift by the receptionist. The DON stated she did not know why the posted nurse staffing information had not been completed for the above dates. She stated the posted nurse staffing information was completed daily and placed in a folder kept by the receptionist. An interview with the Administrator on 08/26/21 at 1:58 PM revealed posted nurse staffing information was completed daily. The Administrator was unaware that posted nurse staffing information had not been completed for the above dates.	F 732		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		10/6/21

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F 842	Continued From page 12 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 13 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a medical record to include a treatment administration record (TAR) for one of one resident reviewed for treatments. (Resident #82). The findings included: Resident #82 was admitted to the facility on 04/09/21 from the hospital with diagnoses that included an abdominal abscess, severe sepsis with septic shock and an infection to an abdominal surgical site. Resident #82 was	F 842	F842 Resident Records 1) Resident #82 no longer resides in facility, discharged from facility on 4/14/21. 2) On 9/24/21 a Quality Review was performed by Director of Nursing, Assistant Director of Nursing and Unit Manager regarding residents currently receiving wound care and residents with an ostomy to ensure appropriate treatment orders are in place and the treatments appear on the Treatment Administration Record. Issues identified	

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F 842	Continued From page 14 discharged home on 04/14/21. Resident #82's 48 Hour care plan revealed she had altered skin integrity with a goal to improve current skin issues. The interventions included wet to dry dressings to the abdominal incision. Physician orders dated 04/10/21 included change ostomy bag and wafer as needed, assess skin around urostomy site during care, and consult wound care PRN. Review of Resident #82's medical record did not reveal a TAR with any ordered treatments. Review of Resident #82's medication administration record also did not reveal any ordered treatments. Review of a Nurse's progress note dated 04/13/21 revealed Resident #82 was receiving gauze dressings to her abdominal wound. An interview with the Director of Nursing (DON) on 08/27/21 at 1:40 PM revealed there had been issues with nurses not knowing how to put treatments into the system. The DON stated the facility was in the process of correcting this by having a second nurse to double check orders when there is a new admission to the facility. The DON further stated there should be a treatment record for every resident. An interview with the Unit Manager (UM) #2 on 08/27/21 at 2:10 PM revealed nurses had to apply wet to dry dressings to Resident #82's abdominal wound multiple times daily. The UM #2 stated the dressings kept becoming soiled because of the proximity of the wound to the ostomy bag.	F 842	were addressed. 3) The Director of Nursing and Assistant Director of Nursing will review new admission and orders during clinical morning meeting to ensure compliance. The Director of Nursing and/or designee will educate licensed Nurses to initiate upon admission treatment orders for residents with any type of ostomy and/or for residents who require wound care. Nurses will ensure treatment orders appear on the Treatment Administration Record. When receiving verbal orders from physician and/or nurse practitioner the nurses must transcribe the order onto the Treatment Administration Record. This education will be completed by 10/6/21. Education will be on-going, no staff will return to work until they have completed the mandatory education. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. 4) Nurse Management (Director of Nursing, Assistant Director of Nursing, and Unit Manager) will audit 5 residents receiving wound care or ostomy care 2 x weekly for 4 weeks, 1 x weekly for 2 months, and monthly for 3 months to ensure appropriate treatments orders are in place and appear on the treatment administration record. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance	

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F 842	Continued From page 15 She stated the former DON had initiated the wet to dry dressings. An interview with the former DON (DON #2) on 08/31/21 at 11:37 AM revealed she received a verbal order from the Nurse Practitioner for wet to dry dressings to the abdominal wound. The former DON stated she did not know why there was not a TAR for Resident #82.	F 842	Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. Corrective action will be completed by October 6, 2021.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		10/6/21

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F 880	Continued From page 16 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 17 Based on observation, staff interviews and review of facility policies the facility failed to implement their policy on Transmission Based Precautions on a new admission hallway when 1 of 1 staff member (Nurse Aide #1) failed to remove gown before exiting resident rooms, failed to wear gloves to deliver meal trays and dispose of them in the room and perform hand hygiene for 2 of 5 residents observed for infection control (Resident Rooms #405 and #409). This failure occurred during a COVID-19 pandemic. Findings included: A review of the facility's policy titled "Covid-19 Pandemic Plan" dated 8/3/21 read in part; the center will quarantine new admission/re-admission (even those with a negative test) for 14 days except those in the following situations: i. If a resident has been fully vaccinated and has not been exposed to someone with Covid-19 in the past 14 days is not required unless directed by local and state authorities. Exposure history will be documented in the medical record. -Initiate Transmission Based Precautions based on CDC guidance (standard, contact and droplet and eye protection) Including personal protective equipment (PPE), facemask, face shield, eye protection, gown, and gloves. A tour of the 400 hall on August 23, 2021 at 11:07 AM revealed room #405 and room #409 had enhanced droplet precautions signage on their doors. A continuous observation on August 23, 2021 from 12:41 PM to 12:56 PM on the new admission hallway revealed Nursing Assistant	F 880	F880 Infection Prevention & Control 1) NA #1 was educated by the Director of Nursing on 8/24/21 regarding following transmission based precautions by removing gown before exiting resident rooms and to perform hand hygiene when entering and exiting the room. NA #1 was also educated on wearing gloves to deliver meal trays and dispose them in the room, as well as to perform hand hygiene for residents at mealtime. 2) On 9/20/21 through 10/5/21 the Director of Nursing and/or designee performed a Quality Improvement for all staff to include: All Nursing Staff (Licensed Nurses, Certified Nursing Assistant, Medication Aides, and Patient Care Assistant), Receptionist, Administrator, Department Managers, Housekeeping, Dietary, Therapy, and Administrative staff on Personal Protective Equipment (PPE) with special focus on removing gown before exiting room by completing competencies on DONNING/DOFFING Personal Protective Equipment (PPE) and on Hand Hygiene. The Root Cause Analysis was completed by the Regional Director of Clinical Services, Executive Director, and the Director of Nursing on 9/24/2021. 3) The Director of Nursing and/or designee will re-educate staff to include: All Nursing Staff (Licensed Nurses, Certified Nursing Assistant, Medication Aides, and Patient Care Assistant), Receptionist, Administrator, Department Managers, Housekeeping, Dietary, Therapy, and Administrative staff regarding Transmission Based	

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F 880	Continued From page 18 (NA) #1 was delivering meal trays to resident rooms. At 12:41 PM NA #1 was observed to be wearing a face mask, face shield and gown and removed a lunch tray from the meal delivery cart and delivered the tray and set up the tray for resident in room #405. NA #1 was not wearing gloves did not perform hand hygiene when she entered or exited room #405 and did not doff her gown when exiting room #405. NA #1 delivered a meal tray to a resident in room #409 and set up the tray for the resident in room #409. NA #1 was not wearing gloves did not perform hand hygiene when she entered or exited room #409 and did not doff her gown when exiting room #409. An interview was completed with NA #1 on August 23, 2021 at 12:56 PM who stated that she had been on the new admission side (400 Hallway) for one week and was told to wear a gown going into rooms but was not told to change the gown after each room. NA #1 stated that they wear gloves when entering rooms when doing resident care, but we don't wear gloves when passing meal trays. NA #1 was asked why she did not use hand sanitizer when coming in or coming out of rooms and replied that she does not hand sanitize every time coming out of rooms, I hand sanitize as needed. An interview was completed with Nurse #3 on 8/23/21 at 11:25 AM who stated that all the 400 hall was on quarantine and new admissions and everyone is on enhanced droplet precautions. An interview was completed with the Unit Manager on 8/23/21 at 11:27 AM who stated that if you go in a room on the 400 hall you would need a mask, gown, gloves, and face shield.	F 880	Precautions, Personal Protective Equipment , Hand Hygiene when entering/exiting resident rooms, and providing Hand Hygiene for residents at mealtime. The Director of Nursing and/or designee will review “Use PPE (Personal Protective Equipment) When Caring for Patients with Confirmed or Suspected COVID-19”, “Hand Hygiene Guidance”, and “Transmission Based Precautions” information with staff which was provided by the CDC. The “Use PPE When Caring for Patients with Confirmed or Suspected COVID-19” information sheet and “Hand Hygiene Signage” will be posted throughout facility as a reminder to staff. This education will be completed by 10/6/21. This education will also be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. All current staff will be educated prior to their next scheduled shift. Hand Sanitizer and/or hand wipes will be provided to residents during mealtime. The Department Managers to include: Social Worker, Activities, Maintenance Director, Admissions Director, Business Office Manager, Medical Records, Business Development Officer, and MDS Coordinator will be assigned to the dining room and to resident hallways during meal delivery time to ensure staff are providing hand hygiene to residents before meals. Prior to admission the Admissions Coordinator will obtain vaccination and COVID-19 status for new residents and place on the “Admission Notification	

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F 880	Continued From page 19 On 8/24/21 at 9:33 AM the Administrator stated that staff need to put on a new gown before entering each room who is on quarantine status. An interview was completed with the Director of Nursing on 8/26/21 at 3:30 PM who stated that when staff were going into rooms, they need to put on appropriate PPE, gown, gloves and face shields and masks. They should be changing their gowns in between rooms and wear gloves. An interview as completed with the Administrator who stated that it is his expectation that when staff are entering a resident's room's they are to wear appropriate PPE and sanitize or wash hands when entering and exiting new admission rooms. The administrator stated the 400 hallway was not considered a quarantine hallway it was for new admission residents.	F 880	Form". This form will be given to nursing to determine whether to place new admission on transmission based precautions. Once nursing determines the need for transmission based precautions, nursing will post signage on the resident doors and set up PPE outside the door prior to entering room. 4) The Director of Nursing or designee will perform Quality Improvement Monitoring through observation of 5 random employees to ensure employees are wearing PPE (Personal Protective Equipment) correctly when entering a resident room who requires transmission based precautions with special focus on removal of gown prior to exiting room and performing hand hygiene when entering/exiting room 2 X weekly for 4 weeks then 1 X weekly for 2 months then monthly for 3 months. The Director of Nursing or designee will also perform Quality Improvement Monitoring through observation of 5 random employees during meal delivery to ensure staff are performing/offering hand hygiene to residents 2 X weekly for 4 weeks then 1 X weekly for 2 months then monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing or designee for 6 months and/or until substantial compliance is obtained. On 9/24/21 the Executive Director and Director of Nursing introduced the direct plan of correction for Infection Prevention and Control (Transmission Based	

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F 880	Continued From page 20	F 880	Precautions, PPE-Personal Protective Equipment and Hand Hygiene) to the Quality Assurance Performance Improvement Committee. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee Members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set (MDS) Nurse and a minimum of one direct Care giver. Quality Improvement Quality Monitoring schedule modified based on findings. Corrective action will be completed by October 6, 2021.	
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations (conference room and 300 hall), interviews with residents (Resident #25 and #33) and staff and record review, the facility failed to implement pest control recommendations to maintain an effective pest control program. The findings included: 1a. Observations of pest activity occurred during the following:	F 925	F925 Maintains Effective Pest Control Program 1) Resident #25 and #33 rooms, Room 307 bathroom, and the conference room were deep cleaned by housekeeping on 9/1/21. Additionally pest Control Company visited facility on 9/1/21 to spray for insects. Insect light traps were inspected and repaired on 9/1/21 by Rentokil. Pest control recommendations were addressed.	10/6/21

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F 925	Continued From page 21 - 08/23/21 at 12:30 PM, 3 small flying insects were observed on bed A in room 305. - 08/23/21 at 12:41 PM, multiple small flying insects were observed on 4 visibly soiled face cloths that were stacked on top of the toilet tissue dispenser in the bathroom of room 307. - 08/23/21 at 2:00 PM, multiple small flying insects were observed in the conference room. - 08/23/21 at 4:55 PM, multiple small flying insects were observed on 4 visibly soiled face cloths that were stacked on top of the toilet tissue dispenser in the bathroom of room 307. - 08/24/21 at 11:30 AM, multiple small flying insects were observed in the conference room. - 08/25/21 at 11:35 AM, multiple small flying insects were observed in the conference room. - 08/25/21 at 2:27 PM, multiple small flying insects were observed in the conference room. 1b. Resident #25 was admitted to the facility 7/3/14. A quarterly Minimum Data Set (MDS) assessment dated 7/5/21 assessed Resident #25 with adequate hearing, adequate vision, clear speech, understood, able to understand and intact cognition. An interview with Resident #25 on 08/21/21 at 12:30 PM revealed she saw gnat activity often in her room which she reported to staff and someone sprayed her room, but in the last few weeks no one sprayed her room for pests and now she saw more pest activity. 1c. Resident #33 was admitted to the facility on 5/14/15. A quarterly MDS assessment dated 07/11/21 assessed Resident #33 with adequate hearing, adequate vision, clear speech, understood, able to understand and intact cognition.	F 925	2) Current resident rooms were inspected by the Interdisciplinary Team to include: Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS (Minimum Data Set) Nurse, Activities Director, Business Office Manager, Medical Records, Admissions, Housekeeping Manager, Maintenance Director, and Social Worker on 9/1/21 and treated as necessary. The Housekeeping Manager and Dietary Manager deep cleaned kitchen on 9/1/21. 3) The Administrator and/or designee will educate facility staff to include: All Nursing Staff (Licensed Nurses, Certified Nursing Assistant, Medication Aides, and Patient Care Assistant), Receptionist, Administrator, Department Managers, Housekeeping, Dietary, Therapy, Agency and Administrative staff on the process for maintaining residents rooms in a clean and orderly manner and reporting to maintenance when gnats or other pests are noted anywhere within the facility. The staff will be educated to document pest activity in the pest sightings book. This education will be completed by 10/6/21. Education will be on-going, no staff will return to work until they have completed the mandatory education. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. The Maintenance Director will review the pest sighting book in stand-up meeting daily. During morning rounds the Interdisciplinary Team will make	

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F 925	Continued From page 22 During an interview with Resident #33 on 08/21/21 at 12:41 PM, she stated that she saw gnats and large water bugs a couple nights ago in her room which she reported to staff, but she did not recall specifically who she reported this to. Resident #33 said pest activity occurred frequently in her room at night for the last few months. 1d. Review of pest service records revealed the following pest control program recommendations that were not followed: - Pest service records dated 3/11/21, 3/31/21 and 5/3/21 documented that insect light traps were noted not plugged in and in disrepair. Recommendations were to plug in lights and repair broken lights for better reduction of small flies. - Pest service records dated 6/14/21, 6/26/21, 7/23/21 and 7/30/31 documented that there were cracks, gaps or damage to walls allowing pest access and that insect light traps were not working properly. Recommendations were to repair the damages (cracks, gaps) to prevent pest entry and to schedule service of insect light traps to ensure effective flying insect control. A telephone interview occurred on 8/25/21 at 4:38 PM with the previous maintenance director (PMD #1). He stated during the interview that he was not the current maintenance director for the facility, that his last day of employment was 8/4/21. PMD #1 stated that he repaired a few fly traps as recommended but continued to see a few "gnats here and there." PMD #1 stated he treated the rooms for Resident #25 and #33 for "gnat activity" with follow up from Residents who expressed this was effective for a while, but then	F 925	observation and interview residents regarding pest sightings, in daily stand-up meeting and address. Pest Control will make monthly routine visits and when needed. 4) The Administrator or designee will audit 5 resident rooms and a common area to see if rooms are clean and free of visible signs of gnats, water bugs, or other pests 2 x weekly for 4 weeks, 1 x weekly for 2 months, and monthly for 3 months. Any concerns identified will be brought to Maintenance Director and/Housekeeping Supervisor as appropriate for corrective action to be taken. The Maintenance Director will audit insect trap lights to ensure working properly 2 x weekly for 4 weeks, 1 x weekly for 2 months, and monthly for 3 months. Any concerns identified will be addressed. The Administrator will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. Corrective action will be completed by October 6, 2021.	

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 08/31/2021

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

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F 925	Continued From page 23	F 925		

during the summer months reported reoccurring activity. PMD #1 stated he treated rooms on the 500 hall and the copier room for "drain flies" with activity that was reoccurring due to odors. He stated he instructed housekeeping staff to change mop heads and water between each resident room which improved the frequency of flying pest activity. PMD #1 further stated that Resident #33 continued to report pest activity weekly during the summer months and he responded by treating this room weekly. PMD #1 attributed reoccurring "gnat" activity to residents dropping crumbs from snacks eaten in their rooms and that at times staff would not document pest activity in the pest sightings book which would delay notification/treatment of pest sightings. PMD #1 also stated that he was advised of a pest service recommendation in July 2021 to fill/caulk the space around outside air conditioning units to prevent pest entry points, but he did not get a chance to follow up on this and he did not share this recommendation with administration prior to leaving on 8/4/21.

A telephone interview occurred on 08/26/21 at 11:01 AM with the previous Administrator (Administrator #1) until August 2021. She stated that she was not aware that PMD #1 continued to see pest activity or that residents reported continued pest activity, but that during morning staff meetings the maintenance department reported that the pest activity was resolved with the current pest services. Administrator #1 further stated that she was aware of the pest service recommendation to repair/replace insect light traps and that she forwarded this recommendation to the corporate office, but that she did not get a response from the corporate office before she left in August 2021.

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 925	Continued From page 24	F 925		

A telephone interview occurred on 8/26/21 at 5:01 PM with the current Administrator (Administrator #2). Administrator #2 stated he just reviewed the pest service records that day, he had not previously reviewed these records and that he was not previously aware of the recommendations for repairs. Administrator #2 stated that he did notice "gnat" activity when he came to the facility in August 2021 and that he reported this to the pest service vendor for follow up service. He stated he was not aware of the recommendations to repair cracks/gaps in the walls or repair insect light traps, so these repairs had not been completed.

A telephone interview occurred on 8/27/21 at 12:46 PM with the pest service technician. He stated during the interview that he provided pest services to the facility twice in August 2021 (8/11/21 and 8/16/21) for routine services and a follow up to reports of "gnat activity." The interview revealed that on 8/11/21 he communicated to Administrator #2 that the facility needed to clean the baseboards/grout and repair cracks in the walls in the kitchen, which were breeding grounds for pests. He stated that he explained to Administrator #2 that if these areas were not cleaned, pests would breed and make it difficult to get rid of the pest activity. He further stated that this same recommendation was also made during his 8/16/21 service visit.