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 09/11/2023

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 000	INITIAL COMMENTS The survey team entered the facility on 9/7/23 to conduct a complaint investigation. The survey team was onsite 9/7/23. Additional information was obtained offsite on 9/8/23 and 9/11/23. Therefore, the exit date was 9/11/23. Event ID# RVU011. The following intakes were investigated NC00202821, NC00204432, and NC00206918. 2 of the 11 complaint allegations resulted in a deficiency. Event ID# RVU011.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, family member and Wound Physician interviews, the facility failed to identify a skin impairment on a resident during weekly skin assessments for 1 of 1 resident reviewed for pressure ulcers (Resident #21). This failure resulted in Resident #21 being admitted to the hospital and requiring care in the Intensive Care Unit for severe sepsis due to a necrotic (dead tissue) heel wound and	F 686	Resident #21 no longer resides in the facility. Resident #21 discharged from the facility on 4/15/2023 Residents currently residing in the facility have the potential to be affected. On September 19, 2023, the Director of Clinical Services and Nursing Administrative Team completed a	9/19/23

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

Electronically Signed | 09/27/2023

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F 686	Continued From page 1 osteomyelitis (bone infection). The findings included: Resident #21 was admitted to the facility on 2/3/22 with diagnoses that included dementia, muscle weakness, diabetes, and contractures. Review of Physician orders for Resident #21 revealed an order dated 4/4/22 for weekly skin assessments on Thursdays. Review of a Wound Physician's note dated 2/6/23 revealed that a non-pressure related wound on the residents left heel had resolved. The annual MDS for Resident #21 dated 2/8/23 revealed Resident #21 was at risk for pressure ulcers but had no pressure ulcers. The care plan for Resident #21 revised on 4/10/23 revealed she had an activity of daily living self-care performance deficit related to dementia, musculoskeletal impairment, and debility. The interventions included Resident #21 required extensive two-person assistance for repositioning in the bed after care was provided and as necessary. The resident had diabetes. The interventions included checking all of the body for breaks in the skin and treat promptly. On 4/10/23 a care plan for skin impairment was added. The interventions included float heels while in bed, follow facility protocol for treatment of injury, and weekly skin sweeps. Review of Resident #21's weekly skin assessments for March and April of 2023 revealed the following: On 3/2/23, 3/16/23,	F 686	head-to-toe assessment of the facility's current residents to evaluate skin conditions and identify any new skin deficiencies. Areas identified were cross referenced with each residents' Treatment Administration Record to ensure treatments were in place and being implemented timely. The Director of Clinical Services and Nursing Administrative Team reeducated the facility's licensed nursing staff on completing weekly skin assessments to include completing head to toe assessments, ensuring to inspect all areas including areas with dressings in place. If dressings are in place, license staff will check the treatment administration record to ensure physician orders are in place. For any new findings, licensed staff will complete an SBAR, and notify the resident's physician, their responsible party, and the wound nurse. Education of licensed nursing staff was initiated on 9/12/23 and will be completed by 9/19/23. Licensed staff will not be permitted to work until education has been completed. New licensed staff will be educated during new employee orientation by the Director of Clinical Services or designee. The Director of Nursing and/or Nursing designee will randomly perform Quality Observations of two licensed nurses completing skin assessments to ensure accuracy two times a week for four weeks, then weekly x two months, and then monthly for three months.	

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F 686	Continued From page 2 3/23/23, 3/30/23, and 4/6/23, no skin issues were documented on the assessments. On 4/10/23 a skin assessment was completed and noted an open area to Resident #21's left heel. No other skin issues were noted. The assessments were completed by Nurse #3. During an interview on 9/7/23 at 4:07 PM Nurse #3 revealed she always cared for Resident #21 on her shifts. She stated nurses were responsible for weekly skin assessments, and she completed skin assessments for Resident #21 during the months of March and April 2023. She further stated that when doing those skin assessments, she did not address any existing skin issues. It was her understanding that she only needed to address new skin problems during the weekly skin assessments. Nurse #3 revealed that during multiple skin assessments in March and April 2023 she noticed a dressing on Resident #21's left foot but she did not remove the dressing. She explained she had seen the dressing in place on multiple occasions but did not address it because she thought the Wound Nurse was treating the resident's foot. When she completed the skin assessment, she documented no skin issues or no new skin issues because the wrapped foot was not a new finding. She knew the resident had an old, healed wound on her foot in the past but was unsure what was being treated on Resident #21's heel at that time. Nurse #3 stated she did not recall seeing any active orders for wound treatment and she did not question who placed the dressing or why it was in place. She further stated she had never removed or changed the dressing until 4/10/23. On 4/10/23 Nurse #3 noticed drainage on the resident's dressing, and she then notified the Wound Nurse. Nurse #3 described Resident #21's wound as an open red	F 686	An Ad Hoc QAPI Meeting was held on September 12, 2023. The Executive Director is responsible for implementing this plan and will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee (QAPI). The Quality Assurance Performance Improvement Committee Members include, but are not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Medical Director, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The findings will be reviewed and reported monthly for a minimum of three months to the QAPI Committee. Based on findings, audits will be updated and continued if changes are needed.	

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area on the heel with yellow peeling skin surrounding the wound, the wound was small in size. She revealed the Wound Nurse obtained an order for the treatment and the wound was dressed. When asked how the wound looked on 4/12/23 and 4/15/23 when she changed the dressing, Nurse #3 stated she documented the dressing changes but did not complete them. She stated the dressings were changed by the Wound Nurse, but she did view the wound during those dressing changes and the wound appeared the same. Nurse #3 stated during the skin assessments Resident #21 did not have any other wounds.

Review of a nurses note dated 4/10/23, by Nurse #3 read open area to left heel, necrotic tissue, Wound Nurse notified, treatment applied.

Review of a change in condition for Resident #21 on 4/10/23 documented by Nurse #3 revealed an open area was observed to the residents left heel. The Nurse Practitioner notified on 4/10/23. A nurse comment read: left heel open, no signs or symptoms of pain when touching heel. Wound nurse notified; treatment applied.

Review of a facility's weekly wound report completed by the Wound Nurse for the week of 4/3/23 revealed on 4/10/23 Resident #21 had a new left heel wound that measured 1.3 x 1.5 x 0.2.

Review of Physician orders for Resident #21 revealed an order dated 4/10/23 for Left heel-wound cleanser, pat dry, calcium alginate, cover with border dressing daily.

During an interview on 9/8/23 at 10:53 AM

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Medication Aide (MA) #1 revealed she was the MA for Resident #21 on the day she went to the hospital on 4/15/23. She reported she noticed Resident #21 was not "acting like herself" and she was not as responsive. She notified the nurse and Resident #21 was sent out to the hospital. MA #1 stated she did not recall if Resident #21 ever had dressings or a wound. She stated she only completed medication pass for Resident #21 and the nurse completed all other care. She never placed any dressings on Resident #21.

Review of hospital records dated 4/15/23 through 4/28/23 revealed Resident #21 presented on 4/15/23 with altered mental status and hypotension. The History and Physical dated 4/15/23 noted a left foot necrotic wound with discharge, a stage one pressure wound over the right heel and a stage two sacral decubitus. An x-ray of the left foot obtained and resulted on 4/15/23 was concerning for osteomyelitis (infection of the bone). Code sepsis activated when initial labs suggested an infectious source of hypotension with white blood cell count of 25. Resident #21 was treated with fluid resuscitation; vasopressors (medications used to treat low blood pressure) and IV antibiotics. The principle problems were identified as severe sepsis due to necrotic left heel wound and osteomyelitis, acute renal failure and metabolic encephalopathy. Two sets of blood cultures were collected on 4/15/23 and were both negative. Infectious Disease was consulted on 4/18/23 to manage antibiotics which continued until the time of her discharge to a skilled nursing facility in stable condition on 4/28/23.

An interview was conducted on 9/7/23 at 3:51 PM with the Wound Nurse. He revealed he relied on

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F 686	Continued From page 5	F 686		

the nurses to report new wounds or skin issues to him. When a new wound was reported he would assess and report his assessment to the provider. He would then follow the wound treatment orders he received. The Wound Nurse stated on 4/10/23, Nurse #3 reported to him that Resident #21 had a wound to her left heel. He could not recall what the wound looked like but thought it was the size of a nickel. He notified the Nurse Practitioner and obtained a treatment order. He also faxed Resident #21's information to the Wound Doctor for the resident to be seen on the next visit. The Wound Nurse explained Resident #21 was scheduled to be seen by the Wound Doctor on 4/18/12 but the resident was discharged to the hospital before the visit. The Wound Nurse revealed Nurse #3 told him Resident #21's heel wound had a dressing covering it on 4/10/23, but Nurse #3 had not applied dressing. The Wound Nurse stated he had not provided any wound treatment to Resident #21 since early February 2023 before her old wound healed. The Wound Nurse stated he did not recall the resident having a sacral ulcer or issue on her right heel.

An interview on 9/11/23 at 9:30 AM with Resident #21's family member revealed Resident #21 was admitted to the hospital on 4/15/23. He was told by the facility that the resident was not as responsive as she usually was. When he arrived at the hospital, he was told by the hospital Physician that Resident #21 had an infected wound on her left heel. She also had a wound on her bottom. He did not know if the facility had been treating these wounds because he had no knowledge of them before the hospital Physician told him about them.

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During an interview on 8/8/23 at 11:38 AM Nurse Aide (NA) # 4 revealed she frequently cared for Resident #21. She stated she remembered Resident #21 had a small open area on the bottom of her foot and she reported it to Nurse #3, she was unsure of when she reported this. She believed Nurse # 3 applied a dressing to the wound after she was notified. NA #4 did not recall which foot had the open area. She further revealed she did not recall assisting the nurse when she completed skin assessments, and she did not recall the resident having any other skin issues.

During an interview on 9/8/23 at 12:36 PM Nurse Aide (NA) #5 revealed she occasionally cared for Resident #21. She stated the last time she cared for Resident #21, she was not sure of the date, she had redness to her sacral area. NA #5 further stated the skin was red but not open, she reported this to the nurse but did not recall the nurse's name. NA #5 did not recall any wounds on Resident #21's heel and she never placed dressings on any residents.

During an interview on 9/11/23 at 3:28 PM the Director of Nursing (DON) revealed skin assessments were completed weekly by the assigned nurse and the skin assessments should be head to toe. The DON described "head to toe" as all the resident's skin should be observed from head to toe, if there was an existing dressing it should be removed and observed. All new or worsened areas were reported to the Wound Nurse. The DON stated she did not know Resident #21 had a dressing or wound to her left heel prior to 4/10/23. She was not aware that Nurse #3 had not been removing a dressing during the weekly skin assessment. She further

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F 686	Continued From page 7 stated she was not aware of any other wounds on Resident #21. An interview was conducted on 9/11/23 at 2:22 PM with the Wound Physician. She revealed was familiar with Resident #21, and she had treated a heel wound for the resident. The Wound Physician stated Resident #21's heal wound was resolved in February 2023, and she had not provided any wound treatments for Resident #21 since. She could not be sure of the cause of Resident #21's most recent wound because she did not get to see it. She indicated wounds can progress and change quickly and if the wound opened the resident would be at higher risk for infection.	F 686		