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 12/13/2023

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 An unannounced onsite complaint investigation survey was conducted from 12/06/23 through 12/07/23. The survey team returned on 12/13/23 to validate the credible allegation of IJ removal plan. Therefore, the exit date was changed to 12/13/23. The following intake was investigated NC00209788 and resulted in immediate jeopardy. One (1) of the 5 complaint allegations resulted in a deficiency. Past Noncompliance was identified at: CFR 483.10 at tag F580 at a scope and severity J. CFR 483.15 at tag F620 at a scope and severity J. CFR 483.45 at tag F760 at a scope and severity J. The tag F760 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		

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

Electronically Signed | 12/31/2023

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 12/13/2023

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews and responsible party,	F 580	Past noncompliance: no plan of	

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F 580	Continued From page 2 staff, and Medical Director interviews, the facility failed to notify Resident #1's responsible party (RP) that Resident #1 had low blood sugar levels from insulin administration and the insulin was discontinued on 07/21/23. The insulin was prescribed for Person #2 (potential new admission from the same skilled nursing facility with same first and last name as Resident #1). Resident #1's RP stated if he had been notified in July about the administration of the insulin he would have asked to speak to the Administrator and the Medical Director and informed them Resident #1 did not have a diagnosis of diabetes. Had Resident's #1's RP been notified there was the high likelihood further significant medication errors would not have occurred until September. This deficient practice occurred for 1 of 2 residents reviewed for notification of change. The findings included: Resident #1 was admitted to the facility on 07/17/23. Resident #1's diagnoses according to his correct FL-2 form (state form that describes a patient's medical condition and the amount of care needed when placed in a facility) signed by the medical doctor at the discharging skilled nursing facility and dated 07/05/23 included progressive neurological condition, dementia with behavioral disturbance, non-Alzheimer's dementia, malnutrition, stage IV pressure ulcer and long-term drug therapy. Person #2's medication orders which were entered for Resident #1 on 07/17/23 included in part:	F 580	correction required.	

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F 580	Continued From page 3	F 580		

1. Aspirin oral tablet chewable 81 milligram (mg) tablet - give 1 tablet by mouth daily for hypertension.
2. Eliquis oral tablet 5 mg - give 1 tablet by mouth two times a day for aphasia.
3. Furosemide oral tablet 40 mg - give 1 tablet by mouth one time a day for hypertension.
4. Lantus (long-acting insulin) Subcutaneous Solution 100 units/millimeter (insulin Glargine) inject 55 units subcutaneously two times a day for diabetes mellitus.
5. Synthroid oral tablet 50 micrograms (mcg) (Levothyroxine Sodium) - give 1 tablet by mouth in the morning for thyroid.

Resident #1's medication orders effective 09/16/23 included in part:

1. Brimonidine Tartrate Ophthalmic Solution 0.2% - instill 1 drop in both eyes three times a day.
2. Dorzolamide HCl Ophthalmic Solution 2% - instill 1 drop in left eye two times a day.
3. Flomax Oral Capsule 0.4 mg - give 1 capsule by mouth at bedtime for BPH.
4. Folic Acid Oral Tablet - give 1 tablet by mouth one time a day for malnutrition/weight loss.
5. Melatonin Oral Tablet - give 1 tablet by mouth at bedtime for insomnia.
6. Vitamin B-1 Tablet 100 mg - give 1 tablet by mouth one time a day for risk for malnutrition/weight loss.
7. Vitamin B-12 ER Oral Tablet Extended Release 1000 mcg - give 1 tablet by mouth one time a day for risk for malnutrition/weight loss.

Resident #1's admission nursing assessment dated 07/17/23 revealed he was alert and oriented to person only and unable to verbalize

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F 580	Continued From page 4	F 580		

needs but was listed as his own responsible party.

Review of Resident #1's progress notes and Medication Administration Record revealed the following:

On 07/19/23 an order was written by the Medical Director (MD) to check blood sugar levels before meals and at bedtime for hypoglycemia to begin at 6:00 PM on 07/19/23.

On 07/19/23 at 11:02 AM Resident #1 had a blood sugar level of 65 and his insulin was held. The Nurse Practitioner was made aware. Resident was alert and had no signs or symptoms of distress noted. Resident #1 was given orange juice and a snack. At 11:30 AM Resident #1's blood sugar level went up to 104 documented by Nurse #2.

On 07/20/23 at 5:55 AM Resident #1 had a blood sugar level of 64. He was given a 120 ml health shake to drink. There was no documentation that anyone was notified of the blood sugar level of 64 by Nurse #4 in the progress notes.

Review of a lab report revealed on 07/20/23 at 6:53 AM a lab drawn blood glucose level revealed a blood sugar level of less than 40. There was no indication on the lab that the results had been reviewed by staff. There was no documentation in the nursing progress notes by Nurse #4 who was assigned to the resident that anyone was notified of the lab.

Several attempts were made to contact Nurse #4 who frequently cared for Resident #1 on the 7:00 PM to 7:00 AM shift without success.

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	345388	A. BUILDING _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 5	F 580		

On 07/20/23 at 9:00 AM according to the MAR Resident #1 had Lantus insulin held by Nurse #2 due to low blood sugar level at 5:55 AM of 64. His blood sugar level on 07/20/23 at 10:24 AM was 91.

A telephone interview on 12/07/23 at 12:57 PM with Nurse #2 revealed he remembered Resident #1 and taking care of him and said he was usually the nurse on that hall on the 7:00 AM to 7:00 PM shift. He confirmed he had taken care of the resident on 07/20/23 based on his initials being documented on the MAR for that shift. He stated Resident #1 would not have been able to tell you he was not diabetic and should not have been on insulin. Nurse #2 stated he couldn't remember if Resident #1 had low blood sugar levels or not but said the parameters for notifying the physician were usually on the orders for low and high blood sugar levels. He further stated for a blood sugar level of less than 40 he would have called the provider for further orders but did not recall knowing Resident #1 had a blood sugar level of less than 40. Nurse #2 indicated he could not remember if he called Resident #1's responsible party (RP) to notify him of the low blood sugar levels on any of the days it was low but said if he had he would have documented it in the nursing progress notes and if there was not a note, he must not have contacted the RP.

On 07/21/23 at 6:03 AM Nurse #4 documented Resident #1 had a blood sugar level of 71. There was no documentation in the nursing progress notes that the MD or NP was notified but a note was placed in the MD communication book and a voicemail was left for the responsible party (RP) for Resident #1.

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	345388	A. BUILDING _____ B. WING _____	C 12/13/2023

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F 580	Continued From page 6	F 580		

Several attempts were made to contact Nurse #4 who frequently cared for Resident #1 on the 7:00 PM to 7:00 AM shift without success.

On 07/21/23 at 1:29 PM the Lantus insulin order was discontinued for Resident #1 by the Medical Director (MD) but the before meals and at bedtime blood sugars continued until 09/15/23.

Review of Resident #1's nursing progress notes revealed no indication his responsible party (RP) had been notified of his low and critically low blood sugar levels on 07/20/23 at 5:44 AM which was 64, on 07/20/23 at 6:53 lab drawn blood sugar level which was less than 40 (critically low) or his low blood sugar level on 07/21/23 at 6:03 AM which was 71.

Resident #1's admission Minimum Data Set (MDS) assessment dated 07/31/23 revealed he was severely cognitively impaired, non-verbal, and required extensive assistance of 1-2 staff members with all activities of daily living.

An interview on 12/06/23 at 11:47 AM with the Social Worker revealed she and the Unit Manager had attempted to interview the resident for his care plan meeting on 07/19/23 and it became apparent to them during the meeting the resident was alert and oriented to person only and was unable to talk with them. She stated after the meeting she had called the SW at the discharging skilled nursing facility and obtained the responsible party name and telephone number and had updated the resident's medical record with the information obtained. The SW stated she notified the Admissions Coordinator #1 and the Business Office Manager of the updated

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 12/13/2023

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

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F 580	Continued From page 7	F 580		

information on Resident #1's responsible party that had been entered in the resident's electronic medical record. She further stated Admissions Coordinator #1 called the responsible party (RP) until she finally reached him on 07/24/23 and he came into the facility on 07/24/23 to sign Resident #1's admission paperwork. The SW explained sometime in September it was brought to her attention the facility had the wrong date of birth, diagnoses, and medication orders for Resident #1, so she called the discharging skilled nursing facility and obtained the correct information from the Social Worker at that facility and said the Marketing Director obtained hard copies of the correct information from the discharging skilled nursing facility.

An interview on 12/06/23 at 3:14 PM with the Medical Director (MD) revealed she was familiar with Resident #1 and remembered that somewhere along the course of his stay they had discovered they had the incorrect demographic information on him which resulted in him not being on the correct medications or having the right diagnoses documented at the facility. She stated he was administered insulin, but it was discontinued on 7/21/23 when she realized his blood sugar levels were not consistent with needing insulin. The facility obtained Resident #1's correct demographics, diagnoses, and orders from the discharging skilled nursing facility on 09/15/23. The MD further stated she began calling Resident #1's responsible party on 09/16/23 but was unable to leave a message due to his mailbox being full but said she finally reached him by telephone on 09/19/23 to inform him of the mix-up with his diagnoses, orders, and medications initially received from the discharging skilled nursing facility.

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 12/13/2023

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F 580	Continued From page 8	F 580		

A telephone interview on 12/07/23 at 12:09 PM with Resident #1's RP revealed he had not been notified by anyone at the facility that Resident #1 had received the wrong medications for 2 months of his stay at the facility. He stated no one from the facility had called him on 07/21/23 and told him they had stopped giving Resident #1 insulin and said if they had he would have told them, he needed to "meet with the facility director and the medical director because Resident #1 had never been a diabetic a day in his life." The RP further stated they had not notified him of the insulin or the low blood sugar levels when he had visited Resident #1 on 07/24/23 and signed his admission paperwork. The RP also stated he was not told about other medications Resident #1 had received and had not had diagnoses for receiving the medications. The RP was not aware the facility had the wrong date of birth for Resident #1 until Hospice had asked about his date of birth on 09/15/23 during a telephone conversation. He said he was not aware Resident #1 had received the wrong medications for 2 months and had only been told by the Medical Director that they were "adjusting his medications." The RP indicated he assumed it was because Resident #1 had been placed on Hospice, they were adjusting medications.

An interview on 12/07/23 at 11:34 AM with the Assistant Director of Nursing (ADON) revealed she had served as the Unit Manager for North for about 6 weeks from 06/20/23 through 07/31/23. The ADON indicated she did not remember Resident #1's low and critically low blood sugar levels but said their normal process would have been to notify the Medical Director (MD) or Nurse Practitioner (NP) about the low blood sugar

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 12/13/2023

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

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F 580	Continued From page 9	F 580		

levels, document the notification and contact the resident's guardian, responsible party or family and notify them of the low blood sugar levels and the holding of his insulin and document the notification. The ADON said if it was not documented in the nursing progress notes she would have to assume Resident #1's RP had not been notified of the low blood sugar levels and could not explain why he had not been notified.

An interview on 12/06/23 at 5:00 PM with the Director of Nursing (DON) and the Nurse Consultant revealed the nurses would not have had the correct contact information for Resident #1's RP to notify him of the insulin being discontinued or that he had low blood sugar levels. They both explained Person #2's information listed him as his own responsible party with no telephone number. The DON nor the Nurse Consultant could answer why Resident #1's RP had not been notified of the insulin and low blood sugar levels after the facility had obtained the RP's name and telephone number from the discharging skilled nursing facility on 07/19/23 or why he was not informed when he had visited Resident #1 on 07/24/23 and signed his admission paperwork.

A follow up interview on 12/07/23 at 4:45 PM with the Director of Nursing (DON), and Nurse Consultant with the Administrator present revealed the DON, Administrator nor Nurse Consultant knew why Resident #1's RP had not been notified of the low blood sugar levels or the insulin being discontinued on 07/21/23 when he had visited Resident #1 on 07/24/23 and signed his admission paperwork. The DON and Nurse Consultant stated the nurse assigned to the resident or the Unit Manager should have told the

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 12/13/2023

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 580	Continued From page 10	F 580		

RP about the insulin and low blood sugar levels on 07/24/23 and it should have been documented. The DON stated the expectation with notification was for the resident (if they are their own responsible party), family, guardian, or Power of Attorney to be notified within 24 hours of any changes with a resident. The DON and Nurse Consultant further stated the RP had been notified on 09/19/23 by the Medical Director of the mix-up with his medications and said the MD stated the RP had no concerns regarding the information. They said there was a delay in notifying Resident #1's RP because the MD had tried to contact the son for several days and finally got to speak with him on 09/19/23.

The Administrator was notified of immediate jeopardy on 12/07/23 at 5:15 PM.

The facility provided the following corrective action plan with a completion date of 09/29/23:

As a result of the deficient practice of not securing accurate patient information, Resident #1 received medications prescribed to Resident #2. Medications included 3 doses of Lantus (Long Acting) insulin. Resident #1 was not a diabetic and had not been prescribed insulin.

Resident #1's responsible party was not notified that Resident #1 had three critical low blood sugar readings as a result of receiving insulin and the insulin being discontinued on 7/21/23. At the time of the occurrence Resident #1 was listed as his own responsible party based on information received from the discharging facility that belonged to Resident #2. At the time, the facility had not yet discovered Resident #1 had been receiving medications prescribed to Resident #2.

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F 580	Continued From page 11	F 580		

After realizing Resident #1's cognitive impairment, and several attempts were made to the contact number listed on Resident #2's Admission Record, the Director of Admissions reached back out to the discharging facility's Social Worker on 7/19/23. The discharging facility's Social Worker provided new contact information for Resident #1. The Director of Admissions made several attempts using the new number with no success. Contact was not made until the morning of 7/24/23 by the Admissions Director. The admission agreement was completed by the Director of Admissions in the afternoon on 7/24/23 with Resident #1's responsible party. Resident #1's responsible party was not informed of the low blood sugars or insulin being discontinued on 7/24/23.

All residents residing in the facility have the potential to be affected by the deficient practice. On 9/28/23, the Admissions Director and Admissions Coordinator completed a review of current resident records to verify dates of birth and responsible party/emergency contact information was accurate. Any discrepancies identified were corrected.

On 9/21/23, a Root Cause Analysis was completed by the Director of Nursing and Executive Director related to notification. It was determined Resident #1's responsible party was not notified of critical low blood sugars and insulin being discontinued as result of not having the correct information for Resident #1's responsible party.

On 9/21/23, the Executive Director educated the Admissions Director and Admissions Coordinator

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 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 12	F 580		

on ensuring responsible party/emergency contact information for newly admitted residents is entered into the electronic medical record and is accurate. Prior to admission The Director of Admissions or Admissions Coordinator will validate contact information for residents, responsible parties and/or emergency contact through verbal authentication. The newly hired Admissions Director or Admissions Coordinator will be educated during the Orientation process by the Executive Director, going forward. The Executive Director has been notified of this responsibility.

On 9/21/23, the Director of Nursing initiated education to licensed nurses related to change in condition/notification to include:
" Family/Responsible Party Notification
" Physician Notification
" Physician order (if indicated)
" Appropriate documentation
" If more than 3 attempts are made to notify the responsible party the nurses must notify the Director of Nursing/and or Unit Manager.
" Reviewed situations that would require notification to include:
o an accident involving the resident which results in injury and has the potential for requiring physician intervention.
o a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications.
o A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.

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 12/13/2023

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 580	Continued From page 13	F 580		

After 9/21/23 nurses not educated will receive this education prior to working their next scheduled shift), regarding change in condition/notification to include notifying responsible party and notification to Director of Nursing when the contact information is not present/no longer accurate or responsible party is not able to be reached after 3 attempts. The Director of Nursing will be responsible for tracking nurses not educated on 9/21/23. In the event the facility must use contract nursing, the contracted nurse will be educated by the Director of Nursing prior to the start of their assignment. On 9/21/23, the Director of Nursing assigned a designee from the Nursing Administrative Team to ensure evening and weekend Licensed Nurses were educated prior to the start of their shift. Newly hired Licensed Nurses and will be educated during the Orientation process by the Director of Nursing, going forward. The Director of Nursing has been notified of this responsibility.

Starting on 9/28/23 the Executive Director and/or designee to complete Quality Improvement monitoring for Notification of Changes to MD/NP/Responsible Party and to ensure newly residents have emergency contact/responsible party listed with correct telephone number to be completed weekly for twelve weeks to be completed by 12/21/23 and monthly for 3 months to be completed by 3/21/24.
The Director of Nursing and Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 9/28/23. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance

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 12/13/2023

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 580	Continued From page 14	F 580		

Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.
Compliance date: 09/29/23

The facility's corrective action plan was validated by the following:

" On 12/13/23 the facility's plan of correction was validated upon review of the sign-in sheets for in-service education provided to the admissions staff and business office staff on the admissions policy, verifying demographic information, and how to verify correct information by reviewing two forms of identification of residents, one including a photograph. Review of the monitoring audits revealed no concerns identified. Interviews conducted with the Business Office Manager and the Assistant Business Office Manager and Admissions staff revealed they had received education on the admissions policy and the importance of confirming each resident's correct information prior to the resident being admitted to the facility. Record review of sampled residents recently admitted revealed no concerns.
" In addition, the plan of correction was validated upon review of the sign-in sheets for in-service education provided to all licensed nurses on notification of change in condition policy, admissions policy, discharge policy,

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 12/13/2023

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 580	Continued From page 15 medication errors and change in condition notification and documentation of notification in the electronic medical record (EMR) on 09/21/23. Review of the monitoring audits revealed there were no concerns identified. Interviews conducted with the licensed nursing staff revealed they had received education on notification and documentation of the notification for any change condition or treatment for residents. Record review of sampled residents who recently had changes in condition or treatment revealed no concerns. The facility's compliance date of 9/29/23 was validated.	F 580		
F 620 SS=J	Admissions Policy CFR(s): 483.15(a)(1)-(7) §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the	F 620		

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 12/13/2023

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F 620	Continued From page 16	F 620		

facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

§483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,-
(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and
(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

§483.15(a)(5) States or political subdivisions may

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 12/13/2023

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F 620	Continued From page 17 apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. §483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. §483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to implement their Admissions Policy and Procedure and verify the identity of a cognitively impaired resident when he was admitted to the facility with paperwork from the discharging skilled nursing facility for Person #2 (potential new admission with same first and last name as Resident #1). As a result, Resident #1, who did not have a diagnosis of diabetes, was administered 3 doses of long-acting insulin, and experienced 3 three low blood sugar levels before the insulin was discontinued. In addition, Resident #1 received an anticoagulant, aspirin, a diuretic, and a medication used to treat hypothyroidism from 07/17/23 until 09/15/23 prescribed for Person #2. This deficient practice occurred for 1 of 2 residents reviewed for medication errors and had a high likelihood of serious harm (Resident #1).	F 620	Past noncompliance: no plan of correction required.	

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 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 620	Continued From page 18	F 620		

The findings included:

The Admissions Policy and Procedure for the facility dated 08/19/2018, under Procedure read in part:
"The Marketing Coordinator or Admissions Coordinator will:
- Copy all insurance, Medicare, and Medicaid cards, and attach copies of all applicable payor verification, i.e.: Medicare eligibility verification, Medicaid eligibility, etc. When documents are obtained, copies MUST be scanned into the electronic medical record. There must be 3 attempts to obtain these copies documented on the admission checklist before this can be turned over to the Business Office Manager.
- Complete all documents listed on Admissions Checklist including any State specific forms not listed."

Resident #1 was admitted to the facility on 07/17/23.

Resident #1's diagnoses according to his correct FL-2 form (state form that describes a patient's medical condition and the amount of care needed when placed in a facility) signed by the medical doctor at the discharging skilled nursing facility and dated 07/05/23 included progressive neurological condition, dementia with behavioral disturbance, non-Alzheimer's dementia, malnutrition, stage IV pressure ulcer and long-term drug therapy.

Resident #1's admission nursing assessment dated 07/17/23 revealed he was alert and oriented to person only and unable to verbalize needs but was listed as his own responsible

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 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 620	Continued From page 19	F 620		

party. This assessment was entered by Nurse #3.

Several attempts were made to contact Nurse #3 who was the admitting nurse for Resident #1 without success.

Person #2's medication orders which were entered for Resident #1 on 07/17/23 by Admissions Coordinator #1 included:
1. Aspirin oral tablet chewable 81 milligrams (mg) tablet - give 1 tablet by mouth daily for hypertension.
2. Eliquis oral tablet 5 mg - give 1 tablet by mouth two times a day for aphasia.
3. Furosemide (diuretic) oral tablet 40 mg - give 1 tablet by mouth one time a day for hypertension.
4. Lantus (long-acting insulin) subcutaneous solution 100 units/millimeter (insulin Glargine) inject 55 units subcutaneously two times a day for diabetes mellitus. There were no orders to check blood sugar included in these orders.
5. Synthroid oral tablet 50 micrograms (mcg) (Levothyroxine Sodium) - give 1 tablet by mouth in the morning for thyroid.

Review of Resident #1's correct medication orders received from the discharging skilled nursing facility on 09/15/23 and verified by the Medical Director at the facility on 09/16/23 included the following:
1. Brimonidine Tartrate Ophthalmic Solution 0.2% - instill 1 drop in both eyes three times a day for glaucoma.
2. Dorzolamide HCl Ophthalmic Solution 2% - instill 1 drop in left eye two times a day for glaucoma.
3. Flomax Oral Capsule 0.4 mg - give 1 capsule

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 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 620	Continued From page 20	F 620		

by mouth at bedtime for BPH.
4. Folic Acid Oral Tablet 1 mg - give 1 tablet by mouth one time a day for malnutrition/weight loss.
5. Vitamin B-1 Tablet 100 mg - give 1 tablet by mouth one time a day for malnutrition/weight loss.
6. Vitamin B-12 ER Oral Tablet Extended Release 1000 micrograms (mcg) - give 1 tablet by mouth one time a day for risk for malnutrition/weight loss.

An interview on 12/06/23 at 11:47 AM with the Social Worker revealed she and the Unit Manager had attempted to interview the resident for his care plan meeting on 07/19/23 and it became apparent to them during the meeting the resident was alert and oriented to person only and was unable to talk with them. She stated after the meeting she had called the SW at the discharging facility and obtained the responsible party name and telephone number and had updated the resident's medical record with the information obtained. The SW stated she notified the Admissions Coordinator #1 and the Business Office Manager of the updated information on Resident #1's responsible party that had been entered in the resident's medical record. She further stated the Admissions Coordinator #1 called the responsible party (RP) until she finally reached him on 07/24/23 and he came into the facility on 07/24/23 to sign Resident #1's admission paperwork. The SW explained sometime in September it was brought to her attention the facility had the wrong date of birth, diagnoses, and medications for Resident #1, so she called the discharging skilled nursing facility and obtained the correct information from the Social Worker at that facility and said the Marketing Director obtained hard copies of the correct information from the discharging skilled

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 12/13/2023

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 620	Continued From page 21	F 620		

nursing facility.

An interview on 12/06/23 at 11:55 AM with the Business Office Manager, revealed on 09/15/23 she received a telephone call from the Hospice Nurse who informed her the facility had the wrong date of birth for Resident #1 according to the responsible party (RP) who was a family member. The Hospice Nurse reported to the Business Office Manager the correct date of birth for Resident #1 and the Business Office Manager notified the facility Social Worker of the error with Resident #1's date of birth. The facility Social Worker reached out by telephone to the SW at the discharging skilled nursing facility and obtained the correct information and Resident #1's correct FL-2 (state form that describes a patient's medical condition and the amount of care needed when placed in a facility) and medication orders.

An interview on 12/06/23 at 5:20 PM with the Marketing Coordinator revealed she received referrals and goes to hospitals and facilities to evaluate residents for possible transfer and admission to the facility. She stated she had received a telephone call from the discharging skilled nursing facility and went to the facility to evaluate Resident #1 (could not remember the exact date) for possible admission to the facility. She further stated she could not remember if she had interviewed Resident #1 but said she had seen him and looked over his paperwork provided and agreed to take him. The Marketing Coordinator said the Social Worker at the discharging skilled nursing facility had printed out information and given to her in an envelope on that day (could not remember what day) and she had no reason to believe it wasn't the correct

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 12/13/2023

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 620	Continued From page 22	F 620		

information for Resident #1 that they were admitting to the facility. She indicated they had received the right resident that she had evaluated for admission but had received the wrong information packet with the wrong medication orders. According to the Marketing Coordinator, because the wrong information was received from the discharging skilled nursing facility when she had evaluated Resident #1, the wrong information had been uploaded by Admissions Coordinator #1 to his computer profile at the facility. The Marketing Coordinator said at the time she evaluated Resident #1 she was not aware there were two residents with the same first and last names at the discharging skilled nursing facility but later learned there were, and she had been given the wrong information for the resident. She said the typical packet consisted of an FL-2 form, face sheet, discharge summary and order summary, none of which had pictures of the resident on them. The Marketing Coordinator stated she couldn't remember if she reviewed the information prior to it being entered into the system but had no reason to believe it was not the correct information for Resident #1. The Marketing Coordinator indicated Admissions Coordinator #1 would have been responsible for verifying Resident #1's information through various computer portals. Once the documents were received by Admissions Coordinator #1, she entered the information into the resident's electronic medical profile. According to the Marketing Coordinator, since the issue with Resident #1 being admitted from another facility with the information, orders, and medication orders for Person #2 (who had the same first and last name as Resident #1), the facility had changed their process. The Marketing Coordinator stated they now make copies of

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 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 620	Continued From page 23	F 620		

insurance card, photo identification, Medicare card, and social security card and scan them into the electronic medical record. If the admitting resident was unable to complete the admission packet with the Admissions Coordinator, then the responsible party was contacted to complete the process. She stated when she was initially trained for her position, she was not trained to obtain copies of cards and relied on portals for the information but said now they obtain copies of the cards prior to the resident being admitted and prior to admission now resident's or their responsible party, guardian, or power of attorney must provide two forms of identification of which one must include a photograph of the resident.

Admissions Coordinator #1 was not available for interview.

Admissions Coordinator #2 was not employed by the facility at the time of the error.

An interview on 12/07/23 at 4:45 PM with the Director of Nursing (DON), Administrator, and Nurse Consultant revealed they were aware Resident #1 had been administered medications for which he didn't have diagnoses but said they were following the orders provided by the discharging skilled nursing facility. They all said they were not aware of any issues with Resident #1 and his orders until they were notified by Hospice on 09/15/23 that the date of birth they had for the resident was not correct. The Nurse Consultant stated once they learned the date of birth was incorrect, they called the discharging skilled nursing facility and obtained the correct information and the correct medication orders and had the Medical Director review the information, and evaluate Resident #1. Labs were

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 12/13/2023

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 620	Continued From page 24	F 620		

ordered and they initiated new orders for medications and treatments for the resident. The Nurse Consultant and DON stated the original resident profile (face sheet) created on admission for Resident #1 could not be reviewed because instead of creating a new profile for Resident #1 they had corrected the current profile for the resident and the old information had been erased as a result. The Nurse Consultant further stated they should have created a new profile for the resident instead of correcting the old profile so that both profiles would be visible but said that was not what the Admissions Coordinator #1 had done with Resident #1's information.

An interview on 12/11/23 at 10:46 AM was conducted with Social Worker (SW) #2 from the discharging skilled nursing facility. The interview revealed the Marketing Coordinator from the admitting facility came and assessed both Resident #1 and Person #2 (who had the same first and last name) on 07/12/23 and was handed both residents discharge packets in two different envelopes with the face sheet, discharge summary, MAR, and FL-2 for each resident in the envelope. SW #2 further stated after the Marketing Coordinator left the facility Person #2 decided he didn't want to discharge so she let the Marketing Coordinator know on 07/14/23 that Resident #1 would be coming; however, Person #2 had decided to remain at their facility and not discharge. The interview further revealed at discharge on 7/17/23 Resident #1 was sent to the receiving facility with a second discharge packet which included his medications, face sheet, nursing progress notes, history and physical, order summary and dietary considerations. SW #2 stated after the discharge she was contacted by the Marketing Coordinator from the admitting

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 12/13/2023

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

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F 620	Continued From page 25	F 620		

facility stating they had mixed up the residents and needed Resident #1's records again. SW #2 stated the Marketing Coordinator came to the discharging skilled nursing facility and was handed the information in person. She stated the Marketing Coordinator acknowledged she had been given both Resident #1's and Person #2's packets when she completed the assessments at the discharging skilled nursing facility.

The Administrator was notified of immediate jeopardy on 12/07/23 at 5:15 PM.

The facility provided the following corrective action plan with a completion date of 09/29/23:

The facility failed to ensure Resident #1 was free from a significant medication error when Resident #1 was administered medications prescribed for Person #2. Resident #1 received the following medications:

" Lantus
" Eliquis
" Synthroid
" Lasix
" Aspirin

Prior to Resident #1's admission to our facility, the Director of Admissions conducted a bedside assessment. When leaving the discharging skilled nursing facility, the discharging facility's Social Worker provided physical copies of the Person #2's North Carolina Long Term Care Form (FL-2) with a date of birth of 1/16/56 and medication list for Resident #2. Resident #1 was also admitted to the facility with Person #2's date of birth (DOB: 1/16/56), medical information, and medication orders on 7/17/23.

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 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 620	Continued From page 26	F 620		

Upon arrival on 7/17/23, Resident #1 was alert to person with confusion and memory impairment. The FL2 received provided no relative or contact information. Person #2's admission record from the discharging facility listed the resident as his own responsible party.

On 7/19/23 a care conference meeting was held with Resident #1 led by the Social Services Director. During the care conference, Resident #1 was observed to have notable cognitive impairment, congruent with the signs and symptoms of possible dementia. Resident #1 was listed as his own responsible party. Resident #1 was unable to actively participate.

After realizing Resident #1's cognitive impairment, and several attempts were made to the contact number listed on Resident #2's Admission Record, the Director of Admissions reached back out to the discharging facility's Social Worker on 7/19/23. The discharging facility's Social Worker provided new contact information for Resident #1. The Director of Admissions made several attempts using the new number with no success. Contact was not made until the morning of 7/24/23 by the Admissions Director. The admission agreement was completed by the Director of Admissions in the afternoon on 7/24/23 with Resident #1's responsible party.

On 9/15/23, during a phone conversation between the Resident #1 responsible party and our hospice partner, and while verifying information via telephone, it was discovered that the date of birth we were provided by the discharging facility did not match Resident #1. Upon further investigation, it was also discovered

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 12/13/2023

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 620	Continued From page 27	F 620		

that the initial information received from the discharging facility was that of Person #2 who was also a resident of the discharging facility with the same name as Resident #1.

" On 9/15/23 the correct information, including medication orders for Resident #1 was obtained. Resident #1 was evaluated by the facility Medical Director. Upon review of Resident #1 medications and orders, all unnecessary medications were discontinued.

" On 9/15/23 the Director of Nursing completed a medication error report for Resident #1. The medication error report was completed for the medications received in error by Resident #1.

" Critical medications received in error were Insulin, Eliquis and Synthroid, Lasix and Aspirin. The insulin had previously been discontinued on 7/21/23, prior to this discovery due to low blood sugar levels.

" The Eliquis, Synthroid, Aspirin, and Lasix were discontinued on Friday, 9/15/23. Labs ordered were Thyroid Stimulating Hormone (TSH), Complete Metabolic Panel (CBP), Complete Blood Count (CBC) with differential.

" On 9/22/23 and 9/25/23 lab results (TSH, CBC with diff, and CMP) were reviewed by the Medical Director and determined there were no adverse reactions suffered, and Resident #1 was not at risk for any other adverse reactions because of this incident. Resident #1 was also seen and monitored throughout the weekend by the facility Nurse Practitioner.

" The facility's Medical Director made multiple

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 12/13/2023

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 620	Continued From page 28	F 620		

attempts to reach Resident #1's responsible party by phone starting on 9/15/23 but was unable to leave a message due to full voice mailbox. The Medical Director spoke with the Resident #1's responsible party on 9/21/23 and advised him of the incident. Resident #1's responsible party understood and had no adverse response to the incident.

To help ensure the deficient practice does not reoccur, a chart audit of all residents admitted since 5/17/2023 was conducted by Business Office Manager and Admissions Coordinator on 9/28/23 to ensure information filed in the residents' medical record was accurate and belonged to the residing resident. This audit included verifying the resident information on the demographic sheet, the resident's photograph, and financial information was accurate. Any discrepancies were corrected.

On 9/21/23, a Root Cause Analysis was completed by the Director of Nursing and Executive Director. In conclusion, the facility failed to validate Resident #1 medical information upon admission on 7/17/23.

The Executive Director completed education on 9/21/23 with the facility's admissions team, which includes the Director of Admissions, Admission Coordinator, Business Office Manager and Assistant Business Office Manager to ensure accurate documentation for admitting residents had been obtained prior to entering the facility. Accurate information would include demographic information, financial information, and a photograph. The admissions team was also reeducated to ensure required information, including but not limited to, clinical

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 12/13/2023

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 620	Continued From page 29	F 620		

documentation, medication list, and FL-2s received from a discharging facility were accurate and belonged to the admitting resident. Authentication will be verified by the discharging facility's appointed representative. The facility Business Office Manager and Assistant Business Office Manager were also educated by the Executive Director on ensuring required information, which includes the residents' Social Security Number, Date of Birth, insurance card information and policy information belong to the admitting resident. The Director of Admissions and Admissions and/or Coordinator will validate the newly admitted residents' identity by verbal authentication. Authentication will require the newly admitted resident to verbally provide information, including, but not limited to their name, date of birth, and social security number. If the resident is unable to provide this information, the Director of Admissions and/or Admissions Coordinator will have the resident's guardian, power of attorney or appointed person verbally authenticate the newly admitted resident's identity. Authentication will require the newly admitted resident's guardian, power of attorney or appointed person to verbally provide information, including, but not limited to the resident's name, date of birth, and social security number.

Prior to admission, newly admitted residents or their responsible party will be required to provide two forms of identification, of which one must include a photograph. Copy all insurance cards to include Medicare and Medicaid if available. When documents are obtained, copies must be scanned into the resident's electronic medical record. There must be 3 attempts to obtain these copies documented on the admission checklist before turning them over to the Business Office

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 12/13/2023

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 620	Continued From page 30	F 620		

Manager. Newly hired Admissions or Business Office personnel will be educated on this process during new hire orientation.

"Starting on 9/28/23 the Executive Director and/or designee to complete Quality Improvement monitoring for Admission Process to include two forms of identification, of which one must include a photograph, copy of insurance cards, and review admission packet to be completed weekly for twelve weeks and monthly for 3 months. Weekly monitoring will be completed by 12/21/23. Monthly monitoring will be completed by 3/21/24.

"The Director of Nursing and Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 9/28/23. The Executive Director is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.

Completion date: 09/29/2023.

The facility's corrective action plan was validated by the following:

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 12/13/2023

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 620	Continued From page 31 "On 12/13/23 the facility's plan of correction was validated upon review of the sign-in sheets for in-service education provided to the admissions staff and business office staff on the admissions policy, verifying demographic information, and how to verify correct information by reviewing two forms of identification of residents, one including a photograph. Review of the monitoring audits revealed no concerns identified. Interviews conducted with the Business Office Manager and the Assistant Business Office Manager and Admissions staff revealed they had received education on the admissions policy and the importance of confirming each resident's correct information prior to the resident being admitted to the facility. Record review of sampled residents recently admitted revealed no concerns. The facility's completion date of 9/29/23 was validated.	F 620		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and family member, staff, Nurse Practitioner and Medical Director interviews, the facility failed to prevent significant medication errors when a. Resident #1 was administered medications prescribed for Person #2 (potential new admission with same first and last name as Resident #1). Person #2's information and medication orders were entered for Resident #1 in error on 7/17/23 and this was not discovered until 9/15/23. Resident #1 did not	F 760	Past noncompliance: no plan of correction required.	

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 12/13/2023

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 760	Continued From page 32	F 760		

have a diagnosis of diabetes and was administered 3 doses of long-acting insulin and had three low blood sugar levels before the insulin was discontinued on 07/21/23. In addition, Resident #1 was administered an anticoagulant, aspirin, diuretic, and a medication used to treat hypothyroidism for which he had no diagnoses to treat. b. In addition, Resident #1 did not receive two eye drops prescribed for his diagnosis of glaucoma from 07/17/23 through 09/15/23. This deficient practice occurred for 1 of 2 residents reviewed for medication errors and had a high likelihood for serious harm.

Example b. was cited at a lower scope and severity of D.

The findings included:

1. a. Resident #1 was admitted to the facility on 07/17/23.

Resident #1's diagnoses according to his correct FL-2 form (state form that describes a patient's medical condition and the amount of care needed when placed in a facility) signed by the medical doctor at the discharging skilled nursing facility and dated 07/05/23 included progressive neurological condition, dementia with behavioral disturbance, non-Alzheimer's dementia, malnutrition, stage IV pressure ulcer and long-term drug therapy.

Resident #1's admission nursing assessment dated 07/17/23 revealed he was alert and oriented to person only and unable to verbalize needs but was listed as his own responsible party. The resident's vital signs on admission were stable and there were no abnormalities

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 12/13/2023

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 760	Continued From page 33	F 760		

noted by Nurse #3 for the resident.

Several attempts were made to contact Nurse #3 who was the admitting nurse for Resident #1 without success.

Person #2's medication orders which were entered for Resident #1 on 07/17/23 by the Admissions Coordinator #1 and included:
1. Aspirin oral tablet chewable 81 milligrams (mg) tablet - give 1 tablet by mouth daily for hypertension.
2. Eliquis oral tablet 5 mg - give 1 tablet by mouth two times a day for aphasia.
3. Furosemide (diuretic) oral tablet 40 mg - give 1 tablet by mouth one time a day for hypertension.
4. Lantus (long-acting insulin) subcutaneous solution 100 units/millimeter (insulin Glargine) inject 55 units subcutaneously two times a day for diabetes mellitus. There were no orders to check blood sugar included in these orders.
5. Synthroid oral tablet 50 micrograms (mcg) (Levothyroxine Sodium) - give 1 tablet by mouth in the morning for thyroid.

Review of the Medication Administration Records (MAR) for Resident #1 revealed he received the following medications prescribed for Person #2 from 07/17/23 to 09/15/23. There was a picture of Resident #1 on the MAR:
1. Aspirin 58 doses
2. Eliquis 117 doses
3. Furosemide 58 doses
4. Lantus insulin 3 doses (discontinued on 07/21/23)
5. Synthroid 60 doses

Review of Resident #1's corrected medication

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 12/13/2023

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 760	Continued From page 34	F 760		

orders received from the discharging facility on 09/15/23 and verified by the Medical Director at the facility on 09/16/23 included the following:
1. Brimonodine Tartrate Ophthalmic Solution 0.2% - instill 1 drop in both eyes three times a day for glaucoma.
2. Dorzolamide HCl Ophthalmic Solution 2% - instill 1 drop in left eye two times a day for glaucoma.
3. Flomax Oral Capsule 0.4 mg - give 1 capsule by mouth at bedtime for BPH.
4. Folic Acid Oral Tablet 1 mg - give 1 tablet by mouth one time a day for malnutrition/weight loss.
5. Vitamin B-1 Tablet 100 mg - give 1 tablet by mouth one time a day for malnutrition/weight loss.
6. Vitamin B-12 ER Oral Tablet Extended Release 1000 micrograms (mcg) - give 1 tablet by mouth one time a day for risk for malnutrition/weight loss.

Review of Resident #1's progress notes and Medication Administration Record revealed the following:

On 07/18/23 at 9:00 AM Resident #1 received Lantus insulin 55 units subcutaneously administered by Nurse #1 as prescribed on the MAR.

On 07/18/23 at 9:00 PM Resident #1 did not receive Lantus insulin as prescribed and it was documented as refused on the MAR.

On 07/19/23 an order was written to check blood sugars before meals and at bedtime for hypoglycemia to begin at 6:00 PM according to the MAR

On 07/19/23 at 9:00 PM Resident #1 received

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 12/13/2023

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 760	Continued From page 35	F 760		

Lantus insulin 55 units subcutaneously administered by Nurse #2 on the MAR.

On 07/20/23 at 5:55 AM Resident #1 had a blood sugar reading of 64. He was given orange juice and a snack documented by Nurse #4 in the nursing progress notes.

On 07/20/23 at 6:53 AM a lab drawn blood glucose reading revealed a blood sugar reading of less than 40 according to the lab.

On 07/20/23 at 9:00 AM Resident #1 had Lantus insulin held due to low blood sugar level at 5:55 AM of 64. The blood sugar was rechecked at 10:24 AM and it was 91 documented by Nurse #2.

On 07/21/23 at 6:03 AM Resident #1 had a blood sugar reading of 71. He was given orange juice and a snack documented by Nurse #4.

On 07/21/23 at 9:00 AM Resident #1 received Lantus insulin 55 units subcutaneously administered by Nurse #2 according to the MAR.

On 07/21/23 at 1:29 PM the Lantus insulin order was discontinued for Resident #1 but the before meals and at bedtime blood sugars continued until they were discontinued on 09/15/23 according to the MAR.

Several attempts were made to contact Nurse #4 by telephone without success.

Review of Resident #1's admission Minimum Data Set (MDS) assessment dated 07/31/23 revealed he was severely cognitively impaired, non-verbal, and required extensive assistance of

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 12/13/2023

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 760	Continued From page 36	F 760		

1-2 staff for all activities of daily living (ADL).

A telephone interview on 12/07/23 at 11:39 AM with Nurse #1 revealed she remembered Resident #1 and vaguely remembered taking care of him but not any details. She stated he was non-verbal and would not have been able to verbalize to them he was not diabetic and not on insulin. She further stated he was only able to let them know if he was hungry, thirsty or in pain. She said if her initials were in the block on the Medication Administration Record with a check mark, she would have given the resident his insulin as prescribed and said she would have had no way of knowing the resident should not receive insulin or any of the medications he was ordered if it was in his physician orders, transcribed on the MAR and he matched the picture of the resident on the MAR. Nurse #1 stated she cared for the resident a few times but couldn't remember exactly what days before being reassigned to the other unit at the facility. She stated if the picture of the resident on the MAR matched the resident in the bed, they gave the medications as ordered by the physician.

A telephone interview on 12/07/23 at 12:57 PM with Nurse #2 revealed he remembered Resident #1 and taking care of him and said he was usually the nurse on that hall. He stated Resident #1 would not have been able to tell you he was not diabetic and should not have been getting insulin. Nurse #2 stated he couldn't remember if Resident #1 had low blood sugar levels or not but said the parameters for notifying the physician were usually on the orders for low and high blood sugar levels. He further stated he had taken care of the resident a lot until he was moved to another room on another hall and said he always

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 12/13/2023

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 760	Continued From page 37	F 760		

checked to be sure the resident matched the picture of the resident on the MAR before giving medications.

A physician order was written on 09/13/23 to consult Hospice due to a decline in Resident #1's condition (advancement of dementia and intermittent refusal to eat and drink).

An interview on 12/06/23 at 11:55 AM with the Business Office Manager, revealed on 09/15/23 she received a telephone call from the Hospice Nurse who informed her the facility had the wrong date of birth for Resident #1 according to the responsible party (RP) who was a family member. The Hospice Nurse reported to the Business Office Manager the correct date of birth for Resident #1 and the Business Office Manager notified the facility Social Worker of the error with Resident #1's date of birth. The facility Social Worker reached out by telephone to the SW at the discharging facility and obtained the correct information and Resident #1's correct FL-2 (state form that describes a patient's medical condition and the amount of care needed when placed in a facility) and medication orders.

A review of Resident #1's progress notes revealed a note written on 09/15/23 at 9:28 PM by the Director of Nursing (DON) that read: "Resident #1 admitted to the facility from another facility on 07/17/23. It was discovered today that the orders received at the time of admission were for another resident - Person #2 with the same name residing at the transferring facility. The Medical Director was made aware of the situation, order received and carried out to discontinue all medications until correct orders are received. Once correct orders were received,

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 12/13/2023

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 760	Continued From page 38	F 760		

they were reviewed with and verified by the Medical Director."

An interview on 12/06/23 at 3:14 PM with the Medical Director (MD) revealed she was familiar with Resident #1 and remembered that somewhere along the course of his stay they had discovered they had the incorrect demographic information on him which resulted in him not being on the correct medications or having the right diagnoses documented at the facility. She stated he was administered insulin, but it was stopped on 07/21/23 when she realized his blood sugars were not consistent with needing insulin, so it was discontinued but the resident had continued with blood sugars before meals and at bedtime. The MD further stated she couldn't recall all the medications he had been administered in error but said they were all discontinued on 09/15/23 when the facility had obtained his correct demographics, diagnoses, and orders from the discharging facility. She indicated Resident #1 was very frail and his underlying comorbidities had not been revealed on admission and they didn't have a true picture of his medical history until they had received updated and correct information on him on 09/15/23. The MD further indicated that while it was not beneficial that Resident #1 received the wrong medications for 2 months, they had not seen any adverse effects of the resident from the wrong medications being administered. She said she had ordered labs including a complete blood count (CBC), complete metabolic panel (CMP), and thyroid stimulating hormone (TSH) level and the labs were all within normal limits for the resident.

An interview on 12/06/23 at 5:00 PM with the

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 12/13/2023

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 760	Continued From page 39	F 760		

Director of Nursing (DON) and the Nurse Consultant revealed Resident #1 was discharged from another skilled nursing facility on 7/17/23 and they had received the demographic information, orders, and medication orders for Person #2. The DON stated it was not until Hospice notified them on 09/15/23 that they were aware there was a problem with Resident #1's date of birth. She further stated it wasn't until they reached the discharging facility on 09/15/23 that they discovered they also had incorrect diagnoses and medications for Resident #1. She explained their normal admitting procedure was for the Admission Coordinator and the Business Office Manager or Assistant to verify insurance through the various computer portals. Once the information was verified the orders and medications were passed to the admitting nurse or Unit Manager and they verified the information for medications and orders was entered correctly once they received the orders. The DON further explained the nurses would have no way of knowing the information they received regarding diagnoses, orders, and medications was not correct for Resident #1 since he could not verify any information himself. She continued to explain that once his blood sugar levels appeared to remain low, the Medical Director (MD) discontinued the insulin so he only received 3 doses but said they had continued with blood sugar readings before meals and at bedtime since they thought he was diabetic. The DON stated once they discovered the error on 09/15/23 all orders for Resident #1 were discontinued and the Marketing Coordinator obtained the correct information for Resident #1. He was seen by the MD and new orders were written for the right medications to be given. She further stated Resident #1 was evaluated by the MD once the

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 12/13/2023

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 760	Continued From page 40	F 760		

new information was obtained and said the MD indicated there were no adverse effects from him receiving the wrong medications. The DON explained the nurses verified the picture of the resident on the MAR with the resident in the bed to be sure they are giving the right medications to the right resident.

An interview on 12/07/23 at 11:26 AM with the Unit Manager for North which included 100, 200 and 300 halls revealed she had only been employed as the Unit Manager for 90 days. She stated she recalled hearing about Resident #1 and the mix-up with his medications but didn't know any of the details about the situation. She stated typically the Nurses verified the resident's name prior to giving medications but was not aware of them asking residents their date of birth before giving medications. The Unit Manager further stated there was really no way the Nurses would have known they were giving the wrong medications to Resident #1 because he was unable to verbalize and tell them he was not on those medications. She indicated to her knowledge he had not come in with a picture identification and so the Nurses were carrying out the orders prescribed by the Medical Director (MD) and had no way of knowing the medications were incorrect. The Unit Manager further indicated with residents with the same name there should be 2 identifiers such as name and date of birth with a picture to ensure the right resident was receiving the right medications. According to the Unit Manager all residents' pictures are taken upon admission to use as an identifier for the Nurses and staff at the facility.

An interview on 12/07/23 at 11:34 AM with the Assistant Director of Nursing (ADON) revealed

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 12/13/2023

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 760	Continued From page 41	F 760		

she had served as the Unit Manager for North for about 6 weeks from 06/20/23 through 07/31/23. She stated she remembered Resident #1 and the mix-up with his medications. The ADON further stated she remembered Resident #1 was alert but not oriented and was non-verbal. She said his dementia was advanced and he would not have been able to tell the Nurses he was not supposed to receive insulin, or any of the medications he was prescribed that should not have been prescribed for him. The ADON indicated he would not have been capable of validating his date of birth and could only respond to his name being called but was not reliable to answer questions about diagnoses or medications.

A follow up telephone interview on 12/07/23 at 3:00 PM with the Marketing Coordinator revealed she had gone to the transferring facility on 09/15/23 and obtained information for Resident #1 which included his medications, face sheet, nursing progress notes, history and physical, order summary and dietary considerations as well as his FL-2. The Marketing Coordinator stated she handed the information to the Admissions Coordinator #1 who entered the information in the electronic medical record for Resident #1 because that was their process at the time.

b. Resident #1 did not receive 2 eye drops to treat his glaucoma from 7/17/23 through 9/15/23. The eye drops were prescribed as follows:
1. Brimonidine Tartrate Ophthalmic Solution 0.2% - instill 1 drop in both eyes three times a day for glaucoma.
2. Dorzolamide HCl Ophthalmic Solution 2% - instill 1 drop in left eye two times a day for glaucoma.

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	345388	A. BUILDING _____ B. WING _____	C 12/13/2023

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 760	Continued From page 42	F 760		

An interview on 12/06/23 at 3:14 PM with the Medical Director (MD) revealed she was familiar with Resident #1 and remembered that somewhere along the course of his stay they had discovered they had the incorrect demographic information on him which resulted in him not being on the correct medications or having the right diagnoses documented at the facility. She stated that while he should have received other medications for which he had diagnoses; she had not seen any adverse effects from his not receiving those medications particularly the eye drops for his glaucoma.

The Administrator, DON, Nurse Consultant and Regional Vice President of Operations were notified of immediate jeopardy on 12/07/23 at 5:15 PM.

The facility provided the following corrective action plan with a completion date of 09/29/23.

The facility failed to ensure Resident #1 was free from a significant medication error when Resident #1 was administered medications prescribed for Person #2. Resident #1 received the following medications:

" Lantus
" Eliquis
" Synthroid
" Lasix
" Aspirin

Prior to Resident #1's admission to our facility, the Director of Admissions conducted a bedside assessment. When leaving the discharging skilled nursing facility, the discharging facility's Social Worker provided physical copies of the Person #2's North Carolina Long Term Care

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 12/13/2023

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 760	Continued From page 43	F 760		

Form (FL-2) with a date of birth of 1/16/56 and medication list for Person #2. Resident #1 was also admitted to the facility with Person #2's date of birth (DOB: 1/16/56), medical information, and medication orders on 7/17/23.

Upon arrival on 7/17/23, Resident #1 was alert to person with confusion and memory impairment. The FL2 received provided no relative or contact information. Person #2's admission record from the discharging facility listed the resident as his own responsible party.

On 7/19/23 a care conference meeting was held with Resident #1 led by the Social Services Director. During the care conference, Resident #1 was observed to have notable cognitive impairment, congruent with the signs and symptoms of possible dementia. Resident #1 was listed as his own responsible party. Resident #1 was unable to actively participate.
After realizing Resident #1's cognitive impairment, and several attempts were made to the contact number listed on Person #2's Admission Record, the Director of Admissions reached back out to the discharging facility's Social Worker on 7/19/23. The discharging facility's Social Worker provided new contact information for Resident #1. The Director of Admissions made several attempts using the new number with no success. Contact was not made until the morning of 7/24/23 by the Admissions Director. The admission agreement was completed by the Director of Admissions in the afternoon on 7/24/23 with Resident #1's responsible party.

On 9/15/23, during a phone conversation between the Resident #1 responsible party and

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 12/13/2023

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 760	Continued From page 44	F 760		

our hospice partner, and while verifying information via telephone, it was discovered that the date of birth we were provided by the discharging facility did not match Resident #1. Upon further investigation, it was also discovered that the initial information received from the discharging facility was that of Person #2 who was also a resident of the discharging facility with the same name as Resident #1.

"On 9/15/23 the correct information, including medication orders for Resident #1 was obtained. Resident #1 was evaluated by the facility Medical Director. Upon review of Resident #1 medications and orders, all unnecessary medications were discontinued.

"On 9/15/23 the Director of Nursing completed a medication error report for Resident #1. The medication error report was completed for the medications received in error by Resident #1.

"Critical medications received in error were Insulin, Eliquis and Synthroid, Lasix and Aspirin. The insulin had previously been discontinued on 7/21/23, prior to this discovery due to low blood sugar levels.

"The Eliquis, Synthroid, Aspirin, and Lasix were discontinued on Friday, 9/15/23. Labs ordered were Thyroid Stimulating Hormone (TSH), Complete Metabolic Panel (CBP), Complete Blood Count (CBC) with differential.

"On 9/22/23 and 9/25/23 lab results (TSH, CBC with diff, and CMP) were reviewed by the Medical Director and determined there were no adverse reactions suffered, and Resident #1 was not at risk for any other adverse reactions because of

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 12/13/2023

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 760	Continued From page 45	F 760		

this incident. Resident #1 was also seen and monitored throughout the weekend by the facility Nurse Practitioner.

"The facility's Medical Director made multiple attempts to reach Resident #1's responsible party by phone starting on 9/15/23 but was unable to leave a message due to full voice mailbox. The Medical Director spoke with the Resident #1's responsible party on 9/21/23 and advised him of the incident. Resident #1's responsible party understood and had no adverse response to the incident.

To help ensure the deficient practice does not reoccur, a chart audit of all residents admitted since 5/17/2023 was conducted by Business Office Manager and Admissions Coordinator on 9/28/23 to ensure information filed in the residents' medical record was accurate and belonged to the residing resident. This audit included verifying the resident information on the demographic sheet, the resident's photograph, and financial information was accurate. Any discrepancies were corrected.

On 9/21/23, a Root Cause Analysis was completed by the Director of Nursing and Executive Director. In conclusion, the facility failed to validate Resident #1 medical information upon admission on 7/17/23.

The Executive Director completed education on 9/21/23 with the facility's admissions team, which includes the Director of Admissions, Admission Coordinator, Business Office Manager and Assistant Business Office Manager to ensure accurate documentation for admitting residents

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 12/13/2023

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 760	Continued From page 46	F 760		

had been obtained prior to entering the facility. Accurate information would include demographic information, financial information, and a photograph. The admissions team was also reeducated to ensure required information, including but not limited to, clinical documentation, medication list, and FL-2s received from a discharging facility were accurate and belonged to the admitting resident. Authentication will be verified by the discharging facility's appointed representative. The facility Business Office Manager and Assistant Business Office Manager were also educated by the Executive Director on ensuring required information, which includes the residents' Social Security Number, Date of Birth, insurance card information and policy information belong to the admitting resident. The Director of Admissions and Admissions and/or Coordinator will validate the newly admitted residents' identity by verbal authentication. Authentication will require the newly admitted resident to verbally provide information, including, but not limited to their name, date of birth, and social security number. If the resident is unable to provide this information, the Director of Admissions and/or Admissions Coordinator will have the resident's guardian, power of attorney or appointed person verbally authenticate the newly admitted resident's identity. Authentication will require the newly admitted resident's guardian, power of attorney or appointed person to verbally provide information, including, but not limited to the resident's name, date of birth, and social security number.

Prior to admission, newly admitted residents or their responsible party will be required to provide two forms of identification, of which one must include a photograph. Copy all insurance cards to

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 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 47	F 760		

include Medicare and Medicaid if available. When documents are obtained, copies must be scanned into the resident's electronic medical record. There must be 3 attempts to obtain these copies documented on the admission checklist before turning them over to the Business Office Manager. Newly hired Admissions or Business Office personnel will be educated on this process during new hire orientation.

"Starting on 9/28/23 the Executive Director and/or designee to complete Quality Improvement monitoring for Admission Process to include two forms of identification, of which one must include a photograph, copy of insurance cards, and review admission packet to be completed weekly for twelve weeks and monthly for 3 months. Weekly monitoring will be completed by 12/21/23. Monthly monitoring will be completed by 3/21/24.

"The Director of Nursing and Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 9/28/23. The Executive Director is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.

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 12/13/2023

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 760	Continued From page 48 Completion date: 09/29/2023 The facility's corrective action plan was validated by the following: On 12/13/23 the facility's plan of correction was validated upon review of the sign-in sheets for in-service education provided to the admissions staff and business office staff on the admissions policy, verifying demographic information, and how to verify correct information by reviewing two forms of identification of residents, one including a photograph. Review of the monitoring audits revealed no concerns identified. Interviews conducted with the Business Office Manager and the Assistant Business Office Manager and Admissions staff revealed they had received education on the admissions policy and the importance of confirming each resident's correct information prior to the resident being admitted to the facility. Record review of sampled residents recently admitted revealed no concerns. The facility's completion date of 9/29/23 was validated.	F 760		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		12/14/23

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 12/13/2023

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 867	Continued From page 49 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

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 12/13/2023

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 867	Continued From page 50 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).	F 867		

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	345388	A. BUILDING _____ B. WING _____	C 12/13/2023

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 867	Continued From page 51 Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following a recertification and complaint survey dated 08/31/21. The area of infection control and prevention was originally cited during a recertification and complaint survey dated 08/31/21. The area was subsequently recited during the onsite revisit and complaint survey dated 12/13/23. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.	F 867	On 12/13/23, The Executive Director held an Ad Hoc Quality Assurance and Performance Improvement meeting with the facility Interdisciplinary Team. Members of the committee included the Director of Clinical Services, Social Services, Dietary Manager, Admissions Director, Minimum Data Set Coordinator, Activities Director, Medical Records Director, Dietary Manager, Environmental Service Manager, and Business Office Manager. During this meeting, the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the Quality	

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 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 52 The findings included: The tag is cross referenced to: F880- Based on observation, record review and staff interviews, the facility failed to implement their hand hygiene policy as part of their infection control policy when the Treatment Nurse did not perform hand hygiene prior to beginning treatments, or prior to donning gloves to remove soiled coverings with drainage from several wounds on a resident's (Resident #9) left leg and foot wound, and right inner thigh wound. The Treatment Nurse doffed her gloves after removing the coverings and donned new gloves without sanitizing her hands and proceeded to apply the treatment to the wounds and covered them with border gauze dressings. This occurred for 1 of 2 residents reviewed for wound care. During the recertification and complaint survey dated 08/31/21, the facility failed to implement their policy on Transmission Based Precautions on a new admission hallway when 1 of 1 staff member 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. An interview with the Director of Nursing (DON), Administrator and Nurse Consultant on 12/13/23 at 12:32 PM revealed monthly Quality Assurance (QA) meetings were held to review measures put in place and discussed with the Medical Director and other departments for their response and feedback to issues identified. When issues were identified a review and corrective action plan was	F 867	Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. Additionally, the Ad Hoc meeting focused on F880 and Infection Control. The discussion included hand hygiene, hand hygiene before, during and after patient care, donning, and doffing of personal protective equipment, and the understanding of Transmission Based Precautions. The facility Quality Assurance reviewed facility findings and developed a new plan of correction for maintaining compliance in these areas. To help assist with the deficient practice from reoccurring, on 12/6/23, the facility infection preventionist began reeducating facility staff on the facility Infection Control policies and procedures which included, but were not limited to, hand hygiene, hand hygiene before, during and after patient care, hand hygiene after performing non- patient care tasks, donning, and doffing of personal protective equipment, and the understanding of Transmission Based Precautions. Staff members reeducated included nursing staff, administrative staff, dietary staff environmental services staff, and therapy staff. Education will be completed by 12/14/23. Any newly hired staff will be educated during new hire orientation or prior to the start of their first shift. The facility infection preventionist also began conducting clean dressing change	

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	345388	A. BUILDING _____ B. WING _____	C 12/13/2023

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F 867	Continued From page 53 implemented and if there was no improvement, the QA committee revisited it. The DON and Administrator felt interventions put into place were beginning to aid in preventing repeat deficiencies but need to be revisited by the QA committee to ensure ongoing compliance in all areas. The Nurse Consultant stated the previous QA for infection control was effective however the new citation was under a different issue under a broad heading. The interview revealed the facility would be providing staff education to ensure proper procedures and hand hygiene were followed.	F 867	competencies with all Licensed Nursing Staff and Nurse Aide II Staff on 12/6/23. Clean dressing change assessments included verbal understanding and discussion of the competency, direct observation and return demonstration. All clean dressing change competencies with Licensed Nursing Staff and Nurse Aide II Staff will be completed by 12/14/23. Any newly hired Licensed Nursing Staff or newly hired Nurse Aide II staff will be educated on clean dressing change during new hire orientation or prior to the start of their first shift. Completion date for these observations will be May of 2024. The Director of Nursing and/or Nursing designee will randomly perform Quality Observations with five randomly selected facility staff members twice weekly for four weeks on hand hygiene, hand hygiene before, during and after patient care, hand hygiene after performing non- patient care tasks, donning, and doffing of personal protective equipment, and the understanding of Transmission Based Precautions. Staff members observed will include nursing staff, administrative staff, dietary staff, environmental services staff, and therapy staff. Thereafter, observations with five randomly selected staff members once weekly for two months, and then with five staff members once monthly for three months. The Director of Nursing and/or Nursing designee will randomly perform Quality Observations with Licensed Nursing staff and Nurse Aide II personnel to ensure proper clean dressing changes with facility	

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F 867	Continued From page 54	F 867	residents. The Director of Nursing and/or Nursing designee will observe three randomly selected Licensed Nurses or Nurse Aide II perform clean dressing changes twice weekly for four weeks. Thereafter, clean dressing change observations with 3 Licensed Nurses or Nurse Aide II will be conducted once weekly for two months, and with 3 Licensed Nurses or Nurse Aide II once monthly for three months. The QAPI Committee will evaluate the effectiveness and amend as needed. 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 monthly. The Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for four months for validation. Date of Completion for this plan of correction is 12/14/2023	
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	F 880		12/14/23

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F 880	Continued From page 55	F 880		

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:
(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

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F 880	Continued From page 56 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: Based on observation, record review and staff interviews, the facility failed to implement their hand hygiene policy as part of their infection control policy when the Treatment Nurse did not perform hand hygiene prior to beginning treatments, or prior to donning gloves to remove soiled coverings with drainage from several wounds on a resident's (Resident #9) left leg and foot wound, and right inner thigh wound. The Treatment Nurse doffed her gloves after removing the coverings and donned new gloves without sanitizing her hands and proceeded to apply the treatment to the wounds and covered them with border gauze dressings. This occurred for 1 of 2 residents reviewed for wound care. The findings included: The facility's policy entitled Hand Hygiene which is part of their Infection Control Policies and Procedures last revised on 02/05/21 under	F 880	The treatment nurse failed to perform hand hygiene prior to beginning treatment, or prior to donning gloves to remove soiled coverings with drainage from several wounds on Resident #9. The treatment nurse was reeducated by the facility Infection Preventionist on hand hygiene before, during, and after wound care and as needed during patient care (12/6/23). The Infection Preventionist also educated the treatment nurse on donning and doffing personal protective equipment (12/6/23). Additionally, a review of precautions, including but not limited to, barrier and enhanced barrier precautions, use of gloves, and the use of hand sanitizer was also discussed (12/6/23). Residents currently residing in the facility have the potential to be affected.	

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F 880	Continued From page 57 "Process" read in part: "Hand hygiene should be performed: " Before initiating a clean procedure " Before and after patient care " After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wound dressings " After glove removal" A wound observation was made on 12/06/23 at 11:00 AM on Resident #9 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. The Treatment Nurse donned a clean pair of gloves without sanitizing or washing her hands and removed the drainage-soaked towel from the resident's left lower leg and foot (placed after her shower). She doffed her gloves after removing the towel and without sanitizing her hands, donned new gloves and applied the Medi-honey treatment to the wound bed that had been cleaned by her assistant. The Treatment Nurse then applied the border gauze dressing to the lower leg wound, doffed her gloves, and washed her hands. Resident #9 complained of knee pain, so the Treatment Nurse stopped her treatment of wounds to get the resident pain medication. On 12/06/23 at 12:10 PM the wound observation continued with the Treatment Nurse on Resident #9. Resident #9 had been medicated for her knee pain and said the medication was effective. The Treatment Nurse placed a drape on the floor underneath Resident #9's feet. She donned clean gloves without first washing or sanitizing her hands and removed the gauze squares from the resident's right inner thigh wound. The	F 880	To help assist with the deficient practice from reoccurring, the facility infection preventionist began conducting clean dressing change competencies with all Licensed Nursing Staff and Nurse Aide II Staff on 12/6/23. Clean dressing change assessments included verbal understanding and discussion of the competency, direct observation and return demonstration. All clean dressing change competencies with Licensed Nursing Staff and Nurse Aide II Staff will be completed by 12/14/23. Any newly hired Licensed Nursing Staff or newly hired Nurse Aide II staff will be educated on clean dressing change during new hire orientation or prior to the start of their first shift. The Director of Nursing and/or Nursing designee will randomly perform Quality Observations with Licensed Nursing staff and Nurse Aide II personnel to ensure proper clean dressing changes with facility residents. The Director of Nursing and/or Nursing designee will observe three randomly selected Licensed Nurses or Nurse Aide II perform clean dressing changes twice weekly for four weeks. Thereafter, clean dressing change observations with 3 Licensed Nurses or Nurse Aide II will be conducted once weekly for two months, and with 3 Licensed Nurses or Nurse Aide II once monthly for three months. An Ad Hoc QAPI meeting was held to discuss the findings, root cause and plan of action for the deficient practice (12/13/23). The Executive Director is	

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F 880	Continued From page 58 Treatment Nurse then doffed her gloves and without sanitizing her hands donned clean gloves to clean the wound with wound cleanser. After cleaning the wound and with the same gloves on, the Treatment Nurse applied calcium alginate to the wound bed and applied a clean dressing to the thigh wound. She then doffed her gloves and without sanitizing her hands, donned new gloves and cleaned the left foot wound, doffed her gloves again and without sanitizing her hands donned new gloves and cleaned the toe wound. The Treatment Nurse after cleaning the wounds, and with the same gloves on she had cleaned the wounds, applied hydrogel with gauze to the left foot, calcium alginate on the left heel and left ankle and Medi-honey on the left lateral foot. She then with the same gloves on gathered her supplies, using her scissors and touching the calcium alginate tube with the same gloves used to clean and dress the 3 wounds on the resident's left foot. After putting her supplies away, the Treatment Nurse doffed her gloves and washed her hands with soap and water. An interview on 12/06/23 at 2:00 PM with the Treatment Nurse revealed she was aware that she didn't sanitize her hands before she donned her gloves to begin treatments on Resident #9 and that she had not sanitized her hands after every time she had doffed her gloves. She stated she was new in her role and was nervous about being watched while she provided care to Resident #9. She stated she had realized her mistake after the treatment had been completed. An interview on 12/06/23 at 5:00 PM with the Director of Nursing and Nurse Consultant revealed the Treatment Nurse was new to her role at the facility and had been re-educated	F 880	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. Date of Completion for this plan of correction will be 12/14/2023	

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F 880	Continued From page 59 about proper hand washing while providing treatments. She stated she felt like the Treatment Nurse was nervous about being watched and was nervous because this was her first experience with someone from an agency watching her provide treatments.	F 880		