STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies cited as result of the complaint investigations. Survey event ID# SCEO11.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide structured activities of interest for a cognitively impaired resident for 1 of 3 sampled residents (Resident #51). The findings included: Resident #51 was admitted to the facility on 03/03/15 with diagnoses that included toxic encephalopathy, congestive heart failure, chronic respiratory failure, chronic kidney disease and others. The admission Minimum Data Set (MDS) dated 03/10/15 specified that at the time the resident did not have impaired cognition and was interviewed for daily activity preferences. The MDS specified the resident said it was very important that she had reading materials, listened to music and was around pets. In addition, the resident stated that it was very important that she went outside when the weather was nice and participated in religious services. Review of Resident #51's medical record revealed an activity admission assessment completed by the Activity Director dated 03/10/15	F 248	Resident #51 no longer resides in the facility. Residents with dementia residing in the center have the potential to be affected. Activity assessments as well as activity care plans were reviewed and updated as indicated necessary for residents currently residing in the facility by the Activity Director. The Executive Director/Director of Clinical Services provided reeducation to the Activities¿ employees regarding the provision of an ongoing activities program designed to meet the physical and psychosocial well-being of each resident. This includes providing structured activities of interest for residents who are cognitively impaired. Observations will be conducted by the Director of Clinical Services/Administrative Nurse for (5) residents each week for (1) month to ensure that the resident is participating in	9/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 1 that specified the resident was alert, verbal and expressed interests that included: - Games - Music - Reading - Food - Pets - Religion - Television The assessment specified that the goal was for Resident #51 to participate in 1 to 3 activities a week. On 08/24/15 at 12:49 PM Resident #51 was observed in her room awake in bed staring at the privacy curtain. During the observation the resident's television was not on, there were no books in the resident's room and there was no radio for the resident. On 08/25/15 at 10:53 AM Resident #51 was asleep in her bed and the television was on. During the observation the facility was conducting a group activity. On 08/26/15 at 9:30 AM the facility held morning devotions as a group activity. Observations of Resident #51 at 9:30 AM revealed she was in her geri chair and shook her head no when asked if she had been invited to attend morning devotions. On 08/26/15 at 1:20 PM Resident #51 was in her room staring in the direction of the wall. During the observation, her television was on but she was not watching it. On 08/26/15 at 1:55 PM nurse aide (NA) #1 was interviewed and reported that Resident #51 stayed in her room most of the day. She added that the resident ate either breakfast or lunch in the main dining room but that was the only time she knew the resident left her room. The NA added that Resident #51 used to attend activities	F 248	activities as specified by their activity assessment and care plan, then 3 residents each week for 2 months. The observations will be documented on a Quality Improvement and Performance Improvement Monitoring Form. The Director of Clinical Services will report the results of the observations to the Quality Assurance Performance Improvement Committee Meeting each month for (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 2	F 248		

but had declined. The NA reported that usually the activity department would invite and assist residents to the group activities. The nurse aide added that Resident #51 liked to attend church activities but she could not recall the last time Resident #51 attended a group activity. The NA explained that she tried to keep the resident's television on in her room.

On 08/27/15 at 9:50 AM Resident #51 was in her room and her television was on. Resident #51 shook her head no that she was not watching the television.

On 08/27/15 at 10:00 AM NA #2 was interviewed and reported that Resident #51 stayed in her room most of the day. She added that if the resident wanted to go to a group activity she would take her but that she did not know what they resident liked to attend. The NA was unaware of any in-room activities provided for Resident #51.

On 08/26/15 at 11:25 AM the Activity Director (AD) was interviewed and reported that she assessed on residents upon admission to determine activity preferences. The AD explained that Resident #51 attended group activities in the past but had declined and stayed in her room. The AD stated that Resident was at risk for social isolation and that she tried to take her snacks and ask her if she needed anything. The AD reported that no in-room visits had been provided for Resident #51 during the week of 08/23/15 through 08/27/15 and offered no explanation. The AD also reported that Resident #51 did not have a radio in her room to offer her music therapy and that the facility had a pet therapy dog but Resident #51 had not been offered a visit. The AD provided Resident #51's activity attendance for group and in-room visits that specified Resident #51 had 6 activities in 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 3 months.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors, and risk factors for 1 of 1 sampled residents reviewed for the most recent comprehensive Minimum Data Set (Resident #110). Resident #110 was admitted on 09/23/14 with diagnosis of hypertension, gastroesophageal reflux disease (GERD), renal insufficiency, neurogenic bladder, diabetes mellitus, thyroid disorder and peripheral vascular disease (PVD). Review of the Annual Minimum Data (MDS) dated 04/29/15 revealed Resident #110 had short and long term memory loss and severely impaired to daily decision making. The MDS indicated Resident #110 triggered the Care Area Assessment (CAA) in the area of Cognitive Loss/Dementia and Psychoacitve Medications. Review of Resident #110's Cognitive Loss/Dementia and Psychoactive Medications CAA dated 04/29/15 revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors related to the care plan. An interview was conducted with the Social Worker on 08/27/15 at 11:05 AM revealed she generally put in the information for cognitive loss/dementia. She further stated she had company training but had not had any formal MDS/CAA training. The CAA analysis of findings assessment concerning psychotropic drug use indicated	F 272	For Resident #110, the comprehensive Annual Minimum Data Set dated 4/29/2015 was modified so that Care Area Assessments could be completed for Cognitive Loss/Dementia as well as Psychoactive Medications. The corrections were completed by the Minimum Data Set CoordinatorResidents that currently reside in the facility requiring comprehensive assessments have the potential to be affected. For residents that currently reside in the facility, a review of the most current comprehensive assessment including Care Areas that triggered has been conducted by the MDS Coordinator to ensure that Care Areas that triggered have appropriate information to support the need to continue with a plan of care or not. Modifications have been completed as indicated necessary. Re-education was provided to the Social Workers and MDS Coordinator(s) by the Regional Case Mix Coordinator regarding ensuring that comprehensive assessments completed include completed Care Area Assessments for care areas that triggered. A review of comprehensive assessment and Care Area Assessment completion will be conducted for (3) residents per week for (3) months to ensure that Care Area Assessments have been completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 5 Resident #110 was prescribed psychotropic medication Ziprasidone HCL 80 milligram (mg) take 1 (one) capsule by mouth every 12 hours (antipsychotic) and Duloxetine HCL 60mg capsule take one capsule by mouth every day for depression (an antidepressant). The analysis of findings stated Resident #110 at risk for s/e (side effects) Cymbalta and Geodon. Comments under the heading of care plan consideration stated monitor s/e (side effects) and notify MD (medical doctor) as indicated. An interview was conducted with the MDS Coordinator on 08/27/15 at 11:18 AM. The MDS Coordinator verbalized understanding the CAA analysis of findings should contain a comprehensive assessment including description, risks and contributing factors for each triggered area of concern. Upon review of Resident 110's CAA analysis of findings, the MDS Coordinator verbalized the CAA analysis of findings should have contained a detail description of the triggered area. An interview was conducted with the Director of Nursing (DON) on 08/27/15 at 11:56 AM. She stated her expectation was for the MDS Coordinator to follow the federal guidelines and complete the CAA summaries accurately and completely.	F 272	for areas triggered during completion of the comprehensive assessment. The Director of Clinical Services will report the results of these reviews at the Quality Assurance Performance Improvement Committee Meeting each month for (3) months. The QAPI committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		9/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, record review and staff interview, the facility failed to accurately assess the dental condition for 1 of 2 residents sampled for dental needs. (Resident #49). The findings included: Resident #49 was admitted to the facility originally on 10/14/11 and readmitted on 05/22/15. His diagnoses included acute respiratory failure, pneumonia, chronic airway obstruction, anxiety and depression. The annual Minimum Data Set (MDS) dated	F 278	For Resident #49, the Annual Minimum Data Set dated 4/24/2015 was modified by the Minimum Data Set Coordinator. Residents residing in the center that have Minimum Data Sets completed have the potential to be affected. For residents that currently reside in the facility, a review of the most current comprehensive assessment including Care Areas that triggered has been conducted by the MDS Coordinator to ensure that Care Areas that triggered have appropriate information to support the need to continue with a plan of care or not. Modifications have been completed as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7 04/24/15 coded Resident #49 as having intact cognition, receiving a mechanically altered diet, and having no teeth problems. Subsequently the area of dental status did not trigger for comprehensive assessment. On 08/24/15 at 3:44 PM Resident #49 stated he had no natural teeth but could chew his food without problems. Observations revealed he had no evidence of teeth and he stated he had no dentures. On 08/27/15 at 10:07 AM the MDS nurse was interviewed. She stated she thought he had some remnants of partial teeth. Observation with the MDS nurse at this time revealed Resident #49 had no evidence of any teeth in his mouth. MDS nurse stated that she must have missed seeing he had no teeth and miscoded the MDS. She further stated that miscoding the MDS resulted in her not assessing the resident's dental status and possible needs.	F 278	indicated necessary. Re-education has been provided to the Minimum Data Set Coordinators by the Regional Case Mix Coordinator regarding completion of the MDS accurately to reflect the status of the resident to include dental assessment and dental status. A review of the most recently completed comprehensive minimum data set will be completed for (3) residents per week for (3) months to ensure that the MDS is accurately coded for dental status. The DCS will report the results of the review at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as indicated to sustain substantial compliance.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		9/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to update a resident's care plan to reflect that she did not attend group activities 1 of 3 sampled residents (Resident #51). The findings included: Resident #51 was admitted to the facility on 03/03/15 with diagnoses that included toxic encephalopathy, congestive heart failure, chronic respiratory failure, chronic kidney disease and others. The admission Minimum Data Set (MDS) dated 03/10/15 specified that at the time the resident did not have impaired cognition and was interviewed for daily activity preferences. The MDS specified the resident said it was very important that she had reading materials, listened to music and was around pets. In addition, the resident stated that it was very important that she went outside when the weather was nice and participated in religious services. Review of Resident #51's medical record revealed an activity admission assessment completed by the Activity Director dated 03/10/15 that specified the resident was alert, verbal and expressed interests that included: - Games - Music - Reading	F 280	Resident #51 no longer resides in the facility. Residents residing in the center that do not participate in group activities have the potential to be affected. Activity assessments as well as activity care plans were reviewed and updated as indicated necessary for residents currently residing in the facility. Re-education has been completed by the Regional Case Mix Coordinator/Director of Nursing with the Minimum Data Set Coordinators, the Activities employees, and the Licensed Nurses regarding updating/revising the care plans of residents who do not choose to attend group activities to assure the plan of care reflect individual resident activity needs and preferences. A review of the activities care plan will be completed by the MDS Coordinator/Administrative Nurse for (5) residents per week for (3) months to ensure that residents who do not participate in group activities have their care plan revised to reflect this. The Director of Clinical Services will report the results of this review at 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 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 - Food - Pets - Religion - Television The assessment specified that the goal was for Resident #51 to participate in 1 to 3 activities a week. Resident #51's activity care plan initiated on 05/06/15 and update on 08/12/15 specified Resident #51 "wished to participate" in therapeutic recreation and that she would engage in activities of interest that were adapted to her abilities 1 to 3 times a week. On 08/24/15 at 12:49 PM Resident #51 was observed in her room awake in bed staring at the privacy curtain. During the observation the resident's television was not on, there were no books in the resident's room and there was no radio for the resident. On 08/25/15 at 10:53 AM Resident #51 was asleep in her bed and the television was on. During the observation the facility was conducting a group activity. On 08/26/15 at 9:30 AM the facility held morning devotions as a group activity. Observations of Resident #51 at 9:30 AM revealed she was in her geri chair and shook her head no when asked if she had been invited to attend morning devotions. On 08/26/15 at 1:20 PM Resident #51 was in her room staring in the direction of the wall. During the observation, her television was on but she was not watching it. On 08/26/15 at 1:55 PM nurse aide (NA) #1 was interviewed and reported that Resident #51 stayed in her room most of the day. She added that the resident ate either breakfast or lunch in the main dining room but that was the only time she knew the resident left her room. The NA	F 280	Quality Assurance Performance Improvement Committee Meeting by the MDS Coordinator/Administrative Nurse each month for (3) months. The QAPI Committee will make recommendations for revisions to the plan as indicated necessary to sustain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10	F 280		

added that Resident #51 used to attend activities but had declined. The NA reported that usually the activity department would invite and assist residents to the group activities. The nurse aide added that Resident #51 liked to attend church activities but she could not recall the last time Resident #51 attended a group activity. The NA explained that she tried to keep the resident's television on in her room.

On 08/27/15 at 9:50 AM Resident #51 was in her room and her television was on. Resident #51 shook her head no that she was not watching the television.

On 08/27/15 at 10:00 AM NA #2 was interviewed and reported that Resident #51 stayed in her room most of the day. She added that if the resident wanted to go to a group activity she would take her but that she did not know what they resident liked to attend. The NA was unaware of any in-room activities provided for Resident #51.

On 08/26/15 at 11:25 AM the Activity Director (AD) was interviewed and reported that she assessed on residents upon admission to determine activity preferences. The AD explained that Resident #51 attended group activities in the past but had declined and stayed in her room. The AD stated that Resident was at risk for social isolation and that she tried to take her snacks and ask her if she needed anything. The AD reported that no in-room visits had been provided for Resident #51 during the week of 08/23/15 through 08/27/15 and offered no explanation. The AD also reported that Resident #51 did not have a radio in her room to offer her music therapy and that the facility had a pet therapy dog but Resident #51 had not been offered a visit. The AD provided Resident #51's activity attendance for group and in-room visits that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11 specified Resident #51 had 6 activities in 6 months. The AD reviewed Resident #51's care plan and explained that she had reviewed the care plan but overlooked making changes to the care plan to reflect Resident #51's lack of participation.	F 280		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to provide routine dental care for 1 of 2 residents sampled for dental needs. (Resident #109). The findings included: Resident #109 was admitted to the facility on 02/13/13 with diagnoses including end stage renal disease. Resident #109 was his own responsible party and signed his own admission papers. Review of the medical record revealed Resident #109 had no evidence of being seen by a dentist	F 412	The dentist visited the facility to see Resident #109, however, Resident #109 declined to be seen by the visiting dentist. A dental appointment has been established by the Social Worker/Administrative Nurse for 9/22/2015. Residents residing in the facility requiring dental services have the potential to be affected. The Social Workers completed a review to determine when the residents were most recently seen by the dentist and if any recommendations were missed. Dental appointments were established as indicated necessary by the review. The	9/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 12 since dental notes dated 05/10/13 and subsequent physician orders stated Resident #109 was referred to oral surgery as the mobile dentist was unable to treat him since he attended dialysis on Fridays. There was no other information in the medical record related to dental visits or followup. The annual Minimum Data Set dated 06/09/15 coded him with intact cognition, having no teeth problems and receiving dialysis services. Resident #109 stated during interview on 08/25/15 at 9:50 AM that most of his teeth were missing and he had lost several teeth in the last year. Resident #109 stated he had seen a dentist since admission, however, he stated the dentist came to the facility on the days he was out at dialysis. On 08/26/15 at 1:09 PM Social Workers (SW) #1 and #2 were interviewed. The interview revealed that SW #1 was responsible for arranging podiatry and optometry services and SW #2 was responsible for arranging dental services. SW #2 had just taken over the social work duties including scheduling dental exams on 07/23/15 when the previous SW left employment with the facility. They related the dentist came to the facility approximately every other month and if there was an emergency need the SW arranged for an outside dental consult. They related initial consents for dental services was obtained during the admission process and the resident was then placed on the list for routine dental care. A phone interview was conducted on 08/26/15 at 2:43 PM with the previous SW who had arranged for dental care prior to leaving in July 2015. She	F 412	Social Worker scheduled appointments for resident to be seen in October 2015 that were not having any mouth pain. Appointments were scheduled for two residents to be seen outside of the facility by the Social Worker. The first resident refused to be seen outside of the facility on 9/10/2015. He also refused to be seen by the dentist that came to the facility on 9/11/2015. Another appointment has been scheduled for this resident to be seen outside the facility on 9/22/2015. The second resident went to his appointment on 9/14/2015. Re-education was completed by the Director of Clinical Services/Administrative Nurse with the Social Services employees as well as Licensed Nurses regarding establishing dental appointments for residents requiring dental services in a timely, routine manner and emergently if necessary. The DCS/Administrative Nurse/Social Worker will conduct a review for (5) residents per week for (3) months to ensure that the resident has been seen by the dentist in a timely, routine fashion. The monitoring will be documented on a Quality Assurance and Improvement Monitoring Form. The Director of Clinical Services /Administrative Nurse/ Social Workers will report the results of the monitoring to the Quality Assurance Performance Improvement Committee Meeting each month for (3) months. The QAPI committee will recommend revisions to the plan as indicated to sustain substantial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 13 stated that if a resident was out of the building when the dentist came, the resident could not be seen and Resident #109 was often out of the facility due to dialysis treatments. SW #2 stated on 08/26/15 at 3:09 PM that she called the mobile dentistry office and learned Resident #109 had not been seen since 2013. She further stated that if a resident was out of the building when the dentist came, the resident should have been scheduled for the next time the dentist came to the facility. On 08/27/15 at 8:38 AM, Resident #109's mouth was examined closely and he was observed to have no top teeth and had front and back teeth missing from his lower gum. Interview at this time revealed Resident #109 had seen a dentist once but never was seen again.	F 412	compliance.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		9/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to discard two 50 milliliter bags of intravenous ceftriaxone, an antibiotic medication, in 1 of 2 medication storage refrigerators. The findings included: An observation made on 08/26/15 at 1:35 PM of the medication storage refrigerator on the 100 hall revealed two 50 millimeter bags of intravenous ceftriaxone, an antibiotic, labeled for a specific resident with an expiration date of 08/14/15. An interview with Nurse #1 on 08/26/15 at 1:40 PM about the facility process of checking for expired medications revealed all nurses were responsible for checking for expired medications and placing them in the box to be returned to the pharmacy. She stated the Unit Coordinators would send the expired medications back to the pharmacy. Nurse #1 stated the expired	F 431	The (2) identified 50 milliliter bags of expired antibiotic, Ceftriaxone, was discarded by the Director of Clinical Services/Administrative Nurse on 8/28/2015. Residents residing in the facility have the potential to be affected. A review of all medications and biologicals was completed by the Director of Clinical Services/Administrative Nurses on 8/28/2015 and any expired items were discarded. None were noted. Re-education was provided to currently employed Licensed Nurses by the Director of Clinical Services/Administrative Nurse regarding appropriately removing and discarding expired medications and other biologicals when permitted, and returning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 ceftriaxone should have been sent back to the pharmacy. An interview was conducted on 08/27/15 at 11:26 AM with the Director of Nursing (DON). She stated all nurses should check their medication carts and the medication storage refrigerators for expired medications. The DON stated the ceftriaxone with the expiration date of 08/14/15 should have been taken out of the medication storage refrigerator and sent back to the pharmacy.	F 431	medications to the pharmacy. DCS/Administrative Nurses and Licensed Nurses will be checking the medication rooms and carts on regularly scheduled basis. The DCS/Administrative Nurse will conduct observations of the medication rooms including the medication refrigerators (2) times per week for (3) months to ensure that there are no expired medications or biologicals stored in the medication room or the medication room refrigerator. The monitoring will be documented on a Quality Assurance and Performance Improvement Monitor form The Director of Clinical Services/Administrative Nurse will report the results of the monitoring to the Quality Assurance Performance Improvement Committee Meeting each month for (3) months. The QAPI Committee will recommend revisions to the plan as indicated to sustain substantial compliance.	