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 07/22/2017

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 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F 272	1. Resident #1 no longer resides in the health care facility. 2. Quality Improvement Monitoring of residents Pressure Ulcer Care Area Assessments, (CAA) with ADR's from 5/1/2017 to 8/1/2017 to be performed by the Minimum Data Set Nurse 8/7/2017-8/13/2017. Follow up based on findings. 3. Interdisciplinary team members responsible for the CAA portions of the MDS re educated by the Regional MDS Coordinator on documentation of the Minimum Data Assessment and the Care Area Assessment (CAA) on 8-11-2017 The Director of Nursing Services to perform Quality Improvement Monitoring of the Minimum Data Assessment CAA's two times a week for four weeks, one time a week for four weeks then monthly. 4. The Director of Clinical Services to introduce the plan of correction to the Quality Assurance Performance Improvement, (QAPI) on 8/ 11/ 2017.	8/17/17

LABORATORY DIRECTOR'S/OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 8/11/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to pressure ulcers for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility from another skilled nursing facility on 03/10/17 with diagnoses which included chronic respiratory failure, dementia, rheumatoid arthritis and hypertension. Review of Resident #1's nurse practitioner (NP) progress note dated 03/01/17 at the prior facility revealed the NP documented a wound vacuum removal from a wound on the left back and a wound close to healing on Resident #1's coccyx. Review of Resident #1's admission nursing assessment dated 03/10/17 revealed Resident #1's buttocks and coccyx were red and excoriated. Review of Resident #1's admission Minimum Data Set (MDS) dated 03/17/17 revealed an assessment of moderately impaired cognition.	F 272	The results of the Quality Improvement Monitoring to be reported to the QAPI committee by the Director of Clinical Services or designee in absence of the DCS. Quality Improvement Quality Monitoring schedule to be modified based on findings. QAPI committee consist of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set nurse, and a minimum of one direct caregiver.	8/17/17

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F 272	Continued From page 2 The MDS indicated Resident #1 had no pressure ulcers and used a pressure reduction mattress or seat cushion to reduce or relieve pressure. The MDS indicated Pressure Ulcer was among the areas that triggered for further analysis. Review of Resident #1's Pressure Ulcer Care Area Assessment (CAA) dated 03/17/17 revealed no documentation of findings with a description of the problem, contributing factors and risk factors related to pressure ulcers. The CAA indicated Resident #1's risk for pressure ulcer would be addressed in the care plan and there was no description of skin integrity and documentation of Resident #1's history of pressure ulcers. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Interview with the unit manager, Nurse #1, on 07/20/17 at 10:38 AM revealed Resident #1's buttocks and back had shear wounds upon admission. Interview with the MDS director on 07/21/17 at 9:37 AM revealed the MDS nurse who wrote Resident #1's pressure ulcer CAA no longer worked at the facility. The MDS director reported Resident #1's pressure ulcer CAA did not contain a descriptions, contributing factors, risk factors and analysis of findings. Interview with the Administrator on 07/21/17 at 11:50 AM revealed she expected the MDS nurses to follow the Resident Assessment Instrument process. The Administrator reported the CAAs should contain documentation of descriptions, contributing factors, risk factors and analysis of findings.	F 272		

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F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide a nutritional supplement for 1 of 3 sampled residents at risk for weight loss (Resident #4). The findings included: Resident #4 was admitted to the facility on 11/06/15 with diagnoses which included multiple sclerosis, stage 4 pressure ulcer and anorexia. Review of Resident #4's annual Minimum Data Set (MDS) dated 11/23/16 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #4 required the total assistance of one person with eating and had weight loss.	F 325	1. Resident #4 was provided with a Frozen Nutritional Supplement on 7/21/2017 by the dietary manager. 2. Quality Improvement Monitoring of residents with orders for Nutritional Supplements began on 7/22/2017 by the Dietary Manager. Follow up based upon the outcome of monitoring. 3. The Dietary Manager educated the Dietary Staff on 7/22/2017, that all items listed on meal cards including Nutritional Supplements must be placed on the resident's tray. The Director of Clinical Services and/or Nursing Supervisor in serviced Licensed Nurses and Certified Nurse Aides 7/22/2017-8/13/2017 on checking trays to tray card to assure Nutritional Supplements are on trays, if missing notify dietary. The Dietary Manager and/or Dietary Supervisor to perform Quality Improvement Monitoring of Nutritional Supplements being on trays five times a week for four weeks, three times a week for four weeks, two times a week for four weeks then one time a week for one year.	8/17/17

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F 325	Continued From page 4 Review of a registered dietician's note dated 01/31/17 revealed Resident #4 weighed 82.9 pounds (lbs.) and should continue with supplements which included a frozen nutritional supplement three times daily. The RD documented Resident #1's usual body weight ranged from 85 lbs. to 90 lbs. Review of a RD note dated 02/20/17 revealed Resident #4 weighed 80.7 lbs. the RD documented 100% intake of frozen nutritional supplements three times daily and 60% to 100% of liquid nutritional supplement increased to 120 ml. four times daily. Review of a RD note dated 03/14/17 revealed Resident #4 consumed 100% of the frozen nutritional supplements and liquid nutritional supplements. The RD documented continuance of monitoring and coordination of care. Review of Resident #4's care plan dated 06/28/17 revealed interventions for nutrition included a frozen nutritional supplement three times daily. Review of physician's monthly orders dated 07/03/17 revealed Resident #4 should receive a frozen nutritional supplement three times daily. Review of Resident #4's Medication Administration Record (MAR) revealed documentation of frozen nutritional acceptance at 8:00 AM, 12:30 PM and 6:00 PM from 07/01/17 through 07/20/17. Observation on 07/20/17 at 12:53 PM revealed Resident #4's lunch meal did not contain a frozen nutritional supplement. Resident #4's dietary slip	F 325	4. The Dietary Manager will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 8/11/2017. The results of the Quality Improvement Monitoring will be reported at the QAPI committee by the Dietary Manager or designee in absence of the Dietary Manager. Quality Improvement Quality Monitoring schedule will be modified based on findings. QAPI committee consist of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set nurse, and a minimum of one direct caregiver.	8/17/17

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F 325	Continued From page 5 on the meal tray indicated a frozen nutritional supplement should be served with the lunch meal. Resident #4 was fed the lunch meal by Nurse Aide (NA) #1. Interview with NA #1 on 07/20/17 at 1:13 PM revealed Resident #1 received the food on the lunch tray which contained all ordered items. Observation on 07/21/17 at 8:43 AM revealed Resident #4's breakfast meal did not contain a frozen nutritional supplement. Resident #4's dietary slip on the meal tray indicated a frozen nutritional supplement should be served with the breakfast meal. Resident #4 was fed the breakfast meal by NA #2. Interview with NA #2 on 07/21/17 at 9:00 AM revealed she did not notice the omission of the frozen nutritional supplement. NA #2 explained the dietary department provided frozen nutritional supplements. Interview with Nurse #4 on 07/21/17 at 9:30 AM revealed dietary provided the frozen nutritional supplements and she relied on nurse aides to report if items were omitted. Interview with the dietary manager (DM) on 07/21/17 at 10:02 AM revealed Resident #4 should receive a frozen nutritional supplement three times daily with all meals. The DM explained staff should follow the guidance on the dietary slip and check compliance prior to meal delivery. Interview with the interim Director of Nursing (DON) on 07/21/17 at 10:20 AM revealed she expected Resident #4 to receive the ordered	F 325		

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F 325	Continued From page 6 frozen nutritional supplements. The interim DON reported she expected nursing staff to obtain the frozen nutritional supplement if omitted by the dietary department. Telephone interview with the registered dietician (RD) on 07/21/17 at 2:35 PM revealed Resident #4 should be offered a frozen nutritional supplement three times daily as ordered. The RD explained Resident #4's supplement consumption was an important intervention to provide additional calories for weight maintenance and to meet energy needs for wound healing.	F 325		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to implement a medication order and delayed administration of an antibiotic for 1 of 3 sampled residents. (Resident #2). Resident #2 had a urinary tract infection. Findings included: Resident #2 was readmitted on 07/10/2017 with diagnoses that included cerebrovascular accident, diabetes, and chronic obstructive lung disease and end stage liver disease. The Minimum Data Set (MDS) dated 04/26/2017 assessed Resident #2 as being severely impaired	F 333	1. Resident #2's orders were clarified and resident received medication on 7/21/2017. 2. The Director of Clinical Services to perform Quality Improvement Monitoring of Medications inside Medication Carts reconcile with Resident's Medication Administration Record's (MAR)and Physician Orders , 8/7/2017- 8/11/2017. Follow based on findings. 3. The Director of Clinical Services re-educated Licensed Nurses 7/22/2017-8/13/2017, on the implementation of medication orders and clarification of medication orders with physicians. cont.	8/17/17

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F 333	Continued From page 7 for daily decision making. A review of Resident #2's the Medication Admission Record (MAR) for July 2017 revealed no antibiotic had been given. A review of the progress notes dated 07/10/2017 10:30 PM revealed the resident had returned from the hospital at 8:45 PM. A review of the Physician Assistant's progress note date 7/18/2017 revealed no diagnosis of a urinary tract infection. No antibiotic for a urinary tract infection in the medication review and documented the resident had elevated ammonia level. It documented there was no acute distress for the resident. An interview on 07/21/2017 at 3:47 PM with the Physician's Assistant (PA) revealed she has been contacted by a nurse that day and was informed he had a urine culture done in the Emergency Room. It was positive for a urinary tract infection. We were not aware of this so we could start treatment. She stated it was being started today. She stated it was a significant delay in starting the treatment for it but they were not aware of this or the prescription for the antibiotic for the resident ordered by the hospital. She stated it would have taken 3-5 days for the urine culture results to be returned at the hospital so the delay was not as long as from the day he returned to the facility but from the day of the results of the urine culture from the hospital. It was started today. A review of the medical record revealed the resident returned to the facility 7/10/2017. A review of the prescription label on the Macrobid	F 333	The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of new Physician orders to MAR's then to Medication cart five times a week for four weeks, three times a week for four weeks, two times a week for four weeks then monthly thereafter for one year. 4. The Director of Clinical Services will introduce the plan of correction to the QAPI committee on 8/11/2017. The results of the Quality Improvement Monitoring will be reported to the QAPI Committee By the Director of Clinical Services or Designee in her absence. Quality Improvement Quality Monitoring schedule to be modified basedon findings. QAPI committee consist of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set nurse, and a minimum of one direct caregiver.	8-17-17

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F 333	Continued From page 8 in the medication cart on the 300 hall documented the prescription was filled by the pharmacy on 07/14/2017 and sent to the facility 07/14/2017. A review of the physician telephone orders documented an order on 07/21/2017 for Macrobid 100mg BID for 7 days. A review of the Medication Administration Record for July 2017 revealed the first dose of the Macrobid 100mg BID for 7 days for Resident #2 for a urinary tract infection (UTI) was administered at 8:00 PM on 07/21/2017. An interview on 07/22/2017 at 10:45 AM with Nurse #2 revealed she has signed for the medications the night the pharmacy sent them however she could not remember if there was any medicine for Resident #2. She stated the medications from the pharmacy delivery were given to the hall nurse to put in their cart. There are often several bags coming with a variety of medication from the pharmacy. An interview on 07/21/2017 at 11:00 AM with Nurse # 3 revealed she was on the 300 hall medication cart. She stated Resident #2 had medication card with an antibiotic ordered twice a day for 7 days. She stated the evening nurse passed information to the night nurse who reported this information to the day shift nurse about this medication for Resident #2. She stated she and Nurse #1 tried to follow up but they could not figure out what doctor had called. They could see it on the discharge summary. The unit manager then faxed it to the pharmacy. An interview on 07/21/2017 at 4:15 PM with Nurse #1 revealed they were not aware of the	F 333		

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F 333	Continued From page 9 antibiotic order for Resident #2. Resident #2's sister had a call from the hospital last week and told her that while he was at the hospital they found out he had a urinary tract infection and they had faxed the prescription. Nurse #1 stated they found out it was faxed to the pharmacy, so she called the Physician's Assistant and got a telephone order for the antibiotic Macrobid. The pharmacy didn't let us know about the order. This has happened in the past where a fax goes to the pharmacy and not here after I resident has been to the hospital. I was following up with Resident #2's sister on other paperwork and that's how I found out today about the antibiotic. Review of the progress notes for Resident #2 revealed on 07/21/2017 at 11:30 AM the staff was notified by Responsible Party (RP) about receiving a call from hospital regarding her brother. Review of progress note 07/21/2017 revealed at 1:00 PM staff spoke with the pharmacy technician at the facility's pharmacy concerning the prescription for the resident. The nurse was informed the prescription was received on 07/14/2017 from the hospital. It was for Resident #2 for an antibiotic and they stated they would fax it to the facility. Review of progress note 07/21/2017 2:00 PM revealed the nurse placed a call to the PA about the prescription for Resident #2 that was faxed to the pharmacy and not the facility and the resident had a urinary tract infection. The resident's RP was aware of the prescription being sent to the pharmacy and not the facility and was aware that Resident #2 had a urinary tract infection and was started on the antibiotic to treat it.	F 333		

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F 333	Continued From page 10 An interview on 7/22/2017 at 9:24 AM with the Director of Nursing revealed that the unit manager follows up on paperwork for admissions and readmission from the hospital. If the unit manager is reassigned to another duty then the Assistant Director of Nursing(ADON) or the DON follow up on the paperwork. She stated sometimes people come back from the hospital without paperwork. We can download information from the hospital's portal. I have not experienced a prescription being faxed to the pharmacy and not the facility. My understanding is the doctor called here and said they were faxing a prescription. The nurse too the message but did not have the name of the doctor or the contact information. The nurse the next day tried to figure out who the doctor was. There was no further follow up by the facility regarding the prescription for the resident until the family member brought it up yesterday. That's what it looked like. There was no follow up until the family brought it up yesterday. An interview on 07/22/2017 10:18 AM with Nurse #5 revealed she was on duty the evening Resident #2 returned from the hospital. She stated there were papers with him about a test to be done and a specialist he was to see. She stated she put the papers in front of the MAR and in the consult book. She stated there were no prescriptions with his paperwork that evening. An interview on 07/22/2017 at 10:33 AM with the Pharmacy Technician at the facility's pharmacy revealed Resident #2's prescription for the antibiotic had been received 07/14/2017. It had been sent to the facility on 07/14/2017 and was signed for by Nurse #2at 12:00 AM.	F 333		

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F 333	Continued From page 11 An interview on 07/22/2017 at 10:22 AM with the Consultant Pharmacist for the facility revealed that lots of times they wait to see if the resident is symptomatic before treating them for a urinary tract infection. He stated the antibiotic ordered for Resident #2 based on sensitivity should treat his urinary tract infection even though there was a delay in the start of the medication for several days. (6 days) An observation on 07/22/2017 at 11:00 AM of the 300 hall medication cart revealed Resident #2 had Macrobid 100mg BID for 7 days on a medication card in the cart. The medication label documented the pharmacy had dispensed the antibiotic on 07/14/2017. An interview on 07/22/2017 at 11:10 AM with the 300 hall Nurse #1 revealed she had faxed an order for Resident #2's antibiotic to the pharmacy yesterday. She stated the hall nurses and unit managers check the medication carts for expired medications, medications no longer being used or for medications of discharged residents. She was not aware the Macrobid for Resident #2 was on the cart and had been delivered several days ago. An interview on 07/22/2017 12:05 PM with the Director of Nursing (DON) revealed her expectation was for nurses to follow up immediately on new orders. She stated that when a call come in the nurse is to get information including the caller's name and contact information. They are expected to follow up with the unit manager or DON. She stated she expected no delay in treatment for a resident. The nurses are to check medications as they go. She	F 333		

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	345388	A. BUILDING _____ B. WING _____	C 07/22/2017

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 333	Continued From page 12 stated she expected the nurses to follow up on any medications in the cart that don't have an order and are not on the Medication Administration Record (MAR). An interview on 07/22/2017 at 12:50 PM with the Administrator revealed her expectation was when medication was received, if there was not an order for it, nursing staff were to get clarification for the medication. They were expected to obtain an order for the medication and administer it as ordered without any delay in treatment.	F 333		