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 03/12/2018

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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of Bowel and Bladder, Active Diagnoses, and Swallowing/Nutritional Status for 1 of 3 sampled residents whose assessments were reviewed (Resident #3). The findings included: Resident #3 was readmitted to the facility on 8/11/17 with diagnoses that included paraplegia, pressure ulcer of sacral region Stage IV, pressure ulcer of right buttock Stage IV, pressure ulcer of left buttock Stage IV, dysphagia, and protein calorie malnutrition. A quarterly MDS assessment dated 1/13/18 revealed Section H, Bowel and Bladder, was incorrectly coded with documentation indicating Resident #3 was always continent of bowel and bladder. Section I, Active Diagnoses, had documentation coded indicating Resident #3 was both paraplegic and quadriplegic. Section K, Swallowing/Nutritional Status, had documentation indicating Resident #3 did not have a feeding tube. The care plan dated 5/11/17 and revised on 1/10/18, revealed Resident #3 had altered bowel elimination secondary to a new feeding tube and incontinence related to a disease process that	F 641	Resident # 3, MDS quarterly assessment, with an assessment reference date of 1/13/18, was modified and re-submitted. Quality review of MDS quarterly assessments of current residents with Tube feedings, Foley catheters, paraplegia and quadriplegia, completed by the Regional MDS coordinator and or Director of Nursing , to ensure the MDS is accurately coded in section H/ Bowel and Bladder, H 0300/0400 Section I/ Active Diagnosis Section I 5100 and Section K/ Swallowing/Nutritional Status , Section K 0510B, noted within the specified ARD to include modifications and re-submissions as indicated as based on findings. MDS Coordinator re-educated by the regional MDS Coordinator regarding ensuring Section H/Bowel and Bladder, H 0300 is accurately coded, Section I/Active Diagnosis, I 5100 , Section K/Swallowing/Nutrition / Section K 0510B noted rated to reflect resident's current status and services provided for these residents. MDS Regional Coordinator and MDS facility coordinator to conduct quality monitoring of MDS assessments prior to submitting to ensure accuracy of section H/Bowel and Bladder, Section I Active Diagnosis, Section K Swallowing /Nutrition to reflect the residents current status and	4/5/18

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

Electronically Signed | 03/26/2018

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F 641	Continued From page 1 included paraplegia. Interventions included providing pericare after each incontinent episode. The care plan dated 5/11/17 and revised on 1/10/18, revealed Resident #3 had altered bladder elimination secondary to factors that included paraplegia. Interventions included the resident to wear briefs continually due to her incontinence of the bladder. The care plan date 5/11/17 and revised on 1/10/18, revealed Resident #3 had a potential for imbalanced nutrition secondary to a disease process that included paraplegia and received an enteral feeding. Jevity 1.5 was to be given every 12 hours via feeding pump at 80 milliliters per hour from 5:00pm and turned off at 9:00am. An observation on 3/12/18 at 10:48am revealed Nurse Assistant (NA) #1 and NA #2 transferring Resident #3 via a mechanical lift to her high-back wheel chair. Resident #3 was observed with a covered indwelling catheter bag hung beneath her waist on the chair. An observation on 3/12/18 at 1:10pm revealed Resident #3 was sitting in her chair independently eating a pureed meal placed on the bedside table over her lap. An interview on 3/12/18 at 1:13pm with Nurse #2 revealed Resident #3 had a feeding tube for nutrition for over 1 year. He stated she received supplemental enteral feeding from 5:00pm to 9:00am and was able to eat pureed meals served during the day as she wanted. Nurse #2 indicated Resident #3 had always been incontinent of bowel and bladder since she had resided in the facility.	F 641	services provided for residents, with in the specified ARD times weekly x 4 weeks, 2x weekly x 4 weeks, then weekly, and PRN as indicated. Results to Monthly QAPI, with quality monitors schedule modified based on findings. Root Cause Analysis was completed on the process leading to the deficiency. Accurate coding of residents and adherence to the RAI manual used as guidance.	

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F 641	Continued From page 2 An interview on 3/12/18 at 2:30pm was conducted with the MDS Coordinator. She indicated she was new to MDS assessments as of July 2017 and the facility was actively looking for an additional full-time MDS Coordinator to manage the workload. The MDS Coordinator revealed that a traveling MDS Coordinator with the company had assisted when possible but not consistently. She explained that Section I, Active Diagnoses, rolled over with each MDS assessment and she did not go back in this section to make any changes. The MDS Coordinator explained that Section K, Swallowing/Nutritional Status, was completed by a Dietary Consultant. She indicated that sections on the MDS assessment that were not completed by her were not reviewed for accuracy before signing for completion. An interview with the Director of Nursing (DON) on 3/12/18 at 2:40pm revealed her expectation was for MDS assessments to be coded correctly and if there were any questions during the assessment, MDS should consult with hall staff, a Unit Manager, or the Medical Director. An interview with the Administrator on 3/12/18 at 2:50pm revealed her expectation was for MDS to place their eyes on the residents during the assessment period to insure accuracy of coding.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		4/5/18

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F 657	Continued From page 3 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to update a care plan for 1 of 3 sampled residents receiving enteral feedings (Resident #4). Findings included: Resident #4 was admitted to the facility on 1/31/18 with diagnoses that included cerebrovascular disease, cerebral infarction, diabetes, dysphagia, and encounter for attention to gastrostomy. The admission Minimum Data Set (MDS)	F 657	Resident # 4, care plan is up-dated to reflect the resident's current physician orders for enteral feedings. Quality review of current residents receiving Enteral Tube feeding was completed by the Regional MDS Coordinator to ensure residents that have physician orders for enteral tube feedings, care plans reflect the services provided. MDS facility coordinator/DON/ and licensed nursing staff were re-educated regarding up-dating the care plan timely when new orders are received. Care Plan accuracy to be reviewed in Morning	

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F 657	Continued From page 4 assessment dated 2/7/18 had documentation indicating Resident #4 had intact cognition and had a feeding tube. Review of the care plan dated 2/14/18 included a problem with imbalanced nutrition. Interventions included resident to receive enteral feeding of Jevity 1.5 at 60 cubic centimeters (cc) per hour from 7:00am to 7:00 pm. Review of the Nutritional Evaluation for Tube Fed Resident assessment at admission dated 2/17/18 and written by the Registered Dietician (RD) revealed Resident #4 was not receiving adequate nutritional intake from calories and protein with the current order of Jevity 1.5 at 60cc per hour for 12 hours. She recommended increasing the Jevity 1.5 to 80cc per hour for 12 hours from 7:00am to 7:00pm and adding an additional can via gravity of Jevity 1.5 (237cc) at night before sleeping to increase the total daily caloric intake by 716 calories and increase the total daily protein by 30 grams. Review of a physician's order dated 2/7/18 written by the RD and signed by the physician read, 1.) Increase current tube feed to 80cc per hour for 12 hours from 7:00am to 7:00pm 2.) Give 1 can (237cc) of Jevity 1.5 every night additional after Dilantin administration An observation on 3/12/18 at 1:37pm revealed Resident #4 sitting in his recliner chair receiving an enteral feeding of Jevity 1.5 via a feeding pump at a rate of 80cc per hour. An interview with Nurse #1 on 3/12/18 at 2:00pm	F 657	Clinical Meeting for new orders. Regional MDS and or DON/ to conduct quality monitoring to ensure care plans for residents receiving enteral tube feedings residents are up-dated to reflect new physician order, weekly x 4 weeks, 2 x's week x 4 weeks, then weekly and PRN. Results to Monthly QAPI, with quality monitors schedule modified based on findings.	

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F 657	Continued From page 5	F 657		

revealed she had been a nurse at the facility since 2002 and knew her residents well. She stated Resident #4's order had changed in February to increase his tube feed to 80cc per hour from 60cc per hour. She indicated the MDS Coordinator read the chart for information related to the residents and had not asked her any questions regarding care. Nurse #1 indicated the MDS Coordinator updated the care plans and notified the hall nursing team of any changes. Nurse #1 stated she knew about the increased tube feed rate because she had read the order.

An interview with the Director of Nursing (DON) on 3/12/18 at 2:40pm revealed that the Interdisciplinary Team (IDT) met weekly to discuss wound care and weights of the residents. During the meeting any new orders written for residents receiving enteral feedings were discussed and the care plan was updated at that time. The DON indicated her expectation was for care plans to be updated once the change was made by the IDT team or the MDS Coordinator at the time the new order was written.

An interview with the Administrator on 3/12/18 at 2:50pm revealed her expectation was for care plans to be updated per the new orders immediately.