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 05/25/2023

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 000	INITIAL COMMENTS A complaint investigation was conducted on 5/23/23 through 5/25/23. Event ID #3KST11. The following intakes were investigated NCOO192976, NC00193354, NC00194402, NC00198923, NC00198964, NC00199587, NC00200516, NC00200679, NC00201150, NC00201466, NC00202238, NC00202405. Intake NC00202405 resulted in immediate jeopardy. 13 of the 38 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.45 at tag F757 at a scope and severity J The tag F757 constituted Substandard Quality of Care. Immediate Jeopardy began on 5/10/23 and was removed on 5/25/23. A partial extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		6/23/23

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

Electronically Signed | 06/19/2023

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 05/25/2023

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 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and responsible party, resident and staff interviews, the facility failed to assist Resident #13, to her room in a dignified manner when Nurse Aide #3 pulled Resident #13 backwards in her Geri chair from the nurse's station to her room. This occurred for 1 of 4 sampled residents reviewed for dignity (Resident #13). The findings included:	F 550	1) On 5/24/23 Resident #13 was assessed by licensed nurse and there was no harm or negative outcomes noted. Nurse Aide #3 was educated on 5/24/23 by the Director of Nursing regarding transporting and providing care with dignity. Staff should tell the resident what care is being provided before staff provides care and residents should not be pulled backwards in a wheelchair or geri	

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 05/25/2023

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 550	Continued From page 2 Resident #13 was admitted to the facility on 5/12/23. Her diagnoses included personal history of transient ischemic attack (heart attack), cerebral infarction (stroke) without residual deficits, recurrent severe major depressive disorder, dependence on wheelchair, generalized muscle weakness, unsteadiness on feet, and lack of coordination, among others. The medical record of Resident #13 recorded a family member as her responsible party (RP). An admission Minimum Data Set assessment dated 5/17/23 assessed Resident #13 with adequate hearing/vision, understood by others, usually understands others, clear speech, severely impaired cognition, and required the physical assistance of one staff person for locomotion on the unit. A care plan, dated 5/17/23 identified Resident #3 had self-care performance deficits related to confusion, disease process and impaired balance. Interventions included placing Resident #13 in highly visible areas during waking hours as tolerated, anticipate/meet resident needs, and utilize Geri chair when fatigued, as tolerated. On 5/23/23 a continuous observation of Resident #13 occurred from 12:40 PM until 12:50 PM. Resident #13 was observed at the nurse's station seated in her Geri chair, facing the nurse's station with her arms in her lap and her legs resting on the Geri chair. On 5/23/23 at 12:42 PM Nurse Aide (NA) #3 was observed to approach the back of the Geri chair where Resident #13 was seated and without communication, pulled Resident #13 backwards to her room. Resident #13	F 550	chair. 2)On 6/19/23 Social Service Director and/or designee conducted interviews with staff regarding treating residents with dignity and respect with special focus not transporting residents backwards in wheelchairs or geri-chairs. 3) The Director of Nursing and/or designee will educate staff to include: licensed nurses, nursing assistants, medication aides, therapy, activities staff, housekeeping, dietary, and department managers on treating residents with dignity and respect with special focus on not transporting residents backwards in wheelchairs or ger-chair. Staff will approach residents slowly and inform them of what they are getting ready to do prior to providing care. Staff are not to push or pull residents backwards in a wheelchair or geri chair. This education will be completed by 6/23/23. This education will be included in orientation for newly hired staff. 4)Nurse Management and/or designee will conduct random audits of 5 residents to observe residents during care or while being transported to ensure they are being treated with dignity/respect and not being pushed or pulled backwards 3 times a week for 12 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/19/23. The Director of Nursing is responsible for implementing this plan. 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 05/25/2023

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 550	Continued From page 3 immediately grabbed the arms of the Geri chair with both hands, she raised her left leg straight out in front of her, raised her right leg in the air, and both eyes wide open. Resident #13 maintained this position while she was assisted backwards by NA #3 from the nurse's station into her room. NA #3 was interviewed on 5/23/23 at 12:50 PM and stated she was the assigned NA for Resident #13. NA #3 described Resident #13 as able to make some of her needs known. NA #3 stated she assisted Resident #13 to her room to eat her lunch meal and realized after she started pulling her backwards that she should not have done that. NA #3 stated that she realized what she was doing, but because she had already started pulling Resident #13 backwards towards her room, she just kept going. NA #3 stated "I know not to do that." During an interview with Resident #13 on 5/24/23 at 1:00 PM, she responded "sometimes" to the question if staff ever pulled her backwards in her Geri chair. She did not provide a verbal response when asked how that made her feel. On 5/23/23 at 12:55 PM, Physical Therapist #1 measured the distance from the nurse's station to Resident #13's room at the surveyor's request and stated the distance was 67 feet. During a phone interview with the RP for Resident #13 on 5/24/23 at 2:02 PM, the RP stated that she visited Resident #13 often during the week but had not observed staff pulling her backwards in her Geri chair. The RP stated she was aware staff provided Resident #13 with the Geri chair if she was fatigued, but that pulling her backwards	F 550	Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months	

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 05/25/2023

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 550	Continued From page 4 while in the Geri chair was alarming to her. The Director of Nursing (DON) stated in an interview on 5/25/23 at 11:00 AM staff were educated on providing care in a dignified manner and she expected staff to correct their behavior if they realized they were not providing care with dignity. The DON stated that staff should tell the resident what care is being provided before staff provide care and that residents should not be pulled backwards in a wheelchair. The Administrator stated in an interview on 5/23/23 at 11:05 AM that all residents should receive nursing care with dignity.	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F 565		6/23/23

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 05/25/2023

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 565	Continued From page 5 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews with residents and staff and review of Resident Council minutes, the facility failed to resolve dietary concerns voiced by residents (Resident #3, #4, #9, #12, #14, and #15) during 6 of 7 Resident Council meetings reviewed related to providing foods per resident preference, snacks, and palatable foods (September 2022, October 2022, November 2022, February 2023, March 2023, and April 2023). The findings included: a. Review of Resident Council meeting minutes revealed the following repeated concerns were voiced by Residents #3, #4, #9, #12, #14 and #15 who attended the meetings: - September 2022, snacks not provided, personal food preferences not provided, and residents requested to speak to the corporate dietary manager about their food concerns. - October 2022, likes/dislikes not provided; residents requested to update likes/dislikes for	F 565	1) On 5/26/23 grievances were filed for Residents #3, #4, #9, #12, and #14 for dietary concerns related to providing foods per resident preferences, snacks, and palatable food. Resident #15 no longer resides in facility. 2)The Executive Director and/or Social Service Director reviewed the Resident Council minutes for last 30 days. Grievances expressed were addressed. 3)On 6/1/23 Activity Director and Assistant received education by Director of Quality Life on the grievance process as it relates to resident council. If a resident expresses a concern during resident council the Activities Director or Assistant will complete a grievance form and provide a copy to the appropriate department for follow up and the original to the Social Services Director. Also the Activities Director or Assistant will	

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 05/25/2023

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 565	Continued From page 6 those who have changed their preferences. - November 2022, likes/dislikes not provided. - February 2023, vegetables are served cold. - March 2023, vegetables are served cold, snacks not provided. - April 2023, snacks not provided. b. Resident #15 stated on 5/23/23 at 11:08 AM that the food was awful. She stated, "if not for my son and delivery, I would starve." During a follow up interview on 5/23/23 at 12:30 PM, Resident #15 stated she did not eat the vegetables she received for lunch because they did not look good, she often did not eat breakfast because the eggs were "fake", and the smell made her nauseous. She described meat as so tough you "never stop chewing it" and stated the meats were difficult to cut. c. During an interview on 5/23/2023 at 12:32 PM, Resident #4 stated "The food is usually cold, and I don't like it. It always looks like dog food. I order out a lot." d. Resident #14 stated on 5/24/23 at 11:00 AM "I am not a fan of the vegetables; they are often either not cooked enough or too mushy." e. During an interview on 5/24/23 at 12:30 PM, Resident #3 described the food as "the food is nothing, it don't look like, nothing, and it don't taste like nothing." He stated the vegetables he received for lunch on 5/23/23 were mushy and had a bunch of strings in it. He stated the chicken was dry, with no taste and all his food was cold. He further stated "we tell them about the food all the time and it does no good. By the time you realize the food is cold, they are gone, good luck getting them to come back and heat something	F 565	follow-up/report to the resident council the outcomes of those grievances from the prior month meeting and document in the minutes. The Executive Director will review the Resident Council minutes after the meeting with the Activity Director or Assistant to ensure follow up. 4)Executive Director and/or Social Services Director will conduct random audits of resident council minutes to ensure grievances expressed were followed-up/reported with resolution 3 times a week for 12 weeks. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/19/23. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months.	

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 05/25/2023

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 565	Continued From page 7	F 565		

up for you."

f. Resident #9 stated in an interview on 5/24/23 at 12:33 PM that the food was terrible. He stated the chicken he received for lunch on 5/23/23 was so dry and the vegetables were terrible. He stated, "we tell them during Resident Council, but it is still terrible."

g. On 5/24/23 at 12:35 PM, Resident #12 stated that residents expressed their dietary concerns during Resident Council meetings, but "it does no good, they don't do anything about it, the food here is really not good, the lunch yesterday was cold, and the green beans were overcooked."

During an interview on 5/23/23 at 12:53 PM, the DM stated she was aware of the dietary concerns expressed by residents during Resident Council meetings regarding cold foods, resident preferences, and snacks. She stated the dietary staff conducted test tray audits twice per week and identified that the breakfast meal could be warmer, like the grits. She stated that if the meal trays sat too long on the hall before service, the grits got hard, and the milk got too warm. The DM stated she spoke to 4 residents per week regarding the food and the feedback received was that residents did not always like the food served and that they wanted their food warmer. The DM stated dietary staff were now monitoring food temperatures before the food left the kitchen and nursing staff documented the time meal trays arrived on the halls. The DM stated that nursing staff did not always pass out meal trays as soon as the meal trays were delivered to the halls, but that dietary staff kept the food in the kitchen hot to send hot food to the residents. The DM stated that if residents expressed, they did not receive

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 05/25/2023

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 565	Continued From page 8 their food preferences, nursing staff were asked to come to the kitchen and request the resident's preference. During an interview on 5/24/23 at 11:45 AM, the Director of Nursing stated she was aware of the dietary concerns expressed during Resident Council meetings and that she spoke to nursing staff to encourage them to pass out trays in a timely manner in order to get hot food to the residents, to offer to reheat resident food if the residents expressed the food was not hot enough and to deliver snacks to residents. The Administrator stated in an interview on 5/24/23 at 11:46 AM that he reviewed the Resident Council minutes and noted the repeated concerns voiced about food taste and temperature. The Administrator stated that the facility may not be able to resolve the residents' concerns related to food taste because each resident may have a different opinion about how the food tastes, but his primary concern when he reviewed the minutes was the resident's concerns about food temperature. He stated that in the facility's investigation, the facility determined that the food was hot enough from the kitchen, so residents were encouraged to let staff know if they received food that was not hot enough for them and staff were advised to reheat the food in the microwave. The Administrator further stated that the facility may not be able to resolve the resident concerns related to food taste, but that the facility should be able to provide them with food that was hot enough for them.	F 565		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		6/23/23

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 05/25/2023

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 655	Continued From page 9 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be	F 655		

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 05/25/2023

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 655	Continued From page 10 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a baseline care plan that addressed a resident's blood glucose checks and her need for dialysis for 1 of 1 resident reviewed for baseline care plan (Resident #7). The findings included: Resident #7 was admitted to the facility on 05/10/23 and discharged on 05/14/23. Resident #7's diagnoses included diabetes mellitus and end stage renal disease. The discharge summary from the local Emergency Department dated 05/10/23 read in part, active problems: type one diabetes mellitus with hyperglycemia (high glucose level). Test blood glucose level six times daily. Further review of the discharge summary indicated that Resident #7 had end stage renal disease and was on hemodialysis every Tuesday, Thursday, and Saturday. The discharge Minimum Data Set (MDS) assessment 05/14/23 revealed that Resident #7 was modified independent with daily decision making and required extensive to total assistance with activities of daily living. Review of Resident #7's electronic health record revealed no care plan that addressed her glucose checks or her hemodialysis every Tuesday, Thursday, and Saturday.	F 655	1)Resident #7 no longer resides in the facility. 2)On 6/19/23 the Director of Nursing and or Nursing Management reviewed the last 30 days of new admissions to ensure the baseline care plan was completed that included individualized information to provide effective, person centered care for residents that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident□s needs are met appropriately until the Comprehensive plan of care is completed. 3)The Director of Nursing and/or Nursing Management will educate licensed nurses on developing a baseline care plan that includes at minimum, individualized information to provide effective, person centered care for residents by 6/22/23. The education will include: Upon admission the admitting nurse will initiate the baseline care plan then place in a binder at the nurses□ station. The Interdisciplinary (IDT) Team to include: Director of Nursing, Nursing Management,	

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 05/25/2023

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 655	Continued From page 11 The baseline care plan notebook located at both nursing stations in the facility revealed no baseline care plan for Resident #7. The MDS Nurse was interviewed on 05/24/23 at 2:04 PM who stated that she did not complete baseline care plans in the facility. She stated that the admitting nurse was responsible for initiating and completing the baseline care plan form and placing it in the baseline care plan binder at the nursing station. Nurse #1 was interviewed via phone on 05/24/23 at 2:16 PM and confirmed that she admitted Resident #7 to the facility on 05/10/23. She stated she did not complete a baseline care plan for Resident #7 because "I was expecting the MDS nurse to complete them." Nurse #1 stated that the baseline care plan was a handwritten form that was kept at the nursing station, and she believed that the MDS nurse completed them and put them in the appropriate place. The Director of Nursing (DON) was interviewed on 05/24/23 at 3:52 PM. She stated that baseline care plans were done upon admission and were initiated and completed by the admitting nurse. Once completed the handwritten form was to be placed in the binder at the nursing station.	F 655	Minimum Data Set Nurse (MDS), Social Services Director, and Therapy Manager will review the baseline care plan binder in Clinical Morning Meeting daily to ensure completion. On the weekends the nurse supervisor will review baseline care plans to ensure completion. Newly hired licensed nurses will receive education during orientation. On 5/23/23 the Regional Director of Clinical Services educated the IDT Team on reviewing baseline care plans in Clinical Morning Meeting. 4)Nursing Supervisor and/or MDS Coordinator will perform Quality Improvement Monitoring on newly admitted residents to ensure the baseline care plan was completed that included individualized information to provide effective, person centered care with special focus on residents who require hemodialysis and blood glucose monitoring 3 times a week for 12 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/19/23. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance	

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 05/25/2023

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 655	Continued From page 12	F 655	Improvement Committee monthly for three months.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to provide incontinent care that would prevent a resident from soaking through her brief, draw sheet, and fitted sheet and required a total bed linen change for 1 of 7 residents reviewed for activities of daily living (Resident #8). The findings included: Resident #8 was admitted to the facility on 03/25/23 with diagnoses that included diabetes mellitus, dementia, and others. Review of the admission Minimum Data Set (MDS) assessment dated 03/30/23 revealed Resident #8 was moderately cognitively impaired, required extensive assistance with toileting and was always incontinent of bowel and bladder. No behaviors or rejection of care was noted during the assessment reference period. A continuous observation and interviews were made on 05/23/23 at 10:20 AM to 10:51 AM. Resident #8 was resting in bed and stated she needed to be changed but had not turned her call light on because she did not know where it was.	F 677	1)Resident #8. Central Supply Clerk no longer works at facility. The Director of Nursing educated the Activities Director on 5/24/23 regarding addressing the resident when responding to a call light if unable to meet the resident□s need leave the call light on and notify a staff member that can provide the care. 2)On 6/19/23 Director of Nursing and/or designee conducted interviews with staff regarding addressing the resident when responding to a call light if unable to meet the resident□s need leave the call light on and notify a staff member that can provide the care. 3)The Director of Nursing and/or Nursing Management will educate staff to include: licensed nurses, nursing assistants, medication aides, therapy, activities staff, housekeeping, dietary, and department managers on addressing the resident when responding to a call light if unable to meet the resident□s need leave the call light on and notify a staff member that can provide the care. This education will be	6/23/23

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 05/25/2023

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 677	Continued From page 13 The call bell was observed lying on the floor behind her bed out of Resident #8's reach. There was a member of the maintenance staff in her room working on repairing Resident #8's over bed light. Resident #8 was handed her call light and was noted to turn the call light on. At 10:22 AM the Central Supply Clerk was observed to enter Resident #8's room, turn the call light off and exit the room. She was observed delivering supplies to other rooms on the unit but did not return to Resident #8's room. No verbal exchange between Resident #8 and the Central Supply Clerk was observed. At 10:42 AM Resident #8 again turned her call light on. A member of the maintenance staff remained in the room working to repair the overbed light. At 10:42 AM the Activity Director came to the door of Resident #8's room and asked the member of the maintenance staff if he turned the light on. He replied yes, he was still working on the light. The Activity Director stated ok and walked away from the room without asking Resident #8 if she needed anything or turning the call light off. The Maintenance Staff member stated he was working on the overhead light and not the call light and the resident was still able to call for assistance. At 10:47 AM the surveyor requested the Activity Director to come to Resident #8's room and the surveyor let the Activity Director know Resident #8 actually needed to be changed and the Maintenance Staff was referring to the overhead light not the call light. She stated that she would go and provide care to Resident #8. At 10:51 AM the Activity Director returned to Resident #8's room with Nurse Aide (NA) #1 to provide incontinent care. Resident #8 stated that her bed was wet as the Activity Director and NA #1 unfastened Resident #8's brief and rolled her to one side. The brief observed heavily saturated	F 677	completed by 6/23/23. This education will be included in orientation for newly hired staff. 4)Nurse Management and/or designee will conduct random audits of 5 residents to observe residents to ensure call light is responded to appropriately and care is provided 3 times a week for 12 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/19/23. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months.	

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 05/25/2023

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 677	Continued From page 14	F 677		

with urine and feces and when Resident #8 rolled onto her side there was a heavy ammonia odor noted. The draw sheet under Resident #8 was heavily soiled with urine with a brown ring noted. The flat sheet under the draw sheet was also heavily saturated with urine and was noted to have a brown ring on it. When the flat sheet and draw sheet were removed from the bed the blue mattress was shiny and appeared wet with urine. The Activity Director and NA #1 were observed to provide incontinent care and remove the soiled linen and brief from Resident #8's bed, her coccyx and buttock area were observed to be intact and without redness. NA #1 stated "these sheets are very wet" and indicated they were also heavy. NA #1 confirmed he had been caring for Resident #8 since 7:00 AM. This was his first time he was able to provide care to Resident #8 because he was the only NA caring for most of the residents on the unit. He had been performing other required duties and had not had the opportunity to provide care to Resident #8 prior to the observed care.

An interview was conducted with Resident #8 on 05/23/23 at 12:22 PM. Resident #8 stated that the last time she was provided incontinent care was last night, but she could not recall what time or the name of the staff member who provided the care. She stated she knew it was dark outside because her bed was next to the window, and she was always looking outside. Resident #8 stated she "did not think she could go to the bathroom because she was afraid of falling." Resident #8 confirmed that she could not call for assistance because her call light was on the floor and not in her reach. She confirmed that when the Central Supply Clerk entered her room, she did not ask her if she needed anything, "she

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 05/25/2023

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 677	Continued From page 15 turned the call light off and walked out" and "I did not get the chance to tell her what I needed." An interview was conducted with the Central Supply Clerk on 05/23/23 at 2:55 PM who confirmed that she answered Resident #8's call bell earlier on the shift and Resident #8 "did not say she needed anything, and I thought she might have turned it on by mistake because they were working on her light over the bed." The Central Supply Clerk stated she "asked her what she needed but she did not say anything." An interview with NA #2 was attempted on 05/24/23 at 10:27 AM and was unsuccessful. NA #2 worked on Resident #8's unit on third shift on 05/22/23. The Director of Nursing (DON) was interviewed on 05/24/23 at 3:52 PM who stated they had not identified any issues or medications that would cause increase urination for Resident #8, nor had they had identified any issues that would require a more frequent rounding for Resident #8. The DON stated that the staff should be rounding routinely and when requested by the resident.	F 677		
F 757 SS=J	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		6/23/23

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 05/25/2023

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 757	Continued From page 16 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Consultant Pharmacist, Nurse Practitioner, and Medical Director interviews the facility failed to monitor the use of Levemir with finger stick blood glucose levels as ordered by the physician for 1 of 3 residents reviewed for unnecessary medications (Resident #7). Levemir is a long-acting insulin injected under the skin. On 05/14/23 Resident #7's family identified a change in the Resident's condition and requested Nurse #2 check the resident's finger stick blood glucose level. Resident #7's finger stick blood glucose level reading was "HI." The "HI" blood glucose reading indicated severe hyperglycemia (much higher than normal blood glucose levels). Resident #7 was transferred to the Emergency Department (ED) and admitted into the intensive care unit (ICU) diagnosed with diabetic ketoacidosis (DKA) a serious complication of diabetes that can be life threatening requiring an insulin intravenous (IV) drip. Immediate jeopardy began on 05/10/23 when Resident #7 was admitted to the facility and her	F 757	1) Resident #7 no longer resides in facility. Nurse #1 no longer works at the facility. 2)On 5/23/23, current diabetic residents physician orders were reviewed by the Director of Nursing and Unit Manager to ensure blood glucose monitoring orders were in place. A total of 29 residents were reviewed, physician orders were obtained for residents identified without a routine order for blood glucose monitoring. On 5/24/23 the Regional Director of Clinical Services reviewed admissions and readmissions since 5/10/23 to ensure physician orders were transcribed accurately from Discharge Summary into Electronic Medical Record. No corrections needed. On 5/23/23, the Director of Nursing and Regional Director of Clinical Services initiated education to the Licensed Nurses, Medication Aides, and Unit Managers regarding blood glucose	

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 05/25/2023

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 757	Continued From page 17	F 757		

discharge instructions were not implemented and her finger stick glucose checks were not obtained as ordered. Immediate jeopardy was removed on 05/25/23 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of staff education.

The findings included:

Review of the Manufacturer's instructions (revised 04/2021) for the Blood Glucose monitoring system used to check Resident #7's blood glucose on 05/14/23 read in part: the meter displays results between 20-600 milligrams/deciliter (mg/dl). HI appears when the blood glucose level is greater than 600 mg/dl and indicates severe hyperglycemia (much higher than normal glucose levels).

Review of a discharge summary from the local ED dated 05/10/23 read in part, active problems: type one diabetes mellitus with hyperglycemia (high glucose level). Sugars are very labile (up/down), decrease Levemir to 10 units twice daily. Further review of the discharge summary revealed new medication (orders to be implemented upon discharge) read in part, Levemir 10 units under the skin two times a day. Test blood glucose level six times daily.

Resident #7 was admitted to the facility on 05/10/23 with diagnoses that included diabetes mellitus, end stage renal disease with hemodialysis, and adult failure to thrive.

monitoring for diabetics, admission process, notification of a change of condition, and Admission Checklist. "Admissions Checklist (Admissions/Readmissions orders must be verified by a second nurse at the time of admission.) The Admission Checklist assists/guides the nurses through the admission process. The nurses will utilize the admission checklist to ensure they complete all the necessary assessments and steps to include reviewing discharge summary and comparing it to orders in electronic medical record. Admission/Readmission orders must first be verified by MD/NP. After entering orders into the Electronic Medical Record, all orders must be verified by a second nurse. Both nurses must sign the Admission Checklist indicating that the orders have been verified. Each shift will be responsible for carrying out the tasks that have not been completed by previous shift until all tasks are completed. "Blood Glucose Monitoring for diabetics- Diabetic residents must have routine blood sugar checks ordered. If controlled by oral hypoglycemic medication, checks should be performed at least weekly per physician order. If receiving insulin, checks should be performed as ordered or at least daily. "Notification in change of condition- Monitor residents for changes in condition. Complete change in condition assessment (SBAR) and notify the MD/NP and RP. "On 5/23/23 the Regional Director of Clinical Services reeducated the Interdisciplinary Team regarding Clinical Morning Meeting 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 05/25/2023

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 757	Continued From page 18 Review of Resident #7's physician orders dated 05/10/23 revealed the following: Levemir 10 units subcutaneously (under the skin) two times a day for diabetes. Further review of the physician orders revealed no order for blood glucose monitoring six times a day as stated in the discharge summary. The physician orders were entered by Nurse #1. Review of the Medication Administration Record (MAR) dated May 2023 revealed Resident #7 received Levemir insulin twice daily on 05/11/23 and 05/13/23. She received the Levemir insulin one time a day on 05/12/23 and 05/14/23 (day of discharge). Review of the MAR further revealed no glucose checks were scheduled to be completed. Further review of Resident 7's medical record revealed a blood glucose level obtained on 05/12/23 by Medication Aide #2 and the result was 102. Review of a history and physical dated 05/13/23 by Medical Director (MD) #2 read in part, past medical history included type one diabetes and end stage renal disease. The history and physical stated that MD #2 had reviewed the discharge summary. The plan was to monitor glucose checks and continue Levemir. Review of a Nurse's note dated 05/14/23 at 3:16 PM read in part, family at Resident's bedside all shift. Writer checked Resident's blood sugar per family request. Blood sugar elevated. Writer let family know that she would notify on-call Medical Doctor and family stated she would just have Resident sent to the ED for evaluation. Writer	F 757	include the Director of Nursing, Unit Manager, Wound Nurse, MDS, and Executive Director. 3) Daily Clinical Morning Worksheet (Admissions/Readmissions will be reviewed during clinical morning meeting.) The Interdisciplinary Team will review New Admissions/Readmissions during clinical morning meeting to ensure completion and accuracy of orders. The team will compare discharge summary to orders in the electronic medical record. The Director of Nursing and/or Unit Manager will review on the weekends. After 5/23/23, Licensed Nurses and Medication Aides not educated will receive this education prior to working their next scheduled shift by the Director of Nursing or Unit Manager. Education is being provided in person and via telephone by the Director of Nursing or Unit Manager. The Director of Nursing is tracking who has received education. Newly Hired Licensed Nurses and Medication Aides will be educated during the Orientation process by the Director of Nursing, going forward. The Director of Nursing has been notified of this responsibility as of 5/24/23. On 5/24/2023 Ad hoc QAPI with Root cause analysis was conducted 4) The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement Monitoring on new admissions and readmissions to ensure orders are verified by 2 nurses and are entered accurately into the electronic medical record. Additionally to ensure blood glucose monitoring is in place for	

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 05/25/2023

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 757	Continued From page 19 notified the Director of Nursing (DON). The note was electronically signed by Nurse #2. Resident #7 was transferred to the local ER on 05/14/23. Review of Resident #7's hospital admission history and physical dated 05/14/23 read in part; assessment and plan: Diabetic Ketoacidosis initial glucose greater than 800 mg/dl. Received small fluid bolus however limited by congestive heart failure and end stage renal disease. Started on insulin drip. Awaiting available bed in the intensive care unit. Resident #7's insulin drip continued through 05/18/23. The history and physical further stated that Resident #7 would require a hospital stay with anticipated date of discharge of 05/18/23. Resident #7 remained hospitalized at time that the survey began on 05/23/23. Nurse #2 was interviewed via phone on 05/23/23 at 1:30 PM. Nurse #2 confirmed that she was caring for Resident #7 on 05/14/23. She stated she recalled the day; she stated that Resident #7's family had been at bedside all shift as it was Mother's Day. The family stated that Resident #7 was not acting like herself and questioned what her blood glucose level was. Nurse #2 stated that she checked Resident #7's physician orders and realized that there was no order to check blood glucose levels but stated she went ahead and checked the blood sugar as requested by the family and it was "HI". Nurse #2 stated she told the family she was going to go and call the on-call provider and make them aware. She reported that Resident #7 had only been at the facility for a few days and she had not noted any change in her presentation verses her previous encounter	F 757	diabetic residents receiving insulin 3 times a week for 12 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/19/23. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months.	

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 05/25/2023

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 757	Continued From page 20	F 757		

with her. She added that she remained at her baseline condition throughout the shift and was alert and verbal. Nurse #2 stated before she could call the physician, Resident #7's family stated they would call Emergency Medical Services (EMS). Nurse #2 stated she called the DON and made her aware of what had occurred and was instructed to copy the appropriate paperwork and document in the medical record which she had done. She stated that EMS arrived at the facility and transported Resident #7 to the ED. Nurse #2 stated that it "never dawned on her to question her blood glucose level when giving her insulin" earlier in the shift. She assumed that Resident's #7's blood glucose level had been checked on third shift because they never gave insulin without checking a resident's finger stick blood glucose level.

Nurse #1 was interviewed via phone on 05/24/23 at 10:40 AM. Nurse #1 confirmed that she was working on 05/10/23. She stated typically admissions were completed by the nurse on the hall but depending on staffing and what was going on in the facility she assisted with admissions as needed. Nurse #1 stated the discharge summary would be obtained from the hospital and then reviewed either in person or via phone with the Nurse Practitioner (NP) or MD. Once the orders had been approved by the medical provider the orders would be entered into the electronic health record. Nurse #1 stated that she vaguely recalled admitting Resident #7. She stated that if Resident #7's discharge summary indicated that her blood glucose levels were to be checked six times a day then she would have entered that order into the electronic health record. She stated that if she did not enter the order "it had to be an honest mistake because I

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 05/25/2023

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 757	Continued From page 21	F 757		

always check glucose level" with residents who receive insulin

An attempt to speak to MA #2 was made on 05/24/23 at 10:43 AM and was unsuccessful.

The Wound Nurse was interviewed on 05/24/23 at 12:30 PM. He stated he could not recall If he gave Resident #7's insulin or not but if he did, he would have documented it in the medical record. The Wound Nurse stated he "would not give insulin without knowing what the blood sugar" was. He added that if the Medication Aide (MA) had reported that the Resident had no glucose checks ordered he would have questioned that and called the provider to get clarification.

The Consultant Pharmacist was interviewed via phone on 05/24/23 at 12:53 PM and confirmed that she remotely reviewed Resident #7's discharge summary dated 05/10/23 and she had no recommendations based off of her review. She stated that she did not catch that Resident #7 had no ordered glucose checks on her review. She added that when she read the discharge summary, she mistook the glucose checks as a supply order and not as an actual order to check Resident #7's glucose six times a day. The Consultant Pharmacist stated she would have "definitely" requested glucose checks for Resident #7 on her next review, but stated she wished there would have been some glucose checks obtained on Resident #7 during her stay in the facility. She added that there was a one glucose check completed on 05/12/23 that was 102 mg/dl.

The Nurse Practitioner (NP) was interviewed via phone on 05/23/23 at 3:43 PM. The NP stated

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 05/25/2023

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 757	Continued From page 22	F 757		

she reviewed new admissions before she left for the day and then in the morning if the admission came after she had left for the day. She stated that she approved the discharge summary orders and made any changes that were required. The NP stated she recalled verbally approving Resident #7's discharge summary from Nurse #1 and stated that she had not made any changes. She stated that if the discharge summary stated to check glucose levels six times a day that is what should have been entered and completed because she had not made any changes.

MD #2 was interviewed via phone on 05/23/23 at 5:09 PM. MD #2 confirmed that he had evaluated Resident #7 on 05/13/23. He stated that he reviewed the discharge summary and assumed the staff were following the instructions that were entailed in the discharge summary. MD #2 stated that "it was a problem that the staff were administering Levemir twice a day and not checking her sugars." He stated that glucose checks six times a day was a bit much and he would have possibly at some point reduced the glucose checks to four times a day. MD #2 stated "I assume that if we had checked her sugars, we could have prevented her diabetic ketoacidosis and hospitalization."

The DON was interviewed on 05/23/23 at 4:12 PM who stated that when a new admission arrived at the facility or even before sometimes, the facility would obtain the discharge summary and have the orders approved by the NP or MD. Then those orders would be entered into the electronic medical record for completion by the staff. She stated the day following the admission, during the clinical meeting they would review the new admission and ensure that the orders 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 05/25/2023

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 757	Continued From page 23	F 757		

entered correctly as stated on the discharge summary. She could not recall specifically if they had reviewed Resident #7's admission or not. The DON stated that if Resident #7's discharge summary indicated that her glucose levels should be checked six times a day then she would expect to see that in her medical record. The DON confirmed that there was no physician order entered for glucose levels to be obtained for Resident #7.

A follow up interview was conducted with the DON on 05/24/23 at 11:07 AM. The DON stated after reviewing her notes from 05/11/23 (day after Resident #7 admission on 05/10/23) she recalled that Resident #7's admission was not reviewed in the clinical morning meeting because the administrative staff were busy with other duties.

MD #1 was interviewed via phone on 05/23/23 at 3:00 PM who stated that he had been visiting the facility for a couple of months. He explained that MD #2 was covering for him during the week that Resident #7 was admitted, and he had completed the admission history and physical as required. MD #1 stated that the facility took their initial orders from the discharge summary and those orders would be approved by one of the providers at the facility and any necessary changes made accordingly. He stated that if Resident #7's discharge summary indicated that she required glucose checks six times a day the facility should have implemented that upon admission. MD #1 stated that six times a day was a lot, and he would have eventually tried to decrease that to four times a day. For complex residents like Resident #7, MD #1 stated he would have continued glucose checks four times a day and added some sliding scale insulin to help control

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 05/25/2023

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 757	Continued From page 24	F 757		

her glucose level. MD #1 explained that residents that received hemodialysis that were also diabetics had glucose levels that were very labile, meaning they go up and go down and they required a very sensitive scale of insulin and glucose checks to ensure their glucose levels were stable thus preventing diabetic ketoacidosis and/or hospitalization.

The Administrator was notified of the immediate jeopardy (IJ) on 05/24/23 at 11:50 AM.

The facility provided the following IJ removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

The facility failed to monitor Resident #7's glucose level as ordered upon admission to the facility while administering Levemir insulin twice a day as ordered. On 05/14/23 a family member asked the staff to check Resident #7's sugar and it measured HI (unable to record number). The family member called Emergency Medical Services and had Resident #7 transferred to the local Emergency Room. Resident #7 was started on intravenous insulin drip and admitted to the intensive care unit where she currently remains (05/23/23).

" On 5/23/23, current diabetic residents' physician orders were reviewed by the Director of Nursing and Unit Manager to ensure blood glucose monitoring orders were in place. A total of 29 residents were reviewed, physician orders were obtained for residents identified without a routine order for blood glucose monitoring.

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 05/25/2023

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 757	Continued From page 25	F 757		

" On 5/24/23 the Regional Director of Clinical Services reviewed admissions and readmissions since 5/10/23 to ensure physician orders were transcribed accurately from Discharge Summary into Electronic Medical Record. No corrections needed.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

" On 5/23/23, the Director of Nursing and Regional Director of Clinical Services initiated education to the Licensed Nurses, Medication Aides, and Unit Managers regarding blood glucose monitoring for diabetics, admission process, notification of a change of condition, and Admission Checklist.

" Admissions Checklist
(Admissions/Readmissions orders must be verified by a second nurse at the time of admission.) The Admission Checklist assists/guides the nurses through the admission process. The nurses will utilize the admission checklist to ensure they complete all the necessary assessments and steps to include reviewing discharge summary and comparing it to orders in electronic medical record. Admission/Readmission orders must first be verified by MD/NP. After entering orders into the Electronic Medical Record, all orders must be verified by a second nurse. Both nurses must sign the Admission Checklist indicating that the orders have been verified. Each shift will be responsible for carrying out the tasks that have not been completed by previous shift until all tasks are 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 05/25/2023

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 757	Continued From page 26	F 757		

" Blood Glucose Monitoring for diabetics- Diabetic residents must have routine blood sugar checks ordered. If controlled by oral hypoglycemic medication, checks should be performed at least weekly per physician order. If receiving insulin, checks should be performed as ordered or at least daily.

" Notification in change of condition- Monitor residents for changes in condition. Complete change in condition assessment (SBAR) and notify the MD/NP and RP.

" On 5/23/23 the Regional Director of Clinical Services reeducated the Interdisciplinary Team regarding Clinical Morning Meeting to include the Director of Nursing, Unit Manager, Wound Nurse, MDS, and Executive Director.

" Daily Clinical Morning Worksheet (Admissions/Readmissions will be reviewed during clinical morning meeting.) The Interdisciplinary Team will review New Admissions/Readmissions during clinical morning meeting to ensure completion and accuracy of orders. The team will compare discharge summary to orders in the electronic medical record. The Director of Nursing and/or Unit Manager will review on the weekends.

After 5/23/23, Licensed Nurses and Medication Aides not educated will receive this education prior to working their next scheduled shift by the Director of Nursing or Unit Manager.

Education is being provided in person and via telephone by the Director of Nursing or Unit Manager. The Director of Nursing is tracking who

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 05/25/2023

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 757	Continued From page 27	F 757		

has received education.

Newly Hired Licensed Nurses and Medication Aides will be educated during the Orientation process by the Director of Nursing, going forward. The Director of Nursing has been notified of this responsibility as of 5/24/23.

On 5/24/2023 Ad hoc QAPI with Root cause analysis was conducted and Nurse suspended pending investigation.

Date of IJ Removal: 05/25/23

The credible allegation of IJ removal for glucose monitoring was conducted on 05/24/23 and 05/25/23. The admission checklist was verified for the addition of the second nurse verification of orders. Staff interviews were conducted and revealed that they received education regarding glucose monitoring of residents, the signs, and symptoms of change in condition in relation to blood sugar changes and reporting those changes to the medical provider. Administration staff were able to verbalize the procedure for verifying physician orders and the need to have two nurses verify the orders. They were also able to verbalize the procedure for daily clinical meetings and the need for an afternoon clinical meeting if the administration staff were unable to attend the morning clinical meeting to ensure all new and readmissions were reviewed for accuracy and completeness. Staff interviews revealed they were aware that all residents who received insulin or oral diabetic agents for the treatment of diabetes mellitus required some frequency of glucose checks. They should implement orders dictated in the discharge summary or reach out to the provider for orders if

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 05/25/2023

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 757	Continued From page 28 there was any questions or concerns. The IJ removal date of 05/25/23 was validated.	F 757		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation of a lunch meal test tray, interviews with residents and staff, review of Resident Council minutes, and record review, the facility failed to serve foods to 6 of 6 sampled residents based on preferences for taste and temperature (Residents #3, #4, #9, #12, #14, and #15). The findings included: 1 a. Resident #15 was admitted to the facility on 8/30/22, diagnoses include protein calorie malnutrition and hypertension, among others. A significant change Minimum Data Set (MDS) assessment dated 4/21/23 assessed Resident #15 with clear speech, able to understand/be understood, adequate hearing/vision, intact cognition and independent with meals after tray set up. Resident #15 stated on 5/23/23 at 11:08 AM that the food was awful. She stated, "if not for my son	F 804	1) On 5/26/23 grievances were filed for Residents #3, #4, #9, #12, and #14 for dietary concerns related to providing foods per resident preferences, snacks, and palatable food. Resident #15 no longer resides in facility. 2) Dietary Manager completed resident preferences for current residents. 3) On 5/25/2023 the District Dietary Manager educated the Dietary Manager on completing resident food preferences for newly admitted residents within 48 hours and review during care plan meetings. Additionally, District Dietary Manger educated Dietary Manager on following recipes. All dietary staff have been educated to follow recipes by Dietary Manager. This education will be completed by 6/23/23. This education will be included in orientation for newly hired	6/23/23

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 05/25/2023

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 804	Continued From page 29	F 804		

and delivery, I would starve." During a follow up interview on 5/23/23 at 12:30 PM, Resident #15 stated she did not eat the vegetables she received for lunch because they did not look good, she often did not eat breakfast because the eggs were "fake", and the smell made her nauseous. She described meat as so tough you "never stop chewing it" and stated the meats were difficult to cut.

1 b. Resident #4 was admitted to the facility on 5/12/23, diagnoses included diabetes mellitus type 2, hypoglycemia, congestive heart failure, anemia, and hypertension, among others. A quarterly MDS dated 3/22/23 assessed Resident #4 with clear speech, able to understand/be understood, adequate hearing/vision, intact cognition and independent with meals after tray set up.

During an interview on 5/23/2023 at 12:32 PM, Resident #4 stated "The food is usually cold, and I don't like it. It always looks like dog food. I order out a lot."

1 c. Resident #14 was admitted to the facility on 6/23/16, diagnoses included hypertension, gastroesophageal reflux, hyperlipidemia, cerebral infarction due to embolism, of right middle cerebral artery, dysphagia, and contracture of left hand, among others. A quarterly MDS dated 4/25/23 assessed Resident #14 with clear speech, able to understand/be understood, adequate hearing/vision, moderately impaired cognition and required extensive staff assistance with eating.

Resident #14 stated on 5/24/23 at 11:00 AM "I am not a fan of the vegetables; they are often either

staff.

4)Executive Director and/or designee will perform Quality Improvement Monitoring on newly admitted residents to ensure resident preferences are completed within 48 hrs and meal trays are taste tested randomly 3 times a week for 12 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/19/23. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months.

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 05/25/2023

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 804	Continued From page 30	F 804		

not cooked enough or too mushy."

1 d. Resident #3 was admitted to the facility on 8/12/21, diagnoses included hemiplegia affecting left nondominant side, hyperlipidemia, gastroesophageal reflux, hypertension, dental caries, and cerebral infarction, among others. A quarterly MDS dated 3/22/23 assessed Resident #3 with adequate hearing/vision, clear speech, able to understand and be understood, intact cognition, and independent with meals.

During an interview on 5/24/23 at 12:30 PM, Resident #3 described the food as "the food is nothing, it don't look like, nothing, and it don't taste like nothing." He stated the vegetables he received for lunch on 5/23/23 were mushy and had a bunch of strings in it. He stated the chicken was dry, with no taste and all his food was cold. He further stated "we tell them about the food all the time and it does no good. By the time you realize the food is cold, they are gone, good luck getting them to come back and heat something up for you."

1 e. Resident #9 was admitted to the facility on 11/12/21, diagnoses included hyperlipidemia, dysphagia, oropharyngeal phase, anemia, and hypertension, among others. A quarterly MDS dated 4/14/23 assessed Resident #9 with adequate vision/hearing, clear speech, able to understand and be understood, intact cognition, and independent with meals after tray set up.

Resident #9 stated in an interview on 5/24/23 at 12:33 PM that the food was terrible. He stated the chicken he received for lunch on 5/23/23 was so dry and the vegetables were terrible. He stated, "we tell them during Resident Council, but it is still

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 05/25/2023

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 804	Continued From page 31	F 804		

terrible."

1 f. Resident #12 was admitted to the facility on 10/21/22, diagnoses included diabetes mellitus type 2, hyperlipidemia, transient ischemic attack, and cerebral infarction without residual deficits, among others. A quarterly MDS dated 3/6/23 assessed Resident #12 with clear speech, able to understand and be understood, adequate hearing/vision, intact cognition, and independent with meals after tray set up.

On 5/24/23 at 12:35 PM, Resident #12 stated that residents expressed their dietary concerns during Resident Council meetings, but "it does no good, they don't do anything about it, the food here is really not good, the lunch yesterday was cold, and the green beans were overcooked."

2 a. Review of Resident Council meeting minutes revealed Residents voiced concerns related to cold vegetables in February 2023 and March 2023. Sampled Residents #4, #9, #12, and #14 attended the March 2023 Resident Council meeting.

2 b. A continuous lunch meal tray line observation occurred on 5/23/23 from 12:22 PM to 12:38 PM. The lunch menu included marinated chicken thighs, sugar snap peas and tater tots. The tray line was observed with tater tots stored in a long 6-inch stainless steel pan for service. The sugar snap peas were observed in a pool of liquid, with a mushy texture.

A continuous lunch meal test tray observation occurred on 5/23/23 from 12:25 PM to 12:53 PM. The test tray was requested at 12:35 PM and was delivered to the 600-hall on an open metal meal

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 05/25/2023

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 804	Continued From page 32	F 804		

cart at 12:40 PM. The last resident on the 600 hall was served at 12:52 PM and the Dietary Manager (DM) sampled the test tray at 12:53 PM. The DM stated she did not see any steam coming from the foods, the vegetables were overcooked, the chicken needed more seasoning, and the tater tots could be hotter. The surveyor agreed with the DM comments.
Review of the menu/recipes revealed the following instructions:
" Sugar snap peas, steam, or boil peas until tender, drain off excess liquid.
" Marinated chicken thighs, season with salad dressing golden Italian fat free bulk 1 5/8 quart, pour Italian dressing over the chicken, and bake.

During an interview on 5/24/23 at 10:30 AM, Dietary staff #1 (AM Cook), stated she used recipes when cooking. When she prepared the marinated chicken, she did not measure the seasonings, but used a "little" paprika, salt, pepper, thyme, and rosemary, and only "a little Italian dressing". She stated she did not use the amount of Italian dressing per the recipe because it caused the chicken to burn. Dietary staff #1 stated the vegetables were a little mushy, but that was because the residents have said in the past that the vegetables were not done enough, so she boiled them and then placed the vegetables in the steamer to continue cooking. She stated she would have to adjust the time she started preparing the vegetables to keep them from becoming too mushy, since the vegetables continued to cook in the steamer. Dietary staff #1 stated the tater tots were cooked all at once and placed on the tray line because she had not previously been instructed to cook tater tots in smaller batches to keep them hotter.

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 05/25/2023

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 804	Continued From page 33	F 804		

During an interview on 5/23/23 at 12:53 PM, the DM stated she was aware of the dietary concerns expressed by residents during Resident Council meetings regarding cold foods. She stated the dietary staff conducted test tray audits twice per week and identified that the breakfast meal could be warmer, like the grits. She stated that if the meal trays sat too long on the hall before service, the grits got hard, and the milk got too warm. The DM stated she spoke to 4 residents per week regarding the food and the feedback received was that residents did not always like the food served and that they wanted their food warmer. The DM stated dietary staff were now monitoring food temperatures before the food left the kitchen and nursing staff documented the time meal trays arrived on the halls. The DM stated that nursing staff did not always pass out meal trays as soon as the meal trays were delivered to the halls, but that dietary staff kept the food in the kitchen hot to send hot food to the residents.

During an interview on 5/24/23 at 11:45 AM, the Director of Nursing stated she was aware of the dietary concerns expressed during Resident Council meetings and that she spoke to nursing staff to encourage them to pass out trays in a timely manner in order to get hot food to the residents, and to offer to reheat resident food if the residents expressed the food was not hot enough.

The Administrator stated in an interview on 5/24/23 at 11:46 AM that he reviewed the Resident Council minutes and noted the repeated concerns voiced about food taste and temperature. The Administrator stated that the facility may not be able to resolve the residents' concerns related to food taste because each

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 05/25/2023

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 804	Continued From page 34 resident may have a different opinion about how the food tastes, but his primary concern when he reviewed the minutes was the resident's concerns about food temperature. He stated that in the facility's investigation, the facility determined that the food was hot enough from the kitchen, so residents were encouraged to let staff know if they received food that was not hot enough for them and staff were advised to reheat the food in the microwave. The Administrator further stated that the facility may not be able to resolve the resident concerns related to food taste, but that the facility should be able to provide them with food that was hot enough for them.	F 804		