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	345388	A. BUILDING _____ B. WING _____	C 09/23/2024

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 onsite complaint investigation survey was conducted from 09/17/24 through 09/18/24. Addtional information was obtained through 09/23/24. Therefore, the exit date was changed to 09/23/24. Event ID# BHXZ11. The following intakes were investigated NC00215990, NC00216019, NC00216190, NC00217434, NC00218620, NC00221859 and NC0022102. 1 of the 19 allegations resulted in a deficiency.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		10/22/24

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

Electronically Signed | 10/16/2024

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F 607	Continued From page 1 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to implement their abuse policy in the areas of investigating, and protection following an allegation of sexual assault. A thorough investigation was not conducted, and protection was not implemented to prevent further potential abuse. This deficient practice was for 1 of 5 residents (Resident #4) reviewed for abuse. Findings included: A review of the facility's abuse policy entitled Abuse, Neglect, Exploitation, and Misappropriation, last revised 11/16/22 revealed the Abuse Coordinator (Executive Director) or his/her designee would investigate all reports of allegations of abuse, neglect, misappropriation and exploitation. The Abuse Coordinator and/or Director of Nursing would take statements from the victim and suspects and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she would secure all physical evidence. Upon completion of the investigation, a detailed report would be prepared. For protection, the resident will be evaluated for any signs of injury, including a physical exam, and/or psychosocial assessment, increased supervision of the alleged victim and residents, room or staffing changes if needed to protect the resident(s) from the alleged perpetrator, provide the resident with emotional support and counseling during and after the	F 607	1) Resident #4 no longer resides in the facility as of 04/18/2024. On 10/14/2024, the Director of Nursing and Executive Director received education from Regional Vice President of Clinical Service on the abuse policy in the areas of investigating, obtaining written statements from victim, suspects and all possible witnesses including all other employees in the vicinity of the alleged abuse, implement immediate protection of the resident, including physical exam, and/or psychosocial assessment, increased supervision of the alleged victim and residents, room or staffing changes if needed to protect the resident from alleged perpetrator to prevent further potential abuse and anyone identified to be suspended pending investigation. All components of the investigation to remain in the folder. The Regional Vice President of Clinical Services re-educated Social Worker and Unit Manager on the abuse policy in the areas of investigating to include obtaining signed statements from staff, resident interviews, and skin assessments by 10/16/2024. 2) A 30-day quality review lookback for Facility Reported Incidents was completed by the Executive Director, Director of Nursing and or Regional Director of Clinical Services by 10/14/2024 to ensure	

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F 607	Continued From page 2 investigation period, and protection from retaliation. The policy also indicated that for protection, any suspect(s), who was an employee or contract service provider, once he/she has/had been identified, would be suspended pending the investigation. Resident #4 was admitted to the facility on 6/13/22. The quarterly Minimum Data Set (MDS) dated 3/12/24 revealed Resident #4 was cognitively intact. A review of a progress note written by the Unit Manager dated 4/14/24 at 7:28 PM read in part, Resident #4's guardian informed the facility that she was transported to the emergency room from her outpatient appointment due to alleged inappropriate sexual contact that may have occurred at the facility. Facility was unable to assess resident, due to hospitalization. A review of the law enforcement report dated 4/17/24 at 12:57 PM revealed Resident #4 was brought to the hospital for a scheduled cataract surgery when she mentioned to the nursing staff she was sexually assaulted at her facility. Resident # 4 explained Monday morning, 4/15/24 at an unknown time, she woke up and felt pain in her lower abdomen and upper thigh area. She believed someone had sex with her while she was sleeping. Resident #4 stated she did not know who the suspect was. A telephone interview with Resident #4 on 9/18/24 at 10:45 AM revealed the surgical center staff on 4/17/24 asked if she felt safe at her facility and she explained she woke up feeling like	F 607	thorough investigation was conducted as indicated in the facilities abuse policy. 3) The Executive Director, Director of Nursing and or Nursing Supervisor re-educated licensed nurses, certified nursing assistants, non-direct care staff and contract personnel on the abuse policy, conducting a thorough investigation to prevent further potential abuse by 10/16/2024. Newly hired staff will be trained on the abuse policy during orientation. The Executive Director to perform Quality Improvement Monitoring audits on FRIs (Facility Reported Incidents) one times weekly for 12 weeks, monthly for 6 months to ensure the abuse policy is followed and implemented in the areas of thorough investigation to include obtaining written statements from victim, suspects and all possible witnesses including all other employees in the vicinity of the alleged abuse, implement immediate protection of the resident, including physical exam, and/or psychosocial assessment, increased supervision of the alleged victim and residents, room or staffing changes if needed to protect the resident from alleged perpetrator to prevent further potential abuse and anyone identified to be suspended pending investigation beginning 10/21/2024. The Regional Vice President of Operations contacted Alliant QIO and Ombudsman to provide additional training and resources. 4) On 10/14/2024, the Executive Director will present the Plan of Correction to	

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F 607	Continued From page 3 she had been in a fight or had rough sex but did not remember anything that happened while she slept on the night of 4/15/24. Resident #4 explained she was sent to the Emergency Room for a sexual assault exam and did not return to the facility. A review of the nursing staffing schedule for 4/14/24 through 4/17/24 was conducted. A male Nurse Aide, Nurse Aide #2, was scheduled for the 11 PM-7AM shift at the facility on 4/15/24, 4/16/24, and 4/17/24. The investigation report made to the state agency on 4/22/24 revealed Resident #4 was at a pre-operation appointment and during the screening process she reported an alleged inappropriate sexual assault. All employees working within the estimated time frame of the reported incident were interviewed with no findings or witnesses were identified. It also revealed skin assessments were completed on all residents and there were no findings. The Social Worker (SW) interviewed residents with a Brief Interview for Mental Status (BIMS) score of nine or more were interviewed and revealed no witnesses or findings. There were no signed statements from staff, resident interviews, or skin assessments included with the investigation. A telephone interview with Nurse Aide #2 on 9/18/24 at 9:47 AM revealed he had been employed at the facility for 13 years and worked mostly night shifts. Nurse #2 stated he heard about the incident with Resident #4 after she reported it to the hospital, but he was not aware of it before then. Nurse Aide #2 revealed he was not suspended during the investigation and no other staff member took his statement. He	F 607	Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director or Director of Clinical Services and or Nursing Supervisor. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained, monthly for six months and then quarterly for two quarters. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. 5) 10/22/2024	

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F 607	Continued From page 4	F 607		

described hearing about the incident as hearsay and had not heard anything else about it since then.

The facility investigation folder at the time of survey did not include any signed statements from staff, resident interview notes, or skin assessments.

An interview with the Unit Manager occurred on 9/18/24 at 10:27 AM. It revealed Resident #4 was at an outpatient surgical center for cataract surgery when she reported the possible assault. The Unit Manager stated she was close to Resident #4, but she did not report the incident to her, and she and the facility heard about it from the hospital Emergency Room staff. The Unit Manager stated the facility started investigating the allegation when they were told about it. She stated no written statements from staff were completed and a questionnaire for staff was used. She could not recall the questions asked to the staff regarding the incident. She added no male staff members were suspended.

An interview with the SW on 9/18/24 at 11:05 AM revealed she became aware of the incident when the outpatient surgical office called the facility. She stated she was aware there was a male who worked on night shift but was not familiar with the nursing side of the investigation. The SW stated the Director of Nursing (DON) was familiar with that investigation. She stated she completed her side of the investigation with a questionnaire for all residents with a BIMS score of 10 or greater.

An interview with the DON on 9/18/24 at 11:52 AM revealed she served as the DON for the facility since April 2024. She explained the

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F 607	Continued From page 5 former Administrator turned in the initial and five-day investigation paperwork to the state agency after they became aware of the allegation from Resident #4. She stated the investigation paperwork included skin assessments on other residents. Staff from that night shift assignment were interviewed and there were no findings. There were no obscure visitors, and the staff and residents did not see anything. She stated she did not recall who completed the interviews and explained it was part of their investigative process to do skin assessments, but did not recall any detail. The DON further stated she did not recall if the investigation had any statements from staff working on the hall or if any staff members were suspended during the investigation. The DON stated the full facility investigation was in the investigation folder received during the survey. A phone interview with the former Administrator was conducted on 9/18/24 at 1:46 PM. He stated all paperwork, and assessments were submitted to the state agency after the investigation was completed for the alleged sexual assault. He recalled the SW completed the interviews with the residents. He stated he did not recall the specifics, but the DON and SW would have all the necessary paperwork from the investigation.	F 607		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/22/24

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F 880	Continued From page 6 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 7 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews, the facility failed to don appropriate Personal Protective Equipment (PPE) before entering residents' room under transmission-based precautions for 1 of 3 residents reviewed for infection control (Resident #1). The findings included: Review of the facility's policy for Enhanced Barrier Precautions (EBP) dated 09/01/2022 revealed the EBP will be implemented for the prevention of transmission of multidrug-resistant organisms. EBP employs gown and glove use during high resident care activities such as: Dressing Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device Care or use:	F 880	1) Resident #1 was identified as needing Enhanced Barrier Precautions. On 09/17/2024 when the deficient practice was identified, the Director of Nursing re-educated Nurse Aide #1 on proper PPE as required per Enhanced Barrier Precautions during high contact resident care activity specifically as it relates to bathing/ showering. 2) A quality review was completed on current residents as indicated as requiring Enhanced Barrier Precautions to ensure physicians order, care plan and residents room indicated Enhanced Barrier Precaution by the Director of Nursing and MDS nurse on 09/17/2024 when the deficient practice was identified. Additionally, The Director of Nursing,	

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F 880	Continued From page 8 central line, urinary catheter, feeding tube and tracheostomy, Wound Care: any skin opening requiring a dressing. On 09/17/24 at 10:32 AM an observation was made of Nurse Aide #1 entering Resident #1's room to provide a bed bath, dress and assist Resident #1 into her wheelchair for the day. Resident #1 was under EBP for a feeding tube and carbapenem-resistant enterobacterales (CRE). The signage for EBP was posted on the door along with PPE. NA #1 was observed entering the room and testing the sink water to see if it was warm enough while washing her hands. NA #1 was observed applying gloves and began washing Resident #1 from head to toe. NA #1 was observed with gloves on and changed them according to their handwashing policy and procedure but did not wear a gown while bathing, transferring, providing hygiene, changing Resident #1's brief or dressing the resident. An interview was conducted on 09/17/24 at 1:24 PM with NA #1. NA #1 was asked if Resident #1 was under any kind of precautions and replied yes, Enhanced Barrier Precaution's which meant she needed to wear a gown and gloves before entering the resident's room. NA#1 stated she had not put on a gown prior to giving the bed bath, changing the residents brief, assisting with dressing and transferring the resident because a lot was going on that morning, and she had just forgotten to do so. NA #1 stated she always wore gloves and a gown when working with Resident #1 and knew to follow enhanced barrier precautions but today had forgotten the procedure. On 09/17/24 at 1:50 PM during an interview with	F 880	Nurse Managers and or Regional Director of Clinical Services completed a quality review on current residents as indicated as requiring Enhanced Barrier Precautions to ensure physicians order, care plan and residents room indicated Enhanced Barrier Precaution by 10/15/2024. 3) The Regional Director of Nursing re-educated the Director of Nursing on proper PPE as required per Enhanced Barrier Precautions during high-contact residents care activity initially on 09/17/2024 through 10/16/2024. The DON and or Nurse Managers re-educated current licensed nurses, certified nurse aides, therapy on the Enhanced Barrier Precautions policy to include proper PPE required during high-contact resident care activity on 09/17/24 through 10/16/2024. The DON and or Nurse Manager re-educated non-direct care staff, including contract personnel on Enhanced Barrier Precautions policy, proper PPE required to include changing linens on 09/17/2024 through 10/16/2024. The DON and or Nurse Manager re-educated licensed nurses, certified nurse aide, therapy staff, and non-direct care staff on Donning / Doffing with verbal and or return demonstration of understanding 09/17/2024 through 10/16/2024. The DON and or Nurse Manager re-educated all staff on proper handwashing on 09/17/2024 through 10/16/2024. Newly hired staff will be educated on Enhanced Barrier Precautions policy during orientation. The DON and or Unit	

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F 880	Continued From page 9 the Director of Nursing (DON) the DON explained that her former Assistant Director of Nursing oversaw infection control infection control education, but she left employment several weeks prior. The DON stated regardless all the staff knew to abide by the different types of precautions posted on the residents' door and to follow the assigned PPE.	F 880	Manager will conduct Quality Improvement Monitoring five times per week for four weeks, then three times per week for eight weeks, then monthly for six months starting on 09/17/2024 to ensure staff don appropriate PPE before entering residents room under Enhanced Barrier Precautions. The Regional Vice President of Operations contacted RIPS (Regional Infection Preventionist Specialist) to provide additional training and resources. 4) On 10/14/2024, the Executive Director present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director or Director of Clinical Services and or Nursing Supervisor. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained, monthly for six months and then quarterly for two quarters. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. On 09/17/2024, an ADHOC Quality	

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F 880	Continued From page 10	F 880	Assurance Performance Improvement Committee was held to formulate and approve a plan of correction for the deficient practice. Facility will audit to ensure compliance of the deficient practice through audits and education. 5) 10/22/2024	