| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 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 |
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| F 554 SS=E | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews, and record review, the facility failed to assess the ability of a resident to safely self-administer mediations for 3 of 3 residents (Residents #64, #52 and #94) reviewed for self-administration of medications.<br><br>Findings included:<br><br>1. Resident #64 admitted to the facility on 7/6/2018. Resident #64 had diagnoses that included type 1 diabetes mellitus with ketoacidosis, major depressive disorder, and hypothyroidism.<br><br>Review of Admission Minimum Data Set (MDS) dated 7/12/2018 revealed that Resident #64 was cognitively impaired. Resident #64 required extensive assistance with bed mobility, transfers and toileting. Resident #64 required limited assistance with dressing and supervision with eating.<br><br>Review of Care Plans revealed no care plan in place for Resident #64 to self-administer medications or keep medications at the bedside. | F 554 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure documentation complete related to change in condition, Daily Skilled Notes, Medication Administration Record (MAR). QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.<br><br>Root Cause Analysis: Residents self administering medications medical records did not contain documentation of ability to self administer medication. Knowledge deficit regarding Self Administration of Medication Policy. Residents #64, 52 and 94 have been evaluated for Self-Administration of Medication. Plan of care updated as indicated.<br><br>Director of Nursing and or Unit Manager to conduct a Quality Review of current facility residents for evaluation of ability to self administer medications. Follow up based on findings. | 9/28/18 |

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

Electronically Signed | 09/26/2018

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

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| F 554 | Continued From page 1<br><br>Review of the current physician orders revealed no orders for Resident #64 to self-administer glucose tabs or to have glucose tabs at the bedside.<br><br>Review of medical record revealed no assessment in place for Resident #64 to self-administer medications or keep medications at the bedside.<br><br>An observation on 8/27/18 at 10:33am revealed two bottles of Reli-On glucose tablets on the bedside table. Resident #64 stated that she had them since admission. Resident #64 stated that she used them when she felt her sugar was dropping.<br><br>An observation on 8/28/18 at 9:14am revealed that two bottle of Reli-On glucose tablets remained on Resident #64's bedside table.<br><br>An observation on 8/29/18 at 8:26am revealed that the two bottles of Reli-On glucose tablets remained on Resident #64's bedside table.<br><br>An interview with Resident #64's primary nurse on 8/29/18 at 8:28am revealed that she was not aware that Resident #64 had the medication at the bedside. The nurse stated that if Resident #64 were to self-medicate then Resident #64 would be assessed and an order would be received from the doctor that stated that the resident could self-medicate. | F 554 | Director of Nursing and or Unit Manger provided re-education to Licensed Nurses regarding policy for Self Administration of Medications and evaluating residents for ability to self administer medication.<br><br>Director of Nursing and or Unit Manager to complete Quality Improvement Monitoring of residents for evaluation of ability to self administer medications weekly x4, then monthly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. | |

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An Interview with the Director of Nursing on 8/29/18 at 8:34am revealed that Resident #64 was not assessed to self-administer medications or keep medications at the bedside. The DON's expectation would be for the resident to be assessed and deemed safe to self-administer by the physician in conjunction with the nursing staff.

An interview with the Regional Administrator on 8/31/18 at 4:37pm revealed that his expectation would be for the resident to be assessed by the physician and nursing, a physician order to be obtained and a lock in place so the medication could be secured.

2. Resident #52 was admitted to the facility on 9/5/14. Resident #52 had diagnoses that included mood disorder, bipolar disorder, and acute kidney failure.

Review of the Quarterly Minimum Data Set (MDS) dated 7/11/18 revealed that Resident #52 was cognitively impaired. Resident #52 required supervision with bed mobility, toileting and dressing. Resident #52 was independent with transfers and eating.

Review of Care Plans revealed no care plan in place for Resident #52 to self-administer medications or keep medications at the bedside.

Review of the current physician orders revealed

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no orders for Resident #52 to self-administer Refresh eye drops or to have Refresh eye drops at the bedside.

Review of medical record revealed no assessment in place for Resident #52 to self-administer medications or keep medications at the bedside.

An observation on 8/27/18 at 11:23am revealed Refresh eye drops on the over bed table. Resident #52 could not recall how long she has had them but stated she used them for dry/itchy eyes.

An observation on 8/28/18 at 9:13am revealed Refresh eye drops remained on Resident #52's over bed table.

An observation on 8/29/18 at 8:24am revealed Refresh eye drops remained on Resident #52's over bed table.

An interview with Resident #52's primary nurse on 8/29/18 at 8:28am revealed that she was not aware that Resident #52 had the medication at the bedside. The nurse stated that if Resident #52 were to self-medicate then Resident #52 would be assessed and an order would be received from the doctor that stated that the resident could self-medicate.

An Interview with the Director of Nursing on

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8/29/18 at 8:34am revealed that Resident #52 was not assessed to self-administer medications or keep medications at the bedside. The DON's expectation would be for the resident to be assessed and deemed safe to self-administer by the physician in conjunction with the nursing staff.

An interview with the Regional Administrator on 8/31/18 at 4:37pm revealed that his expectation would be for the resident to be assessed by the physician and nursing, a physician order to be obtained and a lock in place so the medication could be secured.

3. Resident #94 was admitted to the facility on 7/16/13 with diagnoses including unspecified dementia with behavioral disturbance, other specified cataract, and unspecified sequelae of unspecified cerebrovascular disease.

Resident #94 annual Minimum Data Set (MDS) dated 2/6/18 specified the resident's cognition was moderately impaired. The MDS also revealed Resident #94 had no rejection of care. The quarterly MDS dated 7/31/18 identified resident's cognition was moderately impaired.

An observation on 08/27/18 at 10:40 AM, Resident #94 was lying on her back with the head of bed raised with no staff person present in her room. Resident #94 held a clear medication cup in her right hand with two tablets in the cup. The larger round tablet was pale yellow, and the smaller round tablet was white.

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A record review revealed no physician order for Resident #94 to self -administer medications.

A record review revealed no evaluation for Resident #94 to self- administer medication.

An interview with Nurse #1 on 08/27/18 at 10:51 AM, Nurse #1 reviewed the medication administration records for the residents on the 300 Hall and reported she had no residents who had physician orders to self-administer medications. Nurse #1 stated she must have stepped away from Resident #94 before the resident had swallowed all her morning medication. Nurse #1 also stated she usually stays with each resident until she has completed the medication administration for the resident. Nurse #1 identified Resident #94's morning medication on 8/27/18, an antitussive 100 mg (clear capsule), a vitamin (white round tablet), an antacid 500 mg chewable tablet (a pale colored large tablet), a stool softener 100 mg (burgundy and white pill), a laxative powder and two antihistamine eye drops, and artificial tear drops.

During an interview on 08/30/18 at 09:50 AM with the facility's north side unit manager, the unit manager stated nurses are expected to stay with the resident until all medications have been administered by the nurse. The unit manager also stated residents should not have medications at their bedside or self-administer medications unless a physician ordered self-administration for the resident and the resident

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| F 554 | Continued From page 6<br>has been evaluated to self-administer medication.<br><br>During an interview with the director of nursing (DON) on 8/31/18 at 07:41 PM, the DON stated her expectation for nurses administering medication was for nurses to administer as the physician has prescribed for each medication. The DON also stated nurses are expected to stay with the resident until all medication has been administered by the prescribed route. The DON stated medications are not to be placed in a cup and left for residents to take without a physician order for self-administration and an evaluation for the resident to self-administer has been completed. | F 554 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. | F 584 | | 9/28/18 |

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| F 584 | Continued From page 7<br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and review of facility records, the facility failed to repair the front door to the facility to sustain the automatic lock feature. The facility also failed to repair broken, splintered and rough edges of doors on 5 of 7 hallways. The affected areas included doors to the activity room, main dining room, smoke prevention doors (on the main hall, 100 and 600 halls), fire doors (300 and 500 halls) and Room #205. The facility further failed to repair cove molding at the floor in a resident bathroom (Room 207).<br><br>Findings included:<br><br>1. The front door was observed on the following dates/times with a sign that instructed visitors to | F 584 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure documentation complete related to change in condition, Daily Skilled Notes, Medication Administration Record (MAR). QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.<br><br>Root Cause Analysis: Routine environmental rounds did not identify | |

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| F 584 | Continued From page 8<br>manually close the door in order to engage the automatic lock feature:<br>8/27/18 at 9:45 AM and 6:00 PM<br>8/28/18 at 9:00 AM and 6:00 PM<br>8/29/18 at 8:30 AM and 10:30 AM<br><br>During an interview on 8/29/18 at 10:30 AM, the receptionist stated her working hours were from 8:00 AM - 4:30 PM, Monday - Friday, and that a second receptionist worked from 4:30 PM to 8:00 PM, Monday - Friday. The receptionist further stated that the front door remained unlocked daily from 8:00 AM - 8:00 PM, and then locked automatically. She stated that currently and for the last few weeks, the door had to be closed manually in order for the automatic lock feature to work.<br><br>During an interview on 8/29/18 at 10:45 AM, the maintenance director stated that approximately three weeks ago, he could not recall the specific date, the piano hinge "sprung" (no longer functioned) and that the front door would not close/lock automatically. He stated that the automatic lock feature was pre-set to engage from 7:45 PM to 6:45 AM, but while the piano hinge was in disrepair, the automatic lock feature did not work, so the front door would not lock. The same day, he made some repairs to the front door so that it would close and latch, but staff/visitors had to manually close the door in order for the automatic lock feature to work. He placed a sign to the front door advising staff/visitors to close the door manually, called vendors and obtained a quote for repair. He stated the quote still had to go through the corporate office for approval.<br><br>On 8/29/18 at 11:00 AM, review of a quote | F 584 | identified areas thus no maintenance/repairs completed.<br>Identified affected areas: front door automatic lock feature, broken/splintered/rough edges on doors (activity room, main dining room, smoke prevention doors (main hall, 100/600 hall), fire doors (300/500 hall and room #205), and cove molding on the floor in room # 207's bathroom have been repaired.<br><br>Executive Director(ED) and Maintenance Director have conducted Quality Review of facility for safe/comfortable/homelike environment; i.e. edges, doors, molding in good repair. Follow up based on findings.<br><br>Executive Director provided re-education for Maintenance Department regarding ensuring areas in good repair providing safe/comfortable/homelike environment. Facility staff re-educated on identifying and the reporting process for needed repairs. ED and or Maintenance to review status of repair/work orders in Stand up Meeting.<br><br>Executive Director and or Maintenance Director to complete Quality Improvement Monitoring of facility for safe/comfortable/homelike environment 5x/week x 4 weeks then weekly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. | |

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provided by the maintenance director that was received by the facility revealed a receipt date of 7/26/18 and expiration date of 8/25/18. Review of an electronic email from the maintenance director to the administrator revealed the administrator was notified on 8/17/18 that the facility had received a quote to repair the front door.

During a follow up interview on 8/31/18 at 4:41 PM, the maintenance director stated that at the time the front door was in need of repair, he could only check his emails in his office. Since he spent most of his time making repairs in the facility, he did not check emails regularly and may have missed seeing the email from the vendor regarding a quote for repairing the front door. He also stated that he just realized that since the quote was less than $500, corporate approval was not required. He stated that he did contact the vendor after receiving the quote several times to schedule a repair, but the repair had not been scheduled. He further stated that he had just contacted the administrator via phone because the administrator was not currently in the facility and obtained approval to call and schedule the repair for the front door. He stated "I dropped the ball and the quote just got missed. I should not have waited that long. I should have forwarded the quote to the administrator first since the cost of the repair was under $500 to see if we could have arranged this repair."

During an interview on 8/31/18 at 8:01 PM, the divisional executive director stated that when the quote to repair the front door was received, the administrator should have been notified immediately to get approval for the repair.
2. a. Observations on 08/28/18 at 9:18 AM the doors to the activity room had broken and

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splintered wood on the lower edges of the doors.
b. Observations on 08/29/18 at 3:14 PM the doors to the activity room had broken and splintered wood on the lower edges of the doors.
c. Observations on 08/30/18 at 3:14 PM the doors to the activity room had broken and splintered wood on the lower edges of the doors.

3. a. Observations on 08/28/18 at 9:20 AM the main dining room door toward the south halls had broken and splintered wood on the lower edges of the door.
b. Observations on 08/29/18 at 3:15 PM the main dining room door toward the south halls had broken and splintered wood on the lower edges of the door.
c. Observations on 08/30/18 at 10:17 AM the main dining room door toward the south halls had broken and splintered wood on the lower edges of the door.

4. a. Observations on 08/28/18 at 9:22 AM the smoke prevention door on the main hall toward the south halls had broken and rough edges on the lower edges of the door.
b. Observations on 08/29/18 at 3:18 PM the smoke prevention door on the main hall toward the south halls had broken and rough edges on the lower edges of the door.
c. Observations on 08/30/18 at 10:18 AM the smoke prevention door on the main hall toward the south halls had broken and rough edges on the lower edges of the door.

5. a. Observations on 08/28/18 at 9:25 AM the smoke prevention door on the 600 hall had broken and rough edges on the lower edges of the door.
b. Observations on 08/29/18 at 3:20 PM the

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smoke prevention door on the 600 hall had broken and rough edges on the lower edges of the door.
c. Observations on 08/30/18 at 10:20 AM the smoke prevention door on the 600 hall had broken and rough edges on the lower edges of the door.

6. a. Observations on 08/28/18 at 9:28 AM the fire door on the 500 hall had broken and rough edges on the lower edges of the door.
b. Observations on 08/29/18 at 3:22 PM the fire door on the 500 hall had broken and rough edges on the lower edges of the door.
c. Observations on 08/30/18 at 10:22 AM the fire door on the 500 hall had broken and rough edges on the lower edges of the door.

7. a. Observations on 08/27/18 at 3:24 PM resident room door #205 had broken and splintered wood on the lower edges of the door.
b. Observations on 08/29/18 at 3:25 PM resident room door #205 had broken and splintered wood on the lower edges of the door.
c. Observations on 08/30/18 at 10:25 AM resident room door #205 had broken and splintered wood on the lower edges of the door.

8. a. Observations on 08/28/18 at 9:35 AM the fire door on the 200 hall had broken and rough edges on the lower edges of the door.
b. Observations on 08/29/18 at 3:28 PM the fire door on the 200 hall had broken and rough edges on the lower edges of the door.
c. Observations on 08/30/18 at 10:28 AM the fire door on the 200 hall had broken and rough edges on the lower edges of the door.

9. a. Observations on 08/28/18 at 9:38 AM the

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| F 584 | Continued From page 12 | F 584 | | |

fire door on the 300 hall had broken and rough edges on the lower edges of the door.
b. Observations on 08/29/18 at 3:30 PM the fire door on the 300 hall had broken and rough edges on the lower edges of the door.
c. Observations on 08/30/18 at 10:30 AM the fire door on the 300 hall had broken and rough edges on the lower edges of the door.

10. a. Observations on 08/28/18 at 9:35 AM the smoke prevention door on the 100 hall had broken and rough edges on the lower edges of the door.
b. Observations on 08/29/18 at 3:28 PM the smoke prevention door on the 100 hall had broken and rough edges on the lower edges of the door.
c. Observations on 08/30/18 at 10:28 AM the smoke prevention door on the 100 hall had broken and rough edges on the lower edges of the door.

11. a. Observations on 08/28/18 at 9:18 AM in the bathroom of resident room #207 revealed the cove molding at the floor was pulled away from the wall in 2 sections.
b. Observations on 08/29/18 at 3:30 PM in the bathroom of resident room #207 revealed the cove molding at the floor was pulled away from the wall in 2 sections.
c. Observations on 08/30/18 at 10:30 AM in the bathroom of resident room #207 revealed the cove floor molding at the floor was pulled away from the wall in 2 sections.

During an environmental tour and interview on 08/31/18 at 4:34 PM, the Maintenance Director explained they used a maintenance log book that was posted at each nurse's station for anyone to

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| F 584 | Continued From page 13<br>write down the location, date and a brief description of repairs that needed to be made. He stated he went over the process for reporting maintenance concerns during orientation when staff were hired. He confirmed there were no major renovation projects going on but he did weekly and monthly preventive maintenance. He stated it was his expectation for housekeeping staff to report problems they observed while cleaning such as damage to cove molding. During an environmental tour he confirmed the damage to the activity room doors, main dining room door, smoke prevention doors, fire doors and resident room door of room #205. He stated the cove molding in the bathroom of resident room #207 needed repair but it had not been reported to him. He also stated it was his expectation for anyone to report damage or splinters on doors because he expected for the residents to be kept safe and safety came first.<br><br>During an interview on 08/31/18 at 7:35 PM, the Divisional Executive Director Administrator stated it was his expectation there was not any damage to doors. He further stated if there was damage to one door it was his expectation for maintenance staff would have to address them all. | F 584 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on physician and staff interview, and record review, the facility failed to accurately code | F 641 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) | 9/28/18 |

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| F 641 | Continued From page 14 | F 641 | | |

the Minimum Data Set assessment in the areas of active diagnoses for 1 of 6 residents (Resident #41) reviewed for active diagnosis of peripheral vascular disease (PVD), and failed to accurately code the height in the area of swallowing/nutritional status for 1 of 5 residents (Resident #85) reviewed for hospitalizations.

Findings included:

1. Resident #41 was admitted to the facility on 9/1/2016. Diagnoses included cerebrovascular disease, hypertension, contracture- right hand, hemiplegia and hemiparesis, hyperlipidemia, muscle weakness, tobacco use, and cerebral infarction.

Review of the Onsite Care Podiatry Consult dated 12/29/2017 and 5/4/2018 at revealed that Resident #41's pertinent medical history included a diagnosis of Peripheral Vascular Disease (PVD).

Review of the Annual Minimum Data Set (MDS), Section I (Active Diagnosis), dated 7/5/2018 revealed that Resident #41 was coded as having the following diagnoses: cerebrovascular disease, hypertension, contracture (right hand), hemiplegia and hemiparesis, hyperlipidemia, muscle weakness, tobacco use, cerebral infarction . PVD was coded as not active.

An interview on 8/29/2018 at 10:40am with the Nurse Practitioner (NP) stated that the diagnosis of PVD would be an active diagnosis for Resident #41. Resident #41 was currently being medicated for the diagnosis and exhibited symptoms of hairless legs and mycotic toenails. Resident #41 also had diagnoses that included

meeting was conducted by the Executive Director to complete a root cause analysis (RCA) and develop corresponding corrective action to ensure MDS assessments coded accurately. QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.

Root cause analysis: Knowledge deficit regarding accurate coding on MDS. Resident's #41 and #85 MDS assessments have been modified. MDS Director / MDS Coordinator / Nutritionist conducted a quality review of current facility residents related to resident height and residents with PVD diagnosis coded correctly. Regional MDS Coordinator validated findings of Quality Review. Follow up based on findings.

Regional MDS provided re-education to MDS staff and Nutritionist regarding accuracy of active diagnosis codes and accuracy of patient's height.

MDS Director / MDS Coordinator to complete Quality Improvement Monitoring of active assessments for accuracy ; 3 assessments per week for 4 weeks, then 3 assessments monthly for 3 months then quarterly and as needed. Regional MDS Coordinator to validate QI Monitor findings monthly x 3 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule

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| F 641 | Continued From page 15<br>hyperlipidemia. Per the NP, "those factors alone were enough to qualify for the active diagnosis of PVD".<br><br>An interview on 8/29/2018 at 10:48am with the MDS Nurse stated that she corroborated the medication and the active diagnosis list from the attending. The MDS Nurse stated that she would then code those diagnoses in Section I of the MDS (Active diagnosis).<br><br>An interview on 8/31/2018 at 4:47pm with the Regional Administrator stated that he expected the active diagnoses to be accurately coded on the MDS.<br><br>2. Review of Resident #85's medical record revealed he was admitted to the facility on 04/10/15 with diagnoses which included peripheral vascular disease and below knee amputation.<br><br>Review of Resident #85's Annual MDS assessment dated 02/01/18 revealed a height of 58 inches.<br><br>Review of resident #85's Quarterly MDS assessment dated 07/25/18 revealed a height of 68 inches.<br><br>On 08/31/18 at 5:00 PM during an interview with the Registered Dietician who completed section K Swallowing/Nutrition portion of the MDS stated there was no double check system for the height because that information rarely changed.<br><br>During an interview on 08/31/18 at 7:50 PM the | F 641 | modified based on findings. | |

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| F 641 | Continued From page 16<br>Divisional Executive Director stated he could not attest to that (discrepancy) because people do not grow 10 inches. | F 641 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document | F 656 | | 9/28/18 |

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| F 656 | Continued From page 17<br>whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to develop a care plan for safe smoking for 1 of 7 sampled residents reviewed for smoking (Resident #59) and failed to develop comprehensive care plans for skin conditions and activities of daily living for 1 of 1 resident reviewed for changes in condition (Resident #203).<br><br>The findings include:<br><br>Resident #59 was readmitted to the facility on 1/16/18 with medical diagnoses including hypertension, seizure disorder, and hemiparesis/hemiplegia (paralysis).<br><br>Resident #59's annual Minimum Data Set (MDS) dated 4/13/18, specified the resident's cognition was severely impaired. The MDS also specified Resident #59 to have an impairment on one side of upper and lower extremity. The MDS also indicated Resident #59 was a smoker.<br><br>A record review of the comprehensive care plan reviewed and updated on 7/18/18 did not include a care area for safety related to smoking. A medical record review revealed a safe smoking evaluation completed on 7/18/18 in which Resident #59 was identified to require staff | F 656 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure comprehensive care plans initiated for smoking, skin and activities of daily living (ADL's). QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.<br><br>Root cause analysis: Failure to complete necessary areas of residents comprehensive care plan. Resident #59 care plan was updated. Resident #203 is no longer in facility.<br><br>Social Workers and MDS Department have conducted a quality review of current residents comprehensive care plans to ensure ADL, skin and smoking comprehensive care plans in place as applicable. Regional MDS Coordinator validated results of Quality Review. Follow up based on findings. | |

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| F 656 | Continued From page 18<br>assistance with smoking.<br><br>An interview with the social worker assistant on 08/29/18 at 01:15 PM, the social worker assistant identified Resident #59 as a resident who required staff assistance with smoking. The social worker assistant acknowledged responsibility for the completion of a safety care area related to smoking for Resident #59's comprehensive care plan. The social worker assistant reported she had failed to do so with Resident #59.<br><br>An interview with the director of nursing (DON) on 8/31/18 at 07:41PM, the DON stated for residents who have been identified as smokers, those residents should have a care area for safety related to smoking included in their comprehensive care plan.<br>2. Resident #203 was admitted to the facility on 07/03/18 with diagnoses which included in part chronic venous hypertension (swelling and pain in legs) with inflammation of left lower extremity, lymphedema (swelling in legs), type 2 diabetes, chronic pain, generalized muscle weakness, difficulty walking, anxiety and depression.<br><br>A review of a hospital discharge summary dated 07/03/18 indicated Resident #203 had a discharge diagnosis of lymphedema of both lower extremities.<br><br>A review of an admission nursing assessment dated 07/03/18 at 3:00 PM revealed Resident #203 was admitted with diagnoses, in part of chronic venous hypertension, lymphedema and cellulitis of unspecified part of limbs.<br><br>A review of a care plan with a focus category labeled Nutrition/Hydration with an | F 656 | Regional MDS provided re-education to MDS staff and Social Workers regarding accuracy of having Care Plans in place.<br><br>Director of Clinical Services and or Unit Mangers/MDS Coordinator to complete Quality Improvement Monitoring of Care Plans in place 3 assessments per week for 4 weeks, 3 assessments monthly for 3 months, then quarterly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. | |

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implementation date of 07/11/18 indicated Resident #203 had a disease process of lymphedema. Further review of care plans revealed there were no comprehensive care plans for skin conditions with approaches or interventions for Resident #203's lymphedema or swelling in legs and there was no care plan for activities of daily living (ADLs).

A review an admission Minimum Data Set (MDS) dated 07/16/18 indicated Resident #203 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #203 required extensive assistance with bed mobility, transfers, dressing, toileting and hygiene.

A review of a physician's progress note dated 07/05/18 indicated Resident #203 was seen for new admission. The notes revealed Resident #203 had chronic lymphedema and had a history of venous stasis ulcers and cellulitis (inflammation) in her lower extremities.

A review of an interdisciplinary progress note dated 07/12/18 at 11:00 AM indicated Resident #203's family requested she go to the emergency room for evaluation and treatment. The note revealed there was noted redness and swelling of Resident #203's legs but she denied complaints of pain or discomfort associated with the swelling.

During an interview on 08/31/18 at 3:15 PM, the Unit Manager stated after review of Resident #203's care plans she verified there was no care plan for skin conditions with approaches or interventions for Resident #203's swelling in her legs and there was no care plan with approaches or interventions for ADLs. She stated she would have expected to see a care plan for skin and

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| F 656 | Continued From page 20<br>ADLs.<br><br>During an interview on 08/31/18 at 6:11 PM, the Director of Nursing stated after review of Resident #203's care plans that she did not have care plans for skin or ADLs. She further stated she would have expected for Resident #203 to have a care plan for skin and ADLs since she had a diagnosis of lymphedema and required staff assistance with ADL care. | F 656 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the | F 657 | | 9/28/18 |

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| F 657 | Continued From page 21<br>comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to review and update the care plan for 1 of 6 sampled residents for activities of daily living (ADL) (Resident #303), 1 of 7 sampled residents for falls/accidents (Resident #154), and 1 of 6 sampled residents for pressure ulcers (Resident #154).<br><br>The findings include:<br><br>1. Resident #303 was readmitted to the facility on 8/31/11 with medical diagnoses inclusive of unilateral primary osteoarthritis of left hip, presence of artificial knee joint, muscle weakness, unsteadiness on feet, difficulty walking not otherwise classified, chronic pain, pain in right hip and adult failure to thrive.<br><br>A record review of the annual Minimum Data Set (MDS) dated 7/12/17 identified Resident #303's cognition to be severely impaired. The MDS identified Resident #303 required limited staff assistance with dressing and one staff person assistance with bathing, personal hygiene, and toileting. The care area assessment included the identified care areas for ADL functional, urinary incontinence, dehydration/fluid maintenance, visual function, falls, nutritional status, and pressure ulcer. The quarterly MDS dated 3/12/18 identified Resident #303 required supervision for dressing with one staff person assistance and total staff dependence for bathing with one staff person assistance.<br><br>A review of the care plan conference record dated | F 657 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure care plans revised timely. QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.<br><br>Root cause analysis: Failure to complete/document care plan revisions timely. Resident #303 and #154 are no longer in the facility.<br><br>MDS Department has conducted a quality review of current residents to ensure timely revisions completed for care plans relating to fall, pressure ulcers and ADL's completed as applicable. Regional MDS Coordinator to validate results of quality review. Follow up based on findings.<br><br>Regional MDS provided re-education to Social Workers, Dietary, Activity Director and MDS regarding having documentation in the Care Plan.<br><br>Director of Clinical Services/MDS Coordinator to complete Quality Improvement Monitoring of documentation of Care Plans in place 3 | |

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| F 657 | Continued From page 22<br>3/7/18 included signatures from the social worker, social worker assistant, activities director and dietary manager as having attended the meeting. The record noted MDS and Interdisciplinary Team (IDT) met and updated the plan of care for Resident #303. The record noted continue with plan of care, no issues.<br><br>A review of the updated comprehensive care plan for Resident #303, the care area for ADL was not updated for the period of 3/7/18 to 6/7/18.<br><br>During an interview on 8/31/18 at 12:52 PM with the MDS coordinator, she indicated the MDS coordinator would be responsible for updating care areas related to nursing, specifically the care area for ADL. The coordinator was interviewed and stated she was not in the position of MDS coordinator on 3/7/18.<br><br>During an interview on 08/31/18 at 07:41 PM with the director of nursing (DON), the DON stated her expectation was all comprehensive care plans are reviewed and updated by each member of the interdisciplinary team. The DON stated the management team which included the MDS coordinator, unit managers and the DON should have ensured the care areas and the comprehensive care plan were updated for each resident. The DON stated the management team failed to ensure the care area for ADL was updated for Resident #303.<br><br>2. Resident #154 was readmitted to the facility on 1/29/18 with medical diagnoses inclusive of type 2 diabetes mellitus with diabetic nephropathy, muscle weakness, and lack of coordination.<br><br>A record review of the annual Minimum Data | F 657 | assessments per week for 4 weeks, 3 assessments monthly for 3 months then quarterly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. | |

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| F 657 | Continued From page 23 | F 657 | | |

Sheet (MDS) dated 1/12/18 identified Resident #154 to be cognitively intact. The MDS also identified Resident #154 required total staff dependence with ADLs, two staff person assistance with bed mobility and transfer, and at risk for developing pressure ulcers. The MDS revealed Resident#154 had experienced a fall with fracture to the lower extremity. The care area assessment identified the care areas for visual function, ADL functional, urinary incontinence, falls, nutritional status, pressure ulcer, psychotropic drug use, and return to the community. The last quarterly MDS dated 4/9/18 identified Resident #154's cognition to be moderately impaired. The quarterly MDS of 4/9/18 also identified an unstageable pressure ulcer for Resident#154.

A record review of the comprehensive care plan reviewed and updated for 5/9/18 to 8/9/18 was not updated for the care areas related to safety (falls) and skin impairment (wound).

During an interview on 8/31/18 at 12:52 PM with the MDS coordinator, she indicated the MDS coordinator would be responsible for updating care areas related to nursing, specifically the care area for safety (falls) and skin impairment (wound). The coordinator interviewed was not in the position of MDS coordinator on 4/9/18 the update for the comprehensive care plan for Resident #154 was performed. The coordinator stated these care areas were not updated for the period of 5/9/18 to 8/9/18.

During an interview on 08/31/18 at 07:41 PM with the director of nursing (DON), the DON stated her expectation was the comprehensive care plans are reviewed and updated by each member of the

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| F 657 | Continued From page 24<br>interdisciplinary team. The DON also stated the management team which included the MDS coordinator, unit managers and the DON should have ensured the care areas and the comprehensive care plan were updated for each resident. The DON stated the management team failed to ensure the care areas for safety and skin impairment were updated for Resident #154. | F 657 | | |
| F 661 SS=D | Discharge Summary<br>CFR(s): 483.21(c)(2)(i)-(iv)<br><br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and | F 661 | | 9/28/18 |

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| F 661 | Continued From page 25<br>non-medical services.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to complete a recapitulation of stay for 1 of 2 closed records reviewed for planned discharge to the community (Resident #203).<br><br>Findings included:<br><br>Resident #203 was admitted to the facility on 07/03/18 with diagnoses which included in part chronic venous hypertension (swelling and pain in legs) with inflammation of left lower extremity, lymphedema (swelling in legs), type 2 diabetes, chronic pain, generalized muscle weakness, difficulty walking and anxiety and depression.<br><br>A review an admission Minimum Data Set (MDS) dated 07/16/18 indicated Resident #203 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #203 required extensive assistance with bed mobility, transfers, dressing, toileting and hygiene.<br><br>A review of a facility document titled Interdisciplinary Discharge Summary revealed a section labeled Recapitulation of Resident's Stay which indicated Resident #203 was admitted to the facility on 07/03/18 and was discharged from the facility on 07/16/18. The reason for admission, treatment provided, progress and reason for discharge were blank. A section on the back of the form with discharge diagnosis and additional comments or concerns were also blank.<br><br>A review of a facility document titled Discharge Plan dated 07/16/18 at 5:00 PM in a section titled | F 661 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop a plan to ensure recapitulation of stay completed for residents upon discharge. QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.<br><br>Root cause analysis: Failure to complete recapitulation of stay per guideline. Resident #203 is no longer in the facility.<br><br>Director of Clinical Services, Unit Managers, Social Work, Activities and Medical Records has conducted a quality review of discharged residents for the last 30 days to ensure a recapitulation of stay is completed for each resident that has been discharged chart. Follow up based on findings.<br><br>Director of Clinical Services provided re-education to Social Workers, Dietary, Activity Director Unit Mangers and Licensed Nursing Staff regarding completing recapitulation of stay per guideline.<br><br>Director of Clinical Services and or Unit Mangers to complete Quality | |

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| F 661 | Continued From page 26<br>Summary of Discharge indicated Resident #203 was discharged to another facility. Further review of the document revealed the following sections labeled Physician Information, Summary of Stay, Functional Mobility/Self Care Skills, Discharge Body Audit with instructions to diagram all alterations in skin integrity; Activity discharge summary, Nursing discharge summary, Nutrition discharge summary, Medication Summary, Treatment Summary and Managing your Future were all blank.<br><br>During an interview on 08/31/18 at 3:15 PM, the Unit Manager stated she was not sure who filled out the Discharge Summary but it was usually completed after the resident discharged from the facility.<br><br>During an interview on 08/31/18 at 5:43 PM, the Social Worker explained the Interdisciplinary Discharge Summary should be completely filled out. She further explained usually a staff member put the Interdisciplinary Discharge Summary on top of the resident's folder after discharge and it was supposed to go to the morning meeting and was completed by the various departments. She confirmed the Interdisciplinary Discharge Form was only partially complete. She stated she did not recall that anyone had instructed her on the requirements to document the recapitulation of a resident's stay. After review of the facility document titled Discharge plan she stated it was supposed to be filled out completely by various departments but it was not complete and she was not sure why it had not been completed.<br><br>During an interview 08/31/18 at 6:11 PM, the Director of Nursing explained the Interdisciplinary Discharge Summary was supposed to be | F 661 | Improvement Monitoring of discharge resident records for complete recapitulation of stay using a random sample of 3 discharge charts per week x 4 weeks, 3 discharge charts/ month x 3 months then quarterly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. | |

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| F 661 | Continued From page 27<br>completed by various departments and she expected for nursing staff to complete the sections that applied to Nursing Services. She stated the discharge forms usually came with the resident's chart to the morning meeting and were expected to be completed by various departments. She stated it was her expectation for nursing staff to complete a nursing discharge summary. After review of the Interdisciplinary Discharge Summary and the Discharge Plan she stated the forms had not been completed.<br><br>During an interview on 08/31/18 at 7:55 PM, the Divisional Executive Director stated it was his expectation for social workers to complete the Interdisciplinary Discharge Summary for recapitulation of a resident's stay. He stated the summary should be there and that is the expectation. | F 661 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to utilize two staff members to transfer a dependent resident from her bed to her wheel chair for 1 of 6 sampled resident reviewed for falls/accidents (Resident #94). | F 689 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure resident transfers | 9/28/18 |

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| F 689 | Continued From page 28<br><br>The findings include:<br><br>Resident #94 was admitted to the facility on 7/16/13 with diagnoses which included peripheral vascular disease, muscle weakness, low back pain, unspecified lack of coordination, and other malaise.<br><br>Resident #94's annual Minimum Data Set (MDS) dated 2/6/18 specified the resident had moderately impaired cognition, required extensive staff assistance of 2 staff with bed mobility, transfers, dressing and toileting use. The Care Area Assessment included visual function, communication, activities of daily living, urinary incontinence, falls, nutrition, dental and pressure ulcer.<br><br>A review of the comprehensive care plan dated 2/6/18, reviewed and updated through 5/5/18 included a focus area of safety (at risk for injury related to falls). The care area for falls included an intervention to ensure the resident wore appropriate footwear when mobilizing in wheelchair.<br><br>A review of the Situation, Background, Assessment, Recommendation (SBAR) communication form dated 2/15/18 nursing note indicated a licensed nurse was called by the nurse aide (NA) to room. The nurse observed Resident #94 seated on the floor in front of a wheelchair. The form indicated NA #1 lowered Resident #94 to the floor during a transfer from the bed to the wheelchair. The form indicated no report of pain or injury by Resident #94.<br><br>A phone interview on 8/30/18 at 5:08 PM was | F 689 | completed as recommended per resident plan of care. QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.<br><br>Root cause analysis: Failure to review the Kardex and follow the correct method to transfer resident. Resident #94 Kardex was updated to ensure it had the correct method of transfer.<br><br>Director of Clinical Services and or Unit Managers have conducted a quality review of current residents to ensure resident transfers completed as recommend per resident plan of care and to ensure Kardex contains up to date resident information. Follow up based on findings.<br><br>Director of Clinical Services and or Unit Manger provided re-education to Certified Nursing Assistants regarding utilization/maintenance of Kardex and completion of transfers as recommended per resident plan of care, including competency demonstration.<br><br>Director of Clinical Services and or Unit Mangers to complete random Quality Improvement Monitoring using a sample size of 3 for resident transfers being completed as recommended per resident plan of care and Kardex current/utilized correctly, twice/week x 2 weeks, weekly x 4 weeks, monthly x 3 months, then | |

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| F 689 | Continued From page 29<br>conducted with the NA #1, who worked with Resident #94 on the day of the fall. NA #1 recalled being present when Resident #94 experienced a fall in February 2018. NA #1 stated she used a gait belt to transfer Resident #94 and as the resident moved from the bed to wheelchair, the resident lost her balance and she lowered Resident #94 to the floor. NA #1 stated she understood the resident to require only one staff person for transfers and she transferred Resident #94 alone when the resident fell. NA #1 notified the licensed practical nurse who completed the SBAR and who examined Resident #94. NA#1 stated she received verbal report from licensed practical nurses and other nurse assistants regarding the number of staff required for transfers for each of her assigned residents. NA #1 was not able to recall from whom she received report regarding number of staff required to transfer for assigned residents on 2/15/18.<br><br>During an interview with the MDS Coordinator on 08/29/18 at 05:01 PM, the MDS Coordinator reported she was not the Coordinator at the time of the annual MDS. The MDS Coordinator provided MDS Section G, ADL for the week of 2/11/18 to 2/17/18. On 2/15/18, day shift, Resident #94 required the assistance of at least 2 staff persons for transfers from the bed to the wheelchair and from the wheelchair to the bed. The MDS Coordinator confirmed the assessment indicated a requirement of 2 staff for transfer.<br><br>During an interview on 8/31/18 at 07:41 PM with the Director of Nursing (DON) stated her expectation was the NA would review each residents' care plan to determine how many staff were required to complete transfers. The DON | F 689 | quarterly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. | |

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| F 689 | Continued From page 30<br>reported the facility investigated the fall and an intervention of Dycem (non slip, rubber-like plastic material used to stabilize) was added to aid in transfers for Resident #94. | F 689 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to secure and label loose pills in the medication carts for 4 of 6 medication carts (100 hall, 200 hall, 400 hall and 500 hall), | F 761 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis | 9/28/18 |

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| F 761 | Continued From page 31<br>failed to discard expired over the counter medication for 3 of 6 medication carts (100 hall, 400 hall, and 500 hall), failed to discard Ipratropium Bromide and Albuterol Sulfate Inhalation Solution within manufacturer's timeframe in 1 of 6 medication carts (400 hall), and failed to date foil packaging for Ipratropium Bromide and Albuterol Sulfate Inhalation Solution in 1 of 6 medication carts (400 hall).<br><br>Findings included:<br><br>A review of the facility policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" (no date) read in part:<br><br>The community should ensure that medications and biologicals:<br><br>4.1 Have an expiry date on the label<br><br>4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines<br><br>Once any drug or biological package is opened, the Community should follow manufacturer/ supplier guidelines with respect to expiration dates for opened medications.<br><br>A review of the manufacturer's guideline for Ipratropium Bromide and Albuterol Sulfate Inhalation Solution read in part:<br><br>Storage Conditions- Once removed from the foil pouch, the individual vials should be used within two weeks.<br><br>1. An observation on 8/27/2018 at 12:10pm of | F 761 | and to develop corresponding corrective action to ensure medications labeled correctly and within current date. QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.<br><br>Root cause analysis: Failure to check the medication charts for proper medication storage and expired medications.<br><br>Director of Clinical Services and or Unit Managers has conducted a quality review of medication carts for proper medication storage and labeling noting medications within current date. Follow up based on findings.<br><br>Director of Clinical Services and or Unit Manger provided re-education to Licensed Nursing Staff regarding checking medication carts to ensure proper medication labeling and storage.<br><br>Director of Clinical Services and or Unit Mangers to complete Quality Improvement Monitoring of Medication Carts to ensure medications labeled stored correctly; (medications within current date). Medication carts will be checked weekly x 8 weeks, then monthly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. | |

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| F 761 | Continued From page 32 | F 761 | | |

the medication cart on 400 hall revealed that Ipratropium Bromide and Albuterol Sulfate Inhalation Solution was opened on 8/8/2018. Continued observation of the medication cart on 400 hall revealed that a second box of Ipratropium Bromide and Albuterol Sulfate Inhalation Solution was opened and not dated. One single vial of Ipratropium Bromide and Albuterol Sulfate Inhalation Solution was observed loose in the second drawer.

An interview with the cart nurse on 8/27/2018 at 12:15pm revealed that she was aware of the storage instructions for the ipratropium bromide and albuterol sulfate inhalation solution. The nurse stated that she forgot to remove the inhalation from the cart within the two week time frame. The nurse also stated that she was not aware of the date the other package of the ipratropium bromide and albuterol sulfate inhalation solution was opened and could not determine if the medication was expired or not. The nurse was not aware of the loose vial of ipratropium bromide and albuterol sulfate inhalation solution in the second drawer.

An interview with the Director of Nursing on 8/30/2018 at 2:05pm revealed that her expectation would be for the medication carts to be cleaned and audited at least one time weekly for expired medications and loose pills by the cart nurse.

2. An observation on 8/27/2018 at 12:10pm of the medication cart on 400 hall revealed that one bottle of Ferrous Sulfate had an expiration date of 6/18/2018.

An interview with the cart nurse on 8/27/2018 at

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12:15pm revealed that she did not check her over the counter medications to ensure that they were within date. The cart nurse stated that pharmacy usually checked the medication carts monthly and she usually checked her cart weekly or every other week to look for expired medications and loose pills.

An interview with the Director of Nursing on 8/30/2018 at 2:05pm revealed that her expectation would be for the medication carts to be cleaned and audited at least one time weekly for expired medications and loose pills by the cart nurse.

3. An observation on 8/27/2018 at 12:25pm of the medication cart on 500 hall revealed a bottle of Iron Supplement Elixir with an expiration date of 2/2018. Further observation of the medication cart on 500 hall revealed 6 loose pills throughout the cart.

An interview with the cart nurse on 8/27/2018 at 12:30pm revealed that she checked her medication cart monthly for any expired medications or loose pills.

An interview with the Director of Nursing on 8/30/2018 at 2:05pm revealed that her expectation would be for the medication carts to be cleaned and audited at least one time weekly for expired medications and loose pills by the cart nurse.

4. An observation on 8/27/2018 at 5:40pm of the medication cart on 200 hall revealed 3 loose pills throughout the cart.

An interview with the cart nurse on 8/27/2018 at

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| F 761 | Continued From page 34<br>5:45pm stated that he spot checked the medication cart when he had time for loose pills and expired medication. The cart nurse also stated that the Unit Manager (UM) would complete a spot check as well.<br><br>An interview with the Director of Nursing on 8/30/2018 at 2:05pm revealed that her expectation would be for the medication carts to be cleaned and audited at least one time weekly for expired medications and loose pills by the cart nurse.<br><br>5. An observation on 8/27/2018 at 5:53pm of the medication cart on 100 hall revealed a bottle of Biotin with an expiration date of 6/2018. Further observation of the medication cart revealed 8 loose pills throughout the medication cart.<br><br>An interview with the cart nurse on 8/27/2018 at 5:57pm stated that she worked as needed and did not have a designated cart. The cart nurse did not indicate whether or not she checked the cart for expired medications or loose pills.<br><br>An interview with the Director of Nursing on 8/30/2018 at 2:05pm revealed that her expectation would be for the medication carts to be cleaned and audited at least one time weekly for expired medications and loose pills by the cart nurse. | F 761 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is | F 842 | | 9/28/18 |

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| F 842 | Continued From page 35 | F 842 | | |

resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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| F 842 | Continued From page 36<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and staff interviews the facility failed to complete documentation on Daily Skilled Nurse's Notes for vital signs on each shift, the condition of a resident's skin on each shift and failed to complete documentation for administration of pain medication for 1 of 1 resident with non-pressure skin conditions on her lower extremities (Resident #203). The facility also failed to document a change of a resident's urinary catheter or urinary drainage bag for 1 of 5 residents sampled with catheters (Resident #2).<br><br>Findings included:<br><br>1. Resident #203 was admitted to the facility on | F 842 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure documentation complete related to change in condition, Daily Skilled Notes, Medication Administration Record (MAR). QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.<br><br>Root cause analysis: Failure to document | |

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| F 842 | Continued From page 37<br>07/03/18 with diagnoses which included in part chronic venous hypertension (swelling and pain in legs) with inflammation of left lower extremity, lymphedema (swelling in legs), type 2 diabetes, chronic pain, generalized muscle weakness, difficulty walking and anxiety and depression.<br><br>A review of a hospital discharge summary dated 07/03/18 indicated Resident #203 had a discharge diagnosis of lymphedema of both lower extremities.<br><br>A review of an admission nursing assessment dated 07/03/18 at 3:00 PM revealed Resident #203 was admitted with diagnoses in part of chronic venous hypertension, lymphedema and cellulitis of unspecified part of limbs. A section labeled skin assessment revealed Resident #203's right and left lower legs were dry and scaly.<br><br>A review of a physician's order dated 07/03/18 indicated Norco 5/325 milligrams by mouth every 4 hours as needed (PRN) for pain.<br><br>A review of Daily Skilled Nurse's Notes dated 07/04/18 in a section labeled skin indicated Resident #203's skin was warm and dry on the 11:00 PM to 7:00 AM (night) shift but there was no documentation on the 7:00 AM - 3:00 PM (day) or 3:00 PM - 11:00 PM (evening) shifts. The document also indicated vital signs were documented on the night shift and evening shift but not for the day shift.<br><br>A review of Daily Skilled Nurse's Notes dated 07/05/18 in a section labeled skin indicated Resident #203's skin was warm and dry on day shift but there was no documentation on the night | F 842 | on change of condition.<br><br>Director of Clinical Services and or Unit Managers conducted a Quality Review of current resident records for documentation complete related to change in condition, Daily Skilled Notes and MAR. Follow up based on findings.<br><br>Director of Clinical Services and or Unit Manger provided re-education to Licensed Nursing Staff regarding documenting on resident's change in condition, completion of MAR and Skilled Notes.<br><br>Director of Clinical Services and or Unit Mangers to complete Quality Improvement Monitoring of a random sample of 5 resident records 5x/week x 4 weeks, weekly x 4 weeks, then monthly and as needed to ensure there is documentation noted for change in condition as applicable as well as MAR and Skilled Nurses Note complete. Findings to be reviewed at monthly QAPI Committee Meeting. | |

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or evening shifts. The document also revealed there were no vital signs documented for any shift.

A review of Daily Skilled Nurse's Notes dated 07/06/18 in a section labeled skin indicated Resident #203's skin was warm and dry on night shift and evening shift but not on day shift and there were no vital signs documented on any shift.

A review of Daily Skilled Nurse's Notes dated 07/07/18 in a section labeled skin indicated Resident #203's skin was dry with abnormal turgor (elasticity of skin) on night shift and day shift but there was no documentation on night shift.

A review of Daily Skilled Nurse's Notes dated 07/08/18 indicated vital signs were documented for Resident #203 on day shift and evening shift but there was no documentation on night shift.

A review of Daily Skilled Nurse's Notes dated 07/10/18 in a section labeled skin indicated Resident #203's skin was warm and dry on day and evening shift but there was no documentation on night shift. The document also indicated vital signs were documented on day shift and evening shift but not on night shift.

A review of Daily Skilled Nurse's Notes dated 07/11/18 in a section labeled skin indicated Resident #203's skin was warm and dry on evening shift but there was no documentation on night or day shift. The document also indicated vital signs were documented on evening shift but not on night shift or day shift.

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A review of Resident #203's Medication Administration record dated 07/11/18 revealed Norco 5/325 mg revealed staff initials were documented with a time of 9:40 AM but there was no documentation for the location of pain, severity level of pain, response to pain medications or a signature related to the staff initials.

A review of Daily Skilled Nurse's Notes dated 07/12/18 in a section labeled skin indicated Resident #203's skin was warm and dry on the evening shift but here was no documentation on night shift or day shift. The document also indicated vital signs were documented on the evening shift but not on night shift or day shift. The document further revealed in the evening shift notes indicated Resident #203 had returned from the hospital and her bilateral lower legs below her knees were red and a small amount of drainage was noted.

A review of Daily Skilled Nurse's Notes dated 07/13/18 indicated vital signs were documented for Resident #203 on day shift and second shift but not on night shift.

A review of Daily Skilled Nurse's Notes dated 07/14/18 in a section labeled skin indicated Resident #203's skin was warm and dry on day and evening shifts but not on night shift. The document also indicated vital signs were documented on evening shift but not on night shift or day shift. A note on the document revealed Resident #203's bilateral lower extremities were red and warm to touch.

A review of Daily Skilled Nurse's Notes dated 07/15/18 revealed there was no documentation in section labeled skin for any shifts for Resident

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#203 and vital signs were documented on day shift but not on night shift or evening shift.

A review of Daily Skilled Nurse's Notes dated 07/16/18 indicated Resident #203 was discharged from the facility.

During an interview on 08/31/18 at 2:49 PM, Nurse #1 stated it was her understanding that if they were doing daily charting then vital signs were supposed to be documented for each shift but sometimes it was missed.

During an interview on 08/31/18 at 3:15 PM, the Unit Manager explained vital signs were supposed to be documented every shift for daily charting on the Daily Skilled Nurse's Notes. She stated she expected for documentation to include assessments of Resident #203's legs since she had a diagnosis of lymphedema. She further stated Nurse #4 had initialed the MAR for Norco 5/325 mg for pain on 07/11/18 but had not documented the location of pain, level of pain or effectiveness of the pain medication.

During an interview on 08/31/18 at 3:57 PM, Nurse #3 explained she had completed Resident #203's admission nursing assessment and the daily charting continued after that. She stated she thought vital signs were supposed to be charted on all shifts each day on the Daily Skilled Nurse's Notes but was not sure why they weren't documented consistently. She explained when staff gave pain medication they were supposed to document the pain level on a scale of 0 (no pain) to 10 (worst pain) on the back of the MAR and document the effectiveness of the pain medication.

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An attempt was made to contact Nurse #4 on 08/31/18 at 5:34 PM but was unsuccessful.

During an interview on 08/31/18 at 6:11 PM, the Director of Nursing explained the Daily Skilled nurses notes were supposed to be completed for daily care. She stated it was her expectation that vital signs should be documented each shift on the Daily Skilled Nurse's Notes. She further stated since Resident #203 had had dry skin areas and lymphedema indicated on her nursing admission assessment nursing staff should have documented more thoroughly. She explained she would have liked to have seen documentation from head to toe for Resident #203. She stated it was her expectation for staff to sign the date and time on MARs when PRN pain medications were given. She further stated staff should document date, time and initial when the medication was given and on the back of the MAR they were expected to document date, time, reason medication was given and effectiveness of medication and their signature.

2. Resident #2 was admitted to the facility on 9/30/13. Diagnoses included neuromuscular dysfunction of bladder.

The annual minimum data set assessment, dated 8/2/18, assessed Resident #2 with intact cognition and the use of an indwelling Foley catheter (FC).

The August 2018 care plan documented the problem for Resident #2 regarding a neuromuscular dysfunction of his bladder which required the use of a FC. The intervention included to change the FC as ordered by the physician.

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Review of Resident #2's August 2018 cumulative physician's orders revealed an order to change the FC and drainage bag as needed, occlusion.

Review of Resident #2's Medication Administration Record, Treatment Administration Record, and nursing progress notes for the months of April 2018 - August 2018, revealed there was no documentation that the FC or drainage bag for Resident #2 had been changed.

Resident #2 was observed on 8/31/18 at 11:55 AM in his room with a FC draining urine into a drainage bag. The drainage bag was dated 8/27/18. Nurse #1 was present and stated that she recalled that the FC for Resident #2 became dislodged and was changed, but that she did not recall the date or which nurse changed the FC for Resident #2.

Resident #2 stated in interview on 8/31/18 at 11:58 AM that his FC was changed earlier in the month of August 2018 by a female nurse who worked the day shift, but that he could not recall her name or the date.

On 8/31/18 at 12:05 PM, during an interview with Nurse #2, (Unit Manager), she stated that she reviewed the medical record for Resident #2 from April 2018 - August 2018 and could not find documentation of the last time his FC and drainage bag were last changed. Nurse #2 also stated that she thought Resident #2's FC and drainage bag were last changed in April 2018, but that she could not find it documented in his medical record and she was not certain.

During an interview with Nurse #3 on 8/31/18 at 4:11 PM she stated that she changed Resident

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| F 842 | Continued From page 43<br>#2's FC because it was broken beyond the port and had to be changed. Nurse #3 further stated that when she changed the FC for Resident #2, she had difficulty deflating the FC bulb, a small amount of blood returned, but the Resident denied pain/discomfort. Nurse #3 further stated that she informed the director of nursing (DON) of the difficulty. Nurse #3 stated that she did not document Resident #2's medical record regarding the catheter change and that she was not certain of the date. Nurse #3 stated she could have changed Resident #2's FC in August 2018, but she thought it was June 2018.<br><br>An interview with the DON on 8/31/18 at 6:11 PM revealed she expected nurses to document in the medical record when a resident's FC and drainage bag were changed. | F 842 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor the interventions the committee put into place following the complaint investigation survey of 03/12/18. This was for deficiencies recited during the facility's current recertification and complaint investigation survey of 08/31/18 in the areas of F 641 Accuracy of | F 867 | On 9/27/2018, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure care plans revised timely. QAPI committee members in attendance included the Executive Director, Director of Clinical Services, MDS Nurses, Unit | 9/28/18 |

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| F 867 | Continued From page 44<br>Minimum Data Set Assessments and F 657 Care Plan Timing and Revisions. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.<br><br>The findings included:<br><br>The citations are cross referenced to:<br><br>1. F 641- Accuracy of Assessments. Based on physician and staff interview, and record review, the facility failed to accurately code the Minimum Data Set assessment in the areas of active diagnoses for 1 of 6 residents (Resident #41) reviewed for active diagnosis of peripheral vascular disease (PVD), and failed to accurately code the height in the area of swallowing/nutritional status for 1 of 5 residents (Resident #85) reviewed for hospitalizations.<br><br>During a complaint investigation survey on 03/12/18 the facility was cited for failure to accurately assess a sampled resident's status related to bowel/bladder, active diagnoses and swallowing/nutritional status. This deficiency was recited during the facility's current recertification and complaint investigation survey of 08/31/18 for 2 sampled residents related to active diagnoses, and swallowing/nutritional status.<br><br>During an interview with the Divisional Executive Director on 08/31/18 at 7:41 PM, he stated that the facility's QAA committee discussed state survey results from one state survey to the next, wrote a plan for correction, developed performance improvement plans, conducted routine monitoring for a period of time and conducted audits to ensure issues/discrepancies | F 867 | Manager, Dietary Manager, Social Workers, Activity Director and Medical Director.<br><br>Root cause analysis: Knowledge deficit regarding coding on MDS and failure to complete/document care plan revisions timely. Residents #41 and #85 were update. Residents #303 and #154 are no longer in the facility<br><br>MDS Director / MDS Coordinator / Nutritionist conducted a quality review of current facility residents related to resident height and residents with PVD diagnosis coded correctly. Regional MDS Coordinator validated findings of Quality Review. Follow up based on findings.<br><br>MDS Department has conducted a quality review of current residents to ensure timely revisions completed for care plans relating to fall, pressure ulcers and ADL's completed as applicable. Regional MDS Coordinator to validate results of quality review. Follow up based on findings.+<br><br>Regional MDS provided re-education to MDS staff and Nutritionist regarding accuracy of active diagnosis codes and accuracy of patient's height.<br><br>Regional MDS provided re-education to Social Workers, Dietary, Activity Director and MDS regarding having documentation in the Care Plan.<br>4<br>MDS Director / MDS Coordinator to complete Quality Improvement Monitoring | |

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| 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 867 | Continued From page 45<br>were addressed. He stated that the QAA committee audited the MDS regularly to ensure they were as accurate as possible, but at times things were missed due to the volume of data captured on the MDS which made it difficult to be certain all mistakes were caught.<br><br>2. F 657- Care Plan timing and Revisions: Based on record review and staff interviews, the facility failed to review/update the care plan for 1 of 6 sampled residents for activities of daily living (ADL) (Resident #303), 1 of 7 sampled residents for falls/accidents (Resident #154), 1 of 6 sampled residents for hospitalizations (Resident #154) and 1 of 6 sampled residents for pressure ulcers (Resident #154).<br><br>During a complaint investigation survey on 03/12/18 the facility was cited for failure to revise a resident's care plan related to enteral feedings. This deficiency was recited during the facility's current recertification and complaint investigation survey of 08/31/18 for failure to revise the care plan for 2 sampled residents related to activities of daily living, accidents and pressure ulcers.<br><br>During an interview with the Divisional Executive Director on 08/31/18 at 7:41 PM, he stated that the facility's QAA committee discussed state survey results from one state survey to the next, wrote a plan for correction, developed performance improvement plans, conducted routine monitoring for a period of time and conducted audits to ensure issues/discrepancies were addressed. He stated that the QAA committee audited care plans regularly to ensure | F 867 | of active assessments for accuracy ; 3 assessments per week for 4 weeks, then 3 assessments monthly for 3 months then quarterly and as needed. Regional MDS Coordinator to validate QI Monitor findings monthly x 3 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.<br><br>Director of Clinical Services/MDS Coordinator to complete Quality Improvement Monitoring of documentation of Care Plans in place 3 assessments per week for 4 weeks, 3 assessments monthly for 3 months then quarterly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345388 | A. BUILDING _____ B. WING _____ | C 08/31/2018 |

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| F 867 | Continued From page 46<br>they were revised/updated, but at times things were missed due to the volume of data captured on the care plan which made it difficult to be certain all mistakes were caught. | F 867 | | |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | 345388 | A. BUILDING: _____ B. WING _____ | 8/31/2018 |

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| HUNTER WOODS NURSING AND REHAB | 620 TOM HUNTER ROAD CHARLOTTE, NC |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| F 623 | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental |

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

The above isolated deficiencies pose no actual harm to the residents

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| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| F 623 | Continued From Page 1 |

disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to provide the resident and the resident's representative (RP) of written notification of the reason for the transfer and did not send a copy of the notice to the Ombudsman for 2 of 4 residents' reviewed for hospitalization (Resident #85 and Resident #87).

The findings included:

Review of Resident #85's medical record revealed he was admitted to the facility on 04/10/15 with diagnoses which included peripheral vascular disease and neurogenic bladder.

Resident #85's medical record revealed he was transferred and admitted to the hospital on 08/14/18 for scrotal swelling. No written notice of transfer was documented as being provided to the resident, the RP or the Ombudsman.

Review of Resident #87's medical record revealed he was admitted to the facility on 02/15/17 with diagnoses which included peripheral vascular disease and neurogenic bladder.

Resident #87's medical record revealed he was transferred and admitted to the hospital on 08/06/18 for scrotal swelling. No written notice of transfer was documented as being provided to the resident, the RP or the Ombudsman.

On 08/31/18 at 5:59 PM during an interview with the Social Worker (SW) she stated the families were informed of the resident's transfer to the hospital by the Nurse at the time of the transfer.

On 08/31/18 at 7:06 AM during an interview with the Admissions Development Coordinator she stated she thought the Nurses' informed the resident's RP of the resident's transfer to the hospital.

On 08/31/18 at 7:05 PM during an interview with the Divisional Executive Director he stated the facility sent a written notice of admission to the hospital to the Ombudsman not the resident or the Resident's Representative.

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