PRINTED: 08/14/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345388	B. WING	B. WING		C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER	REHAB		620	EET ADDRESS, CITY, STATE, ZIP CODE  TOM HUNTER ROAD  ARLOTTE, NC 28213	, 0.,	VEIZUET
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
F 550 SS=D	survey was conducte 7/2/24. The following NC00218407 and NC complaint allegations Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, ar access to persons an outside the facility, in this section.  §483.10(a)(1) A facility with respect and dign resident in a manner promotes maintenancher quality of life, recindividuality. The facil promote the rights of \$483.10(a)(2) The facil access to quality care severity of condition, must establish and more provision of services residents regardless of the services regardless of the services residents regardless of the services residents regardless of the services residents regardless of the services regardless of the services residents regardless of the services regard	intakes were investigated 200218123. Six of the eight resulted in a deficiency. cise of Rights (2)(b)(1)(2)  Rights. ght to a dignified existence, and communication with and discretizes inside and cluding those specified in the symust treat each resident ity and care for each and in an environment that the or enhancement of his or	F	550			7/26/24
		right to exercise his or her f the facility and as a citizen					
	§483.10(b)(1) The fac	cility must ensure that the					
ABODATORY	DIDECTOR'S OF PROVIDERS	SLIPPLIER REPRESENTATIVE'S SIGNATUE	DE .		TITI F	_	(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/19/2024

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.

**Electronically Signed** 

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F 550	interference, coercio	e 1 his or her rights without n, discrimination, or reprisal	F 5	50		
	free of interference, or reprisal from the facil rights and to be supplexercise of his or her subpart.  This REQUIREMENT by: Based on observation interview, and staff in provide incontinence requested incontinence requested incontinence activity. This failure of the activity when she soiled and wet brief. very upset, angry and sampled residents represent.  The findings included The admission date of was 11/6/15.  The 8/2/23 annual Massessment recorded Resident #2 to attend Resident #2 to attend depressive episodes Resident #2 may exactaims and allegation included encouraging included encouraging included encouraging included encouraging included in the supplementation in the suppl	sident has the right to be coercion, discrimination, and ity in exercising his or her corted by the facility in the rights as required under this. It is not met as evidenced ons, record review, resident atterviews, the facility failed to care when Resident #2 ce care before attending an aused Resident #2 to miss remained in her room in a This made the Resident feel dicry. This occurred for 1 of 2 viewed for dignity and it is for Resident #2 to the facility failed to did her favorite activities.  In revised November 2023 bladder incontinence and and the care plan recorded that aggerate events, make false as at times. Interventions geffective communication, ence, providing peri-care		F550 Resident #2 was observed in the din room on 7/2/2024 well-groomed and Current residents that require staff assistance with toileting needs were audited for timely incontinent care by Director of Nursing on 7/2/24. On 7/2/24 to 7/5/24 the Director of Nursing initiated staff education to th nursing department to cover timeline incontinence care in order to attend activities. The facility will educate al employees on hire. As needed traini will continue with all staff. The Director of Nursing or designee conduct random audits related to incontinent care three times a week four weeks then weekly for four week four weeks then weekly for four week The Quality Assurance Performance improvement committee members of but not limited to Administrator, Di of Nursing, Unit Manager, Social Services, Medical director, maintena Director, Housekeeping Services, die Manager, and Minimum data Set Nur and minimum of one direct care give The Director of Nursing will report fin	dry.  the  e ess of I new ng will  for es.  onsist rector  nce etary rse r.	

Facility ID: 923058

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING			C 07/02/2024	
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIINTED \	WOODS NURSING AND	DEHAR		62	20 TOM HUNTER ROAD		
HUNTER	WOODS NORSING AND I	REHAD		С	HARLOTTE, NC 28213		
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F 550	Continued From page	<b>2</b>	F:	550			
F 550	after each incontinent schedule to accommon participation as requerencouraging participation as requerencouraging participation as requerencouraging participation. Resident #2's most redated 5/1/24 recorded adequate vision, with speech, understood, cognition, required sutoilleting hygiene assistincontinence, and always and a 6/7/24 grievance redirector indicated that turned on her call light Nurse Aide (NA) #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that the recorded that NA #1 acare but had to wait. The recorded that NA #1 acare but had to wait. The recorded that the record	t episode, modifying daily odate community life ested by the resident and ation in activities of choice.  Eccent MDS assessment dadequate hearing, corrective lenses, clear understands, intact abstantial to maximum stance, frequent bladder evays incontinent of bowel.  Eccorded by the Activity to n 6/7/24, Resident #2 at at 1:47 PM and requested essist her with incontinence. The investigation findings evas educated to ensure in to the Resident. Post to recorded by the Social evance follow up and rievance.  In of Resident #2 on 7/2/24 at #2 was in the activity room mair and well-groomed.  after she finished the evaluation of the talk about a grievance she iiew on 7/2/24 at 11:00 AM, at on 6/7/24 she put on her Resident #2 further stated, "It re 2 pm, because the eved by my room to see if I	F	550	to the Quality Assurance Performance Improvement meeting monthly for three months. The findings of the monitoring tool will be discussed/reviewed in Qual Assurance Performance Improvement meeting.  Date of compliance will be July 26, 202	J ity	
	I told her I was comin changed." Resident #	and bingo started at 2 (PM). g as soon as I got 2 said she told the Activity bowel movement) on me,					

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F 550	Activity Director said her know Resident #2 but NA #1 never came she sat there in her rethe MDS Nurse came incontinence care. Revery upset and angry I was upset that I had and a half to get char wait that long. It just to myself, and I have to Resident #2 stated the provided incontinence Resident #2 stated the apologized the next of had to leave and stat but that it upset me to wait that long to be close the continent of the continent of the continent in the co	dent #2 reported that the she would find NA #1 to let 2 needed incontinence care, e back. Resident #2 said from in a soiled/wet brief until 2 "much later" and provided resident #2 said "It made me and I told (the MDS Nurse) I to wait for about an hour finged, no one should have to supset me that I can't care for wait on staff to help me."  I that after the MDS Nurse recare, "I felt better."  I felt better."  I falt NA #1 came and lay, and explained why she red, "I told her I understood, or miss bingo and to have to hanged."  M the Activity Director stated	F	5550			
	on 6/7/24 the Activity #2 in her room, seated call light was on. The her watch and said "ifor bingo" and asked coming to bingo. The Resident #2 said "yest call light a few mome incontinence care be Activity Director said identify her NA and Refl. The Activity Director that she would find N Resident #2 needed Activity Director said could not locate her seaten.	with Resident #2 present that Director observed Resident Id in her wheelchair, and her Activity Director looked at It's 1:47 PM it's almost time Resident #2 if she was If that she just turned on her Ints ago to receive If the going to bingo. The If the she asked Resident #2 to It the she asked Resident #2 If the she went to find NA #1 but If the she					

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F 550	was in her room with incontinence care. To that after bingo, which that day, she went to was the Assistant Dir the time, and told the who were both in the not attend bingo. The MDS Nurse said she find out what happen the Activity Director, had to wait for over a incontinence care who she filed a grievar she preferred to get out of her room for mostated "Me in my room tated "Me in my room stated that she no low when she did, she wishift. NA #1 stated that 3 PM shift, she proving Resident #2 around the described that Resid and spent most of her said that around 2 #2's call light was on came and told NA #1 be changed. NA #1 seid "I told her I her back. NA #1 said "I told her I her back. NA #1 said mechanical lift but con NA to help her find it said there were 3 call that are were 3 call that are were 3 call that are were 3 call there were 3 call that are were 3	he DON that Resident #2 her light on and needed he Activity Director stated the extended until 3:30 PM to the MDS Nurse office, who rector of Nursing's (ADON) at the MDS Nurse and the DON, to office, that Resident #2 did the Activity Director said the the would go to Resident #2 to the would go to Resident #2 stated that the the saident #2 stated that the the the would go to receive the and activities, she the m, no, I like to be out."  1	F	550				

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F 550	resident rooms and vother residents it was looked again for the mot find it, so she had the 3 PM to 11 PM st discussing the assign Resident #2 would re NA#1 said the next dapologize to Resident incontinence care on Resident #2 that she "I know (Resident #2 be upset that I did no care, so I went to apologized, she said she was okay, but the was left wet/soiled so appreciated the apolok knew she would be under the work of the revealed she was the Resident #2 on 6/7/2 Nurse #1 stated she Resident #2. Nurse #4 expressed that he "hours", but her light Nurse #1 stated she Resident #2's call light because she was off assisting another nur Nurse #1 said she did on so she did not know assistance. Nurse #1 the unit, she overhead	ts that were on in 2 other when she finished caring for a 3:07 PM. NA #1 said she mechanical lift, but still could at to go. NA #1 said she saw aff at the nurse's station ment, so she knew aceive incontinence care. ay, she went right away to at #2 for not providing 6/7/24 when she told would be back. NA #1 said and I know that she would at come back to give her blogize." When NA #1 Resident #2 responded that at she was upset that she be long. Resident #2 said she bogy, but NA #1 stated, "I proset."  At at 4:35 PM with Nurse #1 assigned Nurse for a for the 7 AM to 3 PM shift. The recalled the incident with at said in the past Resident was on for was on for a few minutes, so could not be certain if an the unit for 30 - 35 minutes are, so she did not see it. It and the Resident #2's light tow that the Resident #2's l	F 55		

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		· ,	(X3) DATE SURVEY COMPLETED	
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F 550	3:00 PM. The MD the incident with F She further stated to her office on 6/ while the ADON a and reported that since 1:47 PM and care. The MDS Ni Resident #2, she for Resident #2 or had provided inco since change of si because she did ricare for Resident Nurse said when she found Resident was on, she was sand crying. The MDS Ni reported she had #1 to come change bingo. The MDS Ni resoiled with feces a The MDS Nurse soiled with feces a The MDS Nurse sincontinence care was still upset and it was hard waiting her.  During an intervier #1, she stated she Resident #2 for the she did not know for Resident #2 or shift until the MDS after change of she	large 6 Was interviewed on 7/1/24 at S Nurse said that at the time of Resident #2, she was the ADON. It that the Activity Director came 7/24 a little before 3:30 PM Ind DON were there together Resident #2's call light was on Id she needed incontinence Iurse said on the way to see Iasked MA #1, the NA assigned In the 3 PM to 11 PM shift, if she Intinence care to Resident #2 Inift. The MA #1 said no Inot know she was assigned to If 2 on that shift. The MDS Ishe went to see Resident #2, Inift #2 in her room, her call light Inseated in her wheelchair, upset IDS Nurse said Resident #2 IDS Nurse said Resident #2 IDS Nurse said, Resident #2 IDS Nurse asked her sometime	F	550			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 550	aware that she was the state of the Activity Direwaited on 6/7/24 for in hour and that a griev Services Director said on 6/8/24 and advise be taken care of . Reseducating staff was in further said that she was that long for som light. The Social Services Director said Resident #2 a couple "so far so good" and same incident occurr Director provided a currolled a couple of the Activity Direwaited on 6/7/24 for in hour and that a griev Services Director said on 6/8/24 and advise be taken care of. Reseducating staff was in further said that she was that long for som light. The Social Services Director said Resident #2 a couple "so far so good" and same incident occurr Director provided a currolled	the MDS Nurse she was not the assigned NA for Resident PM shift so she had not at #2 yet. MA #1 stated that she would go start the Resident #2 and asked MA A #1 stated she was ident with care at the time, she went to assist the MDS #2's care. MA #1 stated assist with Resident #2's M, her call light was off, and already changed her brief. #2 was upset, and crying was crying because she d to wait to be changed.	F 5	50		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER ROAD CHARLOTTE, NC 28213		7/102/2024	
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F 584 SS=D	DON stated Resident reporting incidents ar investigated staff four occur as Resident #2 that she did recall the aware on 6/7/24 that Resident #2 before 2 Resident #2 what she she needed incontine she could not recall the aware of this, but who she delegated to the Resident #2 which wo DON stated that staff call light was on befor needed incontinence Resident #2 to wait for receive care. The DO have been on the unit were on, found out wo rendered the care. The went to Resident #2. The Interesident #2. The Interesident #2 the Activity Director and Interesident and Safe/Clean/Comforta CFR(s): 483.10(i) Safe Envir The resident has a right as a significant was a significant with the same investment of the same investment in the sa	on 7/2/24 at 8:59 AM. The #2 had a history of a when the incident was and that the incident did not described. The DON stated a Activity Director made her she saw the light on for PM and when she asked a needed, Resident #2 said ance care. The DON said the exact time she was made an she was made aware, MDS Nurse to check on as around 3:30 PM. The witnessed Resident #2's re 2 PM because she care and that it upset for over an hour and a half to pN stated that NA #1 should at and observed if call lights that the resident needed and the MDS Nurse said when #2, her call light was on, provided incontinence care DON, the MDS Nurse and III confirmed that it was not at to wait in a wet/soiled brief a half for incontinence care. The ble/Homelike Environment with the a safe, clean, the elike environment, including the elike environment and the exact time incident was a side of the exact time and the exact time incident was a side of the exact time and the exact time incident was and the exact time an	F 5			7/26/24	

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F 584	homelike environmer use his or her person possible.  (i) This includes ensureceive care and semphysical layout of the independence and do (ii) The facility shall ethe protection of the for theft.  §483.10(i)(2) Housek services necessary to and comfortable interested and comfortable interest	clean, comfortable, and at, allowing the resident to hal belongings to the extent suring that the resident can vices safely and that the resident can vices safely and that the resident can vices safely and that the resident can vices a safety risk.  The resident's property from loss resident's property from loss resident's property from loss receping and maintenance of maintain a sanitary, orderly, rior;  The dead and bath linens that are reclosed space in each recified in §483.90 (e)(2)(iv);  That and comfortable lighting retable and safe temperature ally certified after October 1, at temperature range of 71 to remaintenance of comfortable residuals in the residuals and staff interviews the dead clean homelike registed to clean tube	F 58	F584 Intravenous Pole in in Room #201 wa cleaned on 7/2/24.	S
	_	e feeding tube pole and t rooms that had tube		Intravenous Poles were audited for cleanliness by the Director of	

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NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER \	WOODS NURSING AND	REHAB			20 TOM HUNTER ROAD		
				С	CHARLOTTE, NC 28213		
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F 584	Continued From page	e 10	F:	584			
	feeding formula (Roo				Housekeeping on 7/2/24.		
	looding formula (1.00	111 20 1).			On 7/2/24 to 07/05/24 the Director of		
	The findings included	l:			Housekeeping initiated staff education	to	
	J				the housekeeping department to clean		
	An observation was r	nade of Room #201 on			Intravenous Poles during room cleanin	g	
		1. There was a feeding tube			daily or anytime equipment appears dir		
		pole beside the bed. The			The facility will educate all new employ		
		bserved to have dried light			on hire. As needed training will continu	ıe	
	brown substances that appeared to be tube				with all staff.		
	_	dried formula covered the			The Executive Director or designee wil		
	pole, the bottle of the pole, and the floor under				conduct audits related to cleanliness of	all	
	the pole.				medical equipment two times a day 5		
	An observation was	made of Room #201 on			days/week for four weeks and then one time a day for four weeks. The Quality		
		1. There was a feeding tube			Assurance Performance improvement		
		pole beside the bed. The			committee members consist of but not		
		bserved to have dried light			limited to Administrator, Director of		
	-	at appeared to be tube			Nursing, Unit Manager, Social Services	S.	
		dried formula covered the			Medical director, maintenance Director		
	_	pole, and the floor under			Housekeeping Services, dietary Manag		
	the pole.				and Minimum data Set Nurse and		
					minimum of one direct care giver. The		
		nade of Room #201 on			Director of Housekeeping will report		
		There was a feeding tube			findings to the Quality Assurance		
	l'	pole beside the bed. The			Performance Improvement meeting	_	
	·	bserved to have dried light			monthly for three months. The findings	of	
		at appeared to be tube			the monitoring tool will be		
	_	dried formula covered the			discussed/reviewed in Quality Assuran	ce	
	•	pole, and the floor under			Performance Improvement meeting.  Date of Compliance will be July 26, 202	24	
	the pole.				Date of Compliance will be July 20, 20.	<b>-</b> +	
	An observation was r	made of Room #201 on					
		There was a feeding tube					
		pole beside the bed. The					
		bserved to have dried light					
	·	at appeared to be tube					
		dried formula covered the					
	_	pole, and the floor under					
	the pole.						

Facility ID: 923058

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		345388	B. WING			C 07/02/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER ROAD CHARLOTTE, NC 28213	1 '	37/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 584	Continued From pag	e 11	F 58	34			
	07/02/24 at 9:25 AM was asked to observe the dried light brown feeding formula. He housekeepers were feeding formula to hi and floor needed to land left to soak and to remove the dried shousekeeper Director housekeeping staff of carts that were need substances so they here of it. The h	to report any dried tube m. He explained that the pole pe sprayed with a cleaner then a scraper was required substances. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345388	B. WING _			C / <b>02/2024</b>	
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER ROAD CHARLOTTE, NC 28213	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIV X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 584 F 677 SS=D	of her shift but was su the rooms and hallware debris that would need. The Director of Nursin 07/02/24 at 11:46 AM stated that if any mending dried tube feeding for then she expected the it to someone who control of the Administrator wan 4:10 PM who indicates have been cleaned by the facility. ADL Care Provided for CFR(s): 483.24(a)(2)	that room for the remainder apposed to be monitoring tys for spills, trash, or other ad her attention.  In g was interviewed on the Director of Nursing the staff noted the smula on the pole and floor e staff to clean it up or report		677		7/26/24	
	out activities of daily I services to maintain gersonal and oral hygonis REQUIREMENT by: Based on observation interview, and staff in provide incontinence 2 dependent resident activities of daily living The findings included.  The admission date fewas 11/6/15 with diagonal activities of daily living the admission date fewas 11/6/15 with diagonal and or activities of daily living the admission date fewas 11/6/15 with diagonal and or activities of daily living the admission date fewas 11/6/15 with diagonal and or activities of daily living the admission date fewas 11/6/15 with diagonal and or activities of daily living the admission date fewas 11/6/15 with diagonal and or all hygonisms and or al	iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced  ns, record review, resident terviews, the facility failed to care when requested to 1 of s (Resident #2) reviewed for g.  :  or Resident #2 to the facility gnoses that included major anxiety disorder, overactive		F677 Resident #2 was observed in the dir room on 7/2/2024 well-groomed and Current residents that require staff assistance with toileting needs were audited for timely incontinent care b Director of Nursing on 7/2/24. On 7/2/24 to 7/5/24 the Director of Nursing provided staff education to nursing department to cover timeline incontinence care in order to attend activities. The facility will educate a employees on hire. As needed train	dry.  the  he ess of		

` '		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345388	B. WING			C 07/02/2024	
NAME OF P	ROVIDER OR SUPPLIER	0.0000	<del>                                     </del>	STREET ADDRESS, CITY, STATE, ZIP COD	<b>I</b>	07/02/2024	
TO UNE OF TH	TO VIDER OR GOLF EIER			620 TOM HUNTER ROAD	_		
HUNTER \	WOODS NURSING AND	REHAB					
				CHARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	e 13	F 6	77			
	assessment recorded Resident #2 to attend The care plan, revise	inimum Data Set (MDS) If it was very important to If her favorite activities. If November 2023 indicated the land bladder incontinence		will continue with all staff. The Director of Nursing or de conduct random audits relate incontinent care three times a four weeks then weekly for fo The Quality Assurance Perfor improvement committee mem	d to a week for ur weeks. rmance		
	Resident #2 had bowel and bladder incontinence and depressive episodes related to immobility, and a neurogenic disorder. The care plan			of but not limited to Administration of Nursing, Unit Manager, So Services, Medical director, manager,	ator, Director cial		
	recorded that she may exaggerate events, make false claims and allegations at times.  Interventions included encouraging effective communication, checking for incontinence, providing peri-care after each incontinent episode, modifying daily schedule to accommodate community life participation as			Director, Housekeeping Servi Manager, and Minimum data and minimum of one direct ca The Director of Nursing will re to the Quality Assurance Perf Improvement meeting monthl	ices, dietary Set Nurse are giver. eport findings formance		
	requested by the resi participation in activit	dent and encourage ies of choice.		months. The findings of the r tool will be discussed/reviewe Assurance Performance Impr	nonitoring ed in Quality		
	recorded adequate he corrective lenses, cle understands, intact of to maximum toileting	ntinence, and always		meeting. Date of Compliance will be Ju	ıly 26, 2024		
	Director indicated that call light on 6/7/24 at	ecorded by the Activity at Resident #2 turned on her 1:47 PM and requested assist her with incontinence					
	10:30 AM, Resident # activity room seated i well-groomed. Reside finished the activity, s	n of Resident #2 on 7/2/24 at #2 was observed in the in her wheelchair and ent #2 said that after she she wanted to talk about a During an interview on 7/2/24					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			، ا	С
		345388	B. WING				02/2024
NAME OF PI	ROVIDER OR SUPPLIER	2.0000			STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	02/2024
					620 TOM HUNTER ROAD		
HUNTER \	WOODS NURSING AND	REHAB			CHARLOTTE, NC 28213		
(V4) ID	QUIMMADV QT	TATEMENT OF DEFICIENCIES	ID	l	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 677	Continued From page	e 14	F	677	7		
		nt #2 stated that on 6/7/24		011			
		that on 0///24 tht after lunch. Resident #2					
		st have been before 2 pm,					
		Director stopped by my room					
		g to bingo, and bingo started					
	_	was coming as soon as I got					
	changed." Resident #	‡2 said she told the Activity					
		powel movement) on me,					
		dent #2 reported that the					
		she would go and find NA #1					
		ent #2 needed incontinence					
	· ·	r came back. Resident #2					
		her room in a soiled/wet brief came "much later" and					
		e care. Resident #2 said that					
	· .	provided incontinence care					
		ted "That's not her job, so if					
		give me care, that's a					
		nebody is not doing their					
	job." Resident #2 sai	id "I told (the MDS Nurse)					
		about an hour and a half to					
		should have to wait that					
		ated that after the MDS					
	•	tinence care, "I felt better."					
	Resident #2 stated th						
		lay, and explained why she ed, "I told her I understood."					
	Tiad to leave and stat	ed, I told fiel I dilderstood.					
	On 7/1/24 at 12:30 P	M the Activity Director stated					
		rith Resident #2 present that					
	_	Director rounded before the					
	bingo activity at 2:30	PM to take residents to					
	0	attend. The Activity Director					
		arrived at Resident #2's					
	· ·	as seated in her wheelchair,					
	_	the Activity Director looked					
	I -	o Resident #2 and said "it's					
		me for bingo" and asked					
	Resident #2 if she wa	as coming to bingo. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILE			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		, ا	c
		345388	B. WING				02/2024
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHAB	•	6	TREET ADDRESS, CITY, STATE, ZIP CODE 20 TOM HUNTER ROAD CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CTATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	that she just turned moments ago to recogning to bingo. The asked Resident #2 stated Director said she to find NA #1 to let her needed incontinence bingo. The Activity INA #1 but could not Activity Director saw (DON), the Activity If that Resident #2 was in her room with incontinence care. That she went to state even though the act PM, residents came bingo. The Activity continued longer that Resident #2 did not the Activity Director Nurse office, who we Nursing's (ADON) and Nurse and the DON together, that Resident #2 did not the Activity Director, who we happened. During the Director, Resident #2 did not the Activity Director she would go to Resident #2 did not the Activity Director she would go to Resident #4 attend the bingo act had to wait for inconstated that she preferand come out of her activities, she stated be out."	ge 15 ed that Resident #2 said "yes" on her call light a few eive incontinence care before Activity Director said she to identify her NA and t was NA #1. The Activity d Resident #2 that she would know that Resident #2 e care and wanted to go to Director said she went to find locate her so when the the Director of Nursing Director reported to the DON inted to go to bingo, but she her light on and needed The Activity Director stated if the bingo activity because ivity was scheduled for 2:30 as early as 2:00 PM for Director stated bingo at day, until 3:30 PM but that attend. After bingo was over said she went to the MDS as the Assistant Director of t the time, and told the MDS who were in the office ent #2 did not attend bingo. said the MDS Nurse said sident #2 to find out what he interview with the Activity 2 stated that she did not ivity that day because she tinence care. Resident #2 erred to get up, get dressed from for meals and I "Me in my room, no, I like to	F	677			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(	С
		345388	B. WING			1	02/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				6	20 TOM HUNTER ROAD		
HUNTER \	WOODS NURSING AND	REHAB		c	CHARLOTTE, NC 28213		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 677	Continued From pag	ge 16	F	677			
		nger worked at the facility but					
		facility on the 7 AM to 3 PM					
		nat on 6/7/24 7 AM to 3 PM					
	**	ssigned NA for 500 hall and					
		assigned residents. She					
	_	#2 was on her assignment					
		provided morning care to					
		9:00 or 10:00 AM. NA #1					
	described that Resid	dent #2 liked to be up/dressed					
	and spent most of he	er time out of her room. NA					
	#1 said that around	2:40 PM on 6/7/24, Resident					
	#2's call light was or	n, and the Activity Director					
	came and told NA#	1 that Resident #2 needed to					
	be changed. NA #1	said she told the Activity					
	Director that she wo	uld go help Resident #2 but					
	that she had to find	the mechanical lift (device					
		sistance) first. NA #1 said she					
		t #2's call light on before 2:40					
	_	been because she was					
		oms providing care on her last					
		A #1 said after she saw					
	_	n, she went to Resident #2's					
		#2 said she needed to be					
	_	d "I told her I had to find the					
		ack. NA #1 said she looked					
		ft but could not find it, asked					
		ner find it, but did not find it.					
		re 3 call lights on at the time					
		h included Resident #2's light,					
	•	I to the lights that were on in 2					
		s and when she finished					
	_	dents it was 3:07 PM. NA #1					
		in for the mechanical lift, but					
		so she had to go. NA #1 said o 11 PM staff at the nurse's					
		e assignment so she knew					
	_	eceive incontinence care.					
		day, she went right away to					
		nt #2 for not providing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345388	B. WING _				0 <b>2/2024</b>	
	ROVIDER OR SUPPLIER	REHAB		620 TOM HU	RESS, CITY, STATE, ZIP CODE NTER ROAD 'E, NC 28213	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page	e 17	F 6	77				
	apologized, she said she was ok. Resident apology.	would be back. When NA #1 Resident #2 responded that #2 said she appreciated the  4 at 4:35 PM with Nurse #1						
	Resident #2 on 6/7/24 Nurse #1 stated she i Resident #2 because with a resident on and	4 for the 7 AM to 3 PM shift. recalled the incident with she had to assist a nurse other hall. Nurse #1 said she #2's call light on before						
	2:15 PM and in the pathat her call light was was on for a few minu	time between 2:00 PM and ast Resident #2 expressed on for "hours", but her light utes, so Nurse #1 stated she for how long Resident #2's						
	call light was on, beca Nurse #1 said she wa about 30 to 35 minute unit for 15 or 20 minu	ause she did not see it. as off the unit in total for es. Nurse #1 said she left the tes, returned to the unit to off the unit for another 15 to						
	20 minutes, but that s #2's light on so she d	she did not see Resident id not know that the istance. Nurse #1 stated						
	minutes, she overhea	ord the MDS Nurse talking to out how long Resident #2						
	3:00 PM. The MDS N the incident with Resi She further stated tha to her office on 6/7/24 while the ADON and and reported that Res	interviewed on 7/1/24 at Jurse said that at the time of dent #2, she was the ADON. At the Activity Director came 4 a little before 3:30 PM DON were there together sident #2's call light was on MDS Nurse stated the Activity						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345388	B. WING _			C 07/0	2/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE	0.70	
HUNTER \	WOODS NURSING AND I	REHAB		620 TOM HUNTER ROAD CHARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE FO THE APPROPRIA		(X5) COMPLETION DATE
F 677	Continued From page	e 18	F	677			
	Director reported that receive incontinence Resident #2 did not con Nurse said she went found her in her room was seated in her who said Resident #2 reportoom waiting for NA # so she could go to bir just changed her mys Resident #2's brief show moderately" wet with the bed linens were now as not red or excortische looked for NA #1 incontinence care to already left the facility she spoke to NA #1 the when she arrived at the said NA #1 said that she because it was the ergo and had already so the MDS Nurse said she had to wait for he needed incontinence provide the care.	Resident #2 needed to care before bingo and that ome to bingo. The MDS to see Resident #2 and and the call light was on, she eelchair. The MDS Nurse ported she had been in her left to come change her briefingo. The MDS Nurse said "I left." The MDS Nurse said urine, but her clothes and to traine, but her clothes and to to soiled or wet and her skin ated. The MDS Nurse said on 6/7/24 after she provided Resident #2, but NA #1 had and to the mext morning after 7 AM the facility. The MDS Nurse said the next morning after 7 AM the facility. The MDS Nurse she had to leave on 6/7/24 and of her shift, so she had to tayed a little over her shift. She re-educated NA #1 that are relief and if a resident care, the NA had to go and					
	on 6/7/24 in a differer the NA for Resident # MA #1 stated she did assigned NA for Resi PM to 11 PM shift unt sometime after chang checked on Resident	•					
	Nurse she was not av	A #1 said she told the MDS vare that she was the dent #2 for the 3 PM to 11					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING				02/2024
	ROVIDER OR SUPPLIER	REHAB	1	620	REET ADDRESS, CITY, STATE, ZIP CODE 10 TOM HUNTER ROAD HARLOTTE, NC 28213	1 011	V2/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	yet. MA #1 stated that would go start the ince #2 and asked MA #1 stated she was assist care at the time, so we to assist the MDS Nu MA #1 stated when so Resident #2's care, it light was off, and the changed her brief.  The DON, MDS Nursinterviewed on 7/2/24 stated Resident #2 had incidents and when the staff found that the in Resident #2 described did recall the Activity 6/7/24 that she saw the before 2 PM and when what she needed, Reattend bingo but need the DON said she comade aware of this be when she was made MDS Nurse to check around 3:30 PM. The went to Resident #2, MDS Nurse provided	e 19 not checked on Resident #2 at the MDS Nurse said she continence care to Resident to come assist. MA #1 ting another resident with when she finished, she went rse with Resident #2's care. he arrived to assist with was after 3 PM, her call MDS Nurse had already  e and Activity Director were at 8:59 AM. The DON ad a history of reporting he incident was investigated cident did not occur as d. The DON stated that she Director made her aware on he light on for Resident #2 en she asked Residen	F	377	DEFICIENCY)		
	call light on because care. The DON, the N Director all stated that expectation for a resinand a half for inconting that the NA should have	she needed incontinence MDS Nurse and the Activity It it was not a reasonable dent to wait for over an hour nence care. The DON stated ave been on the unit and were on, found out what the					

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345388	B. WING		١	C 7/02/2024		
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER ROAD CHARLOTTE, NC 28213		1702/202-1		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 693 SS=D	both percutaneous er percutaneous endoscenteral fluids). Based comprehensive assessensure that a residen §483.25(g)(4) A reside at enough alone or venteral methods unle condition demonstrate clinically indicated an resident; and §483.25(g)(5) A reside means receives the asservices to restore, if and to prevent complincluding but not limit diarrhea, vomiting, deabnormalities, and nathis REQUIREMENT by:  Based on observation Medical Director internadminister tube feedings ordered by the phyreviewed with tube feedings ordered with tube feedings or of ordered	eral Nutrition c and gastrostomy tubes, idoscopic gastrostomy and copic jejunostomy, and on a resident's esment, the facility must te- ent who has been able to with assistance is not fed by es the resident's clinical es that enteral feeding was d consented to by the  ent who is fed by enteral ppropriate treatment and possible, oral eating skills ications of enteral feeding ed to aspiration pneumonia, ehydration, metabolic sal-pharyngeal ulcers. I is not met as evidenced ons, record review, staff, and views the facility failed to ongs via a gastrostomy tube visician for 1 of 3 residents eding orders (Resident #3).	F 69	F693 Resident #3 feeding tube formul started on 7/1/24. Resident #3 and a 100% of all rewere audited for timely feeding to formula initiated per physician of the Director of Nursing on 7/1/24 On 7/2/24 to 7/5/24 the Director Nursing provided staff education nursing department to cover timenteral feeding formula initiation	esidents tube orders by 4. of of on to the eliness of	7/26/24		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING _				C ( <b>02/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	02/2024
			620 TOM HUNTER ROAD				
HUNTER \	WOODS NURSING AND I	REHAB			CHARLOTTE, NC 28213		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 693	Continued From page	21		693			
1 000	Continued i form page	5 2 1	-	093			
	A physician order det	od 05/05/24 road tubo			importance of following physician orde	īS.	
		ed 05/05/24 read, tube nuous at 65 milliliters (ml)			The facility will educate all new		
		omy tube. Flush gastrostomy			employees on hire. As needed training	1	
		ater every four hours.			will continue with all staff.	,	
		<b>,</b>					
	An observation was n	nade of Resident #3 on			The Director of Nursing or designee wi	II	
	07/01/24 at 11:06 AM	I. Resident #3 was resting in			conduct audits on 100% of all residents		
		ped elevated. There was a			related to enteral feeding care 3x week	for	
		anging from a pole beside			4 weeks and 1x week/for 4 weeks.		
		nere was no tube feeding			The Overlity Assumence Deufermen		
		the pole at the time. There eeding formula unopened			The Quality Assurance Performance improvement committee members con	cict	
		B's counter in his room at the			of but not limited to Administrator, Dire		
	end of his bed.	o counter in the room at the			of Nursing, Unit Manager, Social	5101	
					Services, Medical director, maintenance	е	
	An observation was r	made of Resident #3 on			Director, Housekeeping Services, dieta	ary	
		I. Resident #3 remained in			Manager, and Minimum data Set Nurse	Э	
		ped elevated. The feeding			and minimum of one direct care giver.		
		to hang from a pole sitting			T. D		
		bed. There was no feeding			The Director of Nursing will report		
		from the pole at the time.			findings to the Quality Assurance Performance Improvement meeting		
		of tube feeding formula esident #3's counter at the			monthly for 2 months. The findings of	the	
	end of his bed.	esident #03 counter at the			monitoring tool will be discussed/review		
					in Quality Assurance Performance		
	An observation was n	nade of Resident #3 on			Improvement meeting.		
	07/01/24 at 3:10 PM.	Resident #3 remained in					
	bed with his head of b	ped elevated. The feeding			Date of Compliance will be July 26, 20	24	
		to hang from a pole sitting					
		bed. There was no feeding					
		from the pole at the time.					
		of tube feeding formula					
	_	esident #3's counter at the					
		#1 was in Resident #3's					
		was questioned about eding and replied that					
		eding formula was due to be					
	rehung later in the sh						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING _				C ( <b>02/2024</b>
NAME OF PROVIDER OR SUP		REHAB		6	STREET ADDRESS, CITY, STATE, ZIP CODE 520 TOM HUNTER ROAD CHARLOTTE, NC 28213	<u>,                                    </u>	<b>Y = - V = -</b>
PREFIX (EACH [	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
who stated Repersion be rehung at she had remed 10:00 AM be was empty. Very again about I replied she had required have easily related have tube feed 65 ml per how his head of behave tube feed 65 ml per how as leaking or replace the transplace the transplace the transplace transplace the transplace transplace the transplace tr	s interview 24 at 5:3 that Researlier in ube and Director 0:06 AM Director stated he but did he fire decision	ewed on 07/01/24 at 4:07 PM #3's tube feeding was due to 9:00 PM. She stated that tube feeding at around e bottle that was hanging larse #1 was questioned #3's tube feeding she other residents on the unit dings and stated, "I could t." Nurse #1 obtained her dent #3's orders and stated, us, and I will go hang it back sident #3 on 07/01/24 at sident #3 resting in bed with sted. He was observed to mula infusing via pump at was conducted with Nurse 1 PM, she stated she sident #3's gastrostomy tube the shift, and she had to she just forgot to restart the was interviewed on I who stated he had been since June 2024 but had in the facility for one or two was not too familiar with ave some baseline ditions. He stated that he have residents on ing but he definitely deferred to the Registered Dietitian. stated that the tube feeding	F	693			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		STRUCTION	(X3) DATE SURVEY COMPLETED		
		345388	B. WING			l	02/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP CODE	1 011	02/2024	
HUNTER \	WOODS NURSING AND	REHAB			M HUNTER ROAD LOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 693	Continued From page	e 23	F	693				
	tube was replaced, a	tely been restarted when the nd Resident #3 should not ty of the day without his						
	07/02/24 at 11:46 AM Resident #3's gastros 07/01/24 and had to be was not aware that the immediately restarted gone the majority of the feeding. The Director Resident #3's tube feed	ng was interviewed on I who stated she was aware stomy tube was leaking on the replaced. She stated she the nursing staff had not I his feeding and he had the day without his ordered of Nursing stated that the ding should have been I when his tube was back in order.						
	phone on 07/02/24 at she was familiar with following him often do to the facility. She stated to the facility. She stated to the facility. She stated that feedings in the past at the past. The Dietitian Resident #3 was orde 65 ml per hour contin had been stable over Resident #3 specificatube feeding because was less volume at one easier on his body received the red in the dietal state of the property of the pro	tated that Resident #3 was						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SU COMPLE		
		345388	B. WING		_	C 07/02/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01702	72024	
				620 TOM HUNTER ROAD			
HUNTER \	WOODS NURSING AND I	REHAB		CHARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parentera	al Fluids.	F 69	94	7/	26/24	
	Parenteral fluids mus with professional star accordance with physicomprehensive personal the resident's goals a	t be administered consistent ndards of practice and in sician orders, the on-centered care plan, and					
	Based on observatio	ns, record review, staff, and views the facility failed to		F694 Resident #3 Peripherally Inserted	Central		
	_	to a peripherally inserted		Catheter dressing was changed or	1		
	,	C line or an intravenous line)		07/01/24.			
		/sician for 1 of 1 residents medication (Resident #3).		Resident #3 and 100% residents the	nat		
	receiving intraverious	medication (Resident #5).		require peripherally inserted centra			
	The finding included:			catheter were audited for appropriate dressing changes per physician or	ate		
		ally admitted to the facility on					
		cently readmitted to the		On 07/01/24 to 7/5/24 the Director			
		ith diagnoses that included		Nursing initiated staff education to			
	osteomyenus or press	sure ulcer and an abscess.		nurses to cover timeliness of dress changes and the importance of follows:	•		
	Review of a hospital of	discharge summary dated		physician orders. The facility will e			
	06/17/24 indicated that			all new employees on hire. As nee			
		central catheter (PICC) line al on 06/13/24 at 3:46 PM.		training will continue with all staff.			
	A physician arder det	od 06/20/24 rood		The Director of Nursing or designe			
	A physician order date intravenous (IV) cathe			conduct audit on Resident #3 and of all residents related to periphera			
	, ,	nt upper extremity and apply		inserted central catheter dressing	illy		
		y Thursday on day shift.		changes care 3xW/for 4 weeks the weekly for 4 weeks.	n		
	Review of the Medica	ition Administration Record					
	, ,	23 revealed that on June		The Quality Assurance Performand			
		7, 2024, Nurse #2 initialed		improvement committee members			
	_	at she had cleaned and 3's right upper extremity and		of but not limited to Administrator, of Nursing, Unit Manager, Social	Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING			l	C
NAME OF D	ROVIDER OR SUPPLIER	0.40000			STREET ADDRESS, CITY, STATE, ZIP CODE	071	/02/2024
NAME OF T	NOVIDEN ON 3011 LIEN				320 TOM HUNTER ROAD		
HUNTER V	WOODS NURSING AND	REHAB					
					CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 694	Continued From pag	je 25	F 6	694			
		r dressing to the PICC line.			Services, Medical director, maintenance	е	
	- <b> -</b>				Director, Housekeeping Services, dieta		
	An observation was	made of Resident #3 on			Manager, and Minimum data Set Nurse	•	
	07/01/24 at 11:06 AM	M. Resident #3 was resting in			and minimum of one direct care giver.		
		bed elevated. He was noted					
		in his right upper extremity			The Director of Nursing will report		
		th a clear dressing. The			findings to the Quality Assurance		
		to have rolled up at the edges			Performance Improvement meeting		
		articles on the sticky side of			monthly for 2 months. The findings of t		
		d rolled up. The clear 06/13/24 at 3:59 PM.			monitoring tool will be discussed/review in Quality Assurance Performance	/eu	
	dressing was dated	00/13/24 at 3.59 FW.			Improvement meeting.		
	An observation was	made of Resident #3 on			improvement meeting.		
		M. Resident #3 remained in			Date of Compliance will be July 26, 202	24	
	bed with his head of	bed elevated. He was noted					
	to have a PICC line	in his right upper extremity					
	that was covered wit	th a clear dressing. The					
		to have rolled up at the edges					
		articles on the sticky side of					
	_	d rolled up. The clear					
	dressing was dated	06/13/24 at 3:59 PM.					
	An observation was	made of Resident #3 on					
		Resident #3 remained in					
		bed elevated. He was noted					
		in his right upper extremity					
		th a clear dressing. The					
		to have rolled up at the edges					
		articles on the sticky side of					
	the dressing that had	d rolled up. The clear					
	dressing was dated	06/13/24 at 3:59 PM.					
	An observation was	made of Resident #3 along					
		Nursing on 07/01/24 at 5:12					
		Nursing on 07/01/24 at 3.12  Nursing confirmed that the					
		's PICC line dressing in his					
		was 06/13/24 at 3:59 PM.					
		isly had not been changed"					
	as documented on the						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345388	B. WING			1	0 <b>2/2024</b>
	ROVIDER OR SUPPLIER	REHAB		620	REET ADDRESS, CITY, STATE, ZIP CODE TOM HUNTER ROAD IARLOTTE, NC 28213	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 694	Continued From page	≥ 26	F	694			
F 695 SS=D	at 5:21 PM, Nurse #2 facility at least once a stated she had not chine dressing in the latexplain why it was do she had completed th #2 stated that she had it was dated for that sit had already been of that maybe it was an The Medical Director 07/02/24 at 10:06 AM dressings were scheet to cut down on the ris been two weeks and Medial Director state #3 to get septic (seve has been in place an weeks. "It is not good The Director of Nursi 07/02/24 at 11:46 AM #3's PICC line dressi the physician order. So not get a lot PICC line the first or second on building. However, the physician order is completed weekly an completed as ordered Respiratory/Tracheos CFR(s): 483.25(i) Respirator	I who stated PICC line duled to be changed weekly sk of infection and it had needed to be changed. The did he did not want Resident ere infection) from a line that did not been cared for in two practice."  Ing was interviewed on I who stated that Resident eng should have changed per she added that the facility did es, and this may have been e that she had seen in the e Director of Nursing stated that the dressing was to be did it should have been did.	F	695			7/26/24
	CFR(s): 483.25(i) § 483.25(i) Respirato	ry care, including					., _ 3, _ 1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING _		, ا	C 07/02/2024
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER ROAD CHARLOTTE, NC 28213		3110212024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 695	needs respiratory cacare and tracheal sucare, consistent with practice, the compressive plan, the reside and 483.65 of this such this REQUIREMEN by:  Based on observation interviews the facility tracheostomy (surgioneck) dependent resat the prescribed ratic concentrator and oxion of 3 residents review (Resident #3).  The findings include Resident #3 was inited to 8/20/22 and most resident facility on 06/17/24 with chronic respiratory facility on 06/17/24 with chronic respirator	sure that a resident who are, including tracheostomy ctioning, is provided such professional standards of thensive person-centered ants' goals and preferences, abpart.  To is not met as evidenced ans, record review, and staff and failed to ensure that a cal airway in the front of the sidents' oxygen was delivered e, failed to clean the oxygen are concentrator filter for 1 are for respiratory services descently readmitted to the with diagnoses that included	F	F695 Resident #3 was placed on respisupport/oxygen therapy as order tracheostomy on 07/01/24. Resident #3 and 100% of all resist that require respiratory support/oxygen settings per physician or 07/01/24. The facility will conduct audits for admission with continuous oxygen on 07/01/24 to 07/05/24 the Direct Nursing initiated staff education in nurses to cover respiratory support/oxygen therapy and the importance of following physician to deliver the correct oxygen flow.  The facility will educate all new employees on hire. As needed the will continue with all staff.	red via	
	oxygen via tracheos Further review of ph	tomy collar continuous. ysician orders revealed no oxygen filters or oxygen		The Director of Nursing or design conduct audits for Resident #3 a of resident that receive continuous oxygen, related to respiratory support/oxygen therapy care for	nd 100%	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		DATE SURVEY COMPLETED	
			A. BOILDI	_		<b>1</b> ,	С	
		345388	B. WING			1	/02/2024	
NAME OF P	ROVIDER OR SUPPLIER	-	_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·		
LUNTED	MOODS NUIDSING AND	DELIAD		62	20 TOM HUNTER ROAD			
HUNIER	WOODS NURSING AND	KENAD		С	HARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	o7/01/24 at 11:06 Albed with his head of was noted to have a next to his bed that tracheostomy collar deliver 3.5 liters of concentrator was disubstances that resother white stains alright side of the conparticles. Resident by himself and appeared with his head of was noted to have a next to his bed that tracheostomy collar deliver 3.5 liters of concentrator was disubstances that resother white stains alright side of the conparticles. Resident by himself and appeared by himself and	made of Resident #3 on M. Resident #3 was resting in bed elevated. Resident #3 In oxygen concentrator sitting was connected to his In the concentrator was set to oxygen. The oxygen concentrator sitting The oxygen concentrator was set to The oxygen	F	695	appropriate oxygen settings for 3xweek/for four weeks then weekly for four weeks.  The Quality Assurance Performance improvement committee members con of but not limited to Administrator, Dire of Nursing, Unit Manager, Social Services, Medical director, maintenanc Director, Housekeeping Services, dieta Manager, and Minimum data Set Nurse and minimum of one direct care giver.  The Director of Nursing will report findito the Quality Assurance Performance Improvement meeting monthly for two months. The findings of the monitoring tool will be discussed/reviewed in Qual Assurance Performance Improvement meeting.  Date of Compliance will be July 26, 20.	sist ector ee engs		
	deliver 3.5 liters of concentrator was dissubstances that resorther white stains at	xygen. The oxygen						

Facility ID: 923058

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345388	B. WING_			C <b>7/02/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 620 TOM HUNTER ROAD CHARLOTTE, NC 28213		7/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 695	·	e 29 3 was noted to be in a room ared to be in no acute	F 6	595		
	who confirmed that s #3. She stated that the change out the oxyge concentrator was wo that she did check the setting at least once stated Resident #3 whis tracheostomy collidid not know who cle concentrators or filter nurse on the hallway to her. Nurse #1 was oxygen concentrator setting was on 3.5 little checked it earlier on Nurse #1 was observed concentrator back on check Resident #3's which was 99%. She was not able to change and he had no room what happened. Nurse youngen concentrator very dusty and needed concentrator.  The Housekeeping Double 107/02/24 at 9:25 AM. nursing department were resurgen concentrator. Housekeeping Direct was worth and the process of the concentrator.	trs, she only knew that as the that task was not assigned asked to observe the and confirmed that the ers. She stated she had the shift and it was correct. Wed to place the oxygen a 4 liters and proceeded to oxygen saturation level added that Resident #3 ge the oxygen concentrator mate, so she was not sure se #1 acknowledged the filter and stated that it was ed to be cleaned as did the or the stated that both the and the housekeeping ponsible for cleaning the and filters in the rooms. The tor observed the oxygen dent #3's bedside and stated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION  NG	_	(X3) DATE SURVEY COMPLETED	
		345388	B. WING			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, S 620 TOM HUNTER ROAD CHARLOTTE, NC 282	1	01102/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	
F 695	concentrator could be removed by wiping the housekeeping staff staily and if they saw equipment, they were Director know so he concentrator. He statissues to him regardic concentrator. The Hoobserved to spray the cleaning product and rag. The dirt and deb Housekeeper #1 was 9:39 AM who confirm clean Resident #3's rexplained that she clean on 07/01/24 between his oxygen concentrate returned to his room shift. She stated if she would have told to the Nursing staffing supposed "to bother thousekeeper #1 state quick wipe down of the but if it needed to be that would be up to the Housekeeper #1 again concentrator was not Resident #3's room on The Director of Nursing 07/02/24 at 11:46 AM shift staff were tasked and other needed equipment of the diresponsible for cleaning stated she diresponsible for cleaning the staff were tasked and other needed equipment of the diresponsible for cleaning stated she diresponsible for cleaning the staff were tasked and other needed equipment of the diresponsible for cleaning the staff were tasked and other needed equipment of the diresponsible for cleaning the staff were tasked and other needed equipment of the diresponsible for cleaning the staff were tasked and other needed equipment of the diresponsible for cleaning the staff were tasked and other needed equipment of the diresponsible for cleaning the staff were tasked and other needed equipment of the director of the	e sprayed with cleaner and em down. He stated the nould be looking at them tube feeding formula on the et to let the Housekeeping could properly clean the ed that no one had reported ng Resident #3's usekeeping Director was e oxygen concentrator with a then wipe it down with a ris were easily removed.  Interviewed on 07/02/24 at ed that she was assigned to com on 07/01/24. She eaned Resident #3's room 8:30 AM and 9:00 AM and tor was not dirty and had not for the remainder of her e had noted it to be dirty, he Housekeeping Director g because she was not the oxygen concentrator." ed she was able to do a see concentrator if it needed it escrubbed or deep cleaned see nursing department. In stated that the oxygen dirty when she cleaned in 07/01/24.  In g was interviewed on a who stated that the night it with changing the tubing uipment. The Director of	F	595		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		CONSTRUCTION	COMPLET	
			7 50.25.	_		(	С
		345388	B. WING			07/	02/2024
	ROVIDER OR SUPPLIER  WOODS NURSING AND I	REHAB		6	TREET ADDRESS, CITY, STATE, ZIP CODE 20 TOM HUNTER ROAD HARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842 SS=D	aware of. However, the if the staff went into a needed to be cleaned tell someone that coul #1 was responsible for shift that Resident #3 oxygen via his trached completed the intervier "can absolutely not chand he is the only reselled Records - Ic CFR(s): 483.20(f)(5), \$483.20(f)(5) Resident (i) A facility may not resident-identifiable to accordance with a conagrees not to use or concept to the extent the do so.  §483.70(i) Medical research to do so.	the filters that she was he Director of Nursing stated room, and something I then they should clean it or Id clean it. She added Nurse or checking at least once a was on the correct dose of ostomy collar. The DON ew by stating Resident #3 hange his oxygen settings ident in that room." Identifiable Information 483.70(i)(1)-(5)  Int-identifiable information. Helease information that is to the public. Hease information that is to an agent only in Intract under which the agent disclose the information he facility itself is permitted  cords. Indance with accepted as and practices, the facility all records on each resident  ented; the expect of the information he facility must keep confidential hed in the resident's records, in or storage method of the		842			7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER  WOODS NURSING AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER ROAD CHARLOTTE, NC 28213	1 07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 842	(ii) Required by Law; (iii) For treatment, pa operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research predical examiners, fa serious threat to he by and in compliance §483.70(i)(3) The factored information agunauthorized use.  §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 ye legal age under State §483.70(i)(5) The medici of the results of the results of the results of the results of an and resident review of determinations conduly Physician's, nurse professional's progre	or their resident e permitted by applicable law; eyment, or health care ted by and in compliance ited in administrative proceedings, poses, organ donation ourposes, or to coroners, uneral directors, and to avert eath or safety as permitted ited ited ited ited ited ited ited	F 84	2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING _				C <b>7/02/2024</b>
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		1102/2024
					20 TOM HUNTER ROAD		
HUNTER V	WOODS NURSING AND	REHAB			CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From pag	ne 33	F	342			
	services reports as r	equired under §483.50.					
	•	T is not met as evidenced					
	•	view and staff interviews the			F842		
	facility failed to maintain a complete an accurate medical record when Nurse #2 documented that				Resident #3 Peripherally Inserted Cent	ral	
					Catheter dressing was changed and		
	she changed a perip	herally inserted central			documented on 07/01/24.		
	catheter line (intrave	nous line) dressing on two					
		dressing was not changed as			Resident #3 and 100% of all residents		
		sidents reviewed who			charts was audited for appropriate and		
	required intravenous	medications (Resident #3).			correct nursing documentation for		
	The findings included	d:			dressing changes for Peripherally Inser Central catheter.	ted	
	A physician order da	ted 06/20/24 read			The facility will conduct audits for any		
		neter care instructions,			new admission with PICC line care to		
		th upper extremity and apply			ensure correct documentation.		
		ry Thursday on day shift.					
	· ·				On 07/01/24 to 07/05/24 the Director of	f	
	Review of the Medic	ation Administration Record			Nursing initiated nursing staff education	า to	
		023 revealed that on June			cover the importance of appropriate an	d	
	20, 2024, and June 2	27, 2024, Nurse #2 initialed			correct nursing documentation for 100%	6	
		hat she had cleaned and			of residents including Resident #3.		
		#3's right upper extremity and					
	applied a clean clear	r dressing to the PICC line.			The facility will educate all new		
	A l	manda of Davidson 40			employees on hire. As needed training	j	
		made of Resident #3 on			will continue with all staff.		
		M. Resident #3 was resting in bed elevated. He was noted			The Director of Nursing or designed will		
		in his right upper extremity			The Director of Nursing or designee will conduct audits on Resident #3 and any		
		th a clear dressing. The			new resident related to appropriate and		
		to have rolled up at the edges			correct nursing documentation related to		
		articles on the sticky side of			peripherally inserted central catheter	.5	
	·	d rolled up. The clear			dressing changes and documentation		
		06/13/24 at 3:59 PM.			care 3x W/ for 4 weeks weekly for 4		
	J 1212 2210 2				weeks.		
	An observation was	made of Resident #3 on					
		. Resident #3 remained in			The Quality Assurance Performance		
	bed with his head of	bed elevated. He was noted			improvement committee members cons	sist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	TE SURVEY MPLETED
		345388	B. WING			C 7/02/2024
NAME OF PE	ROVIDER OR SUPPLIER	0.1000	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	7/02/2024
TVAIVIL OF T	COVIDER OR OUT FIELD			620 TOM HUNTER ROAD		
HUNTER V	VOODS NURSING AND I	REHAB	CHARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	Continued From page	e 34	F 84	12		
F 842	to have a PICC line in that was covered with dressing was noted to and had small dirt parthe dressing that had dressing was dated 0.  An observation was n with the Director of Note on Resident #3's right upper extremity. She stated it "obvious as documented on the Nurse #2 was intervie at 5:21 PM, Nurse #2 facility at least once a stated she had not changed in the late of the stated was detected that she had it was dated for that so it had already been of that maybe it was an The Director of Nursin 07/02/24 at 11:46 AM #3's PICC line dressing documented that she	h his right upper extremity a clear dressing. The b have rolled up at the edges cticles on the sticky side of rolled up. The clear 6/13/24 at 3:59 PM.  hade of Resident #3 along cursing on 07/01/24 at 5:12 clursing confirmed that the s PICC line dressing in his was 06/13/24 at 3:59 PM.  sly had not been changed" e MAR.  ewed via phone on 07/01/24 stated she worked at the sweek on Thursdays. She anged Resident #3's PICC st month and could not cumented on the MAR that he dressing change. Nurse d checked the dressing, and hame day, and she assumed hanged. Nurse #2 added hoversight on her part.  hig was interviewed on who stated that Resident hig should have changed per hid if Nurse #2 did not g she should not have did. She added she was se #2 documented that she	F 84	of but not limited to Administrate of Nursing, Unit Manager, Social Services, Medical director, main Director, Housekeeping Services Manager, and Minimum data Stand minimum of one direct cares. The Director of Nursing will repto the Quality Assurance Perfor Improvement meeting monthly months. The findings of the motool will be discussed/reviewed Assurance Performance Improvementing.  Date of Compliance will be July	al Intenance es, dietary et Nurse e giver.  ort findings mance for 2 onitoring in Quality vement	