DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OM	<u>B NO. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	PLE CONSTRUCTION		DATE SURVEY COMPLETED
		345388	B. WING			C 03/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
HUNTER	WOODS NURSING AND	REHAB		620 TOM HUNTER ROAD CHARLOTTE, NC 28256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	i	F OC	00		
	Regulation (DHSR), I Certification Section I investigation at the fa Survey Agency to obt interviews to complet	cility. In order for the State				
F 157 SS=G	the State Agency made and F-309. Event ID#	vided to the facility because de revisions to tags F-157 ¢ QH0Z11. Y OF CHANGES	F 15	57		4/14/17
	(g)(14) Notification of	Changes.				
	consult with the resid	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-				
		ving the resident which as the potential for requiring n;				
	mental, or psychosoc deterioration in health	n, mental, or psychosocial reatening conditions or				
	a need to discontinue	erse consequences, or to				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					03/31/2017

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE : COMPL	
		345388	B. WING				C 14/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		14/2011
HUNTER	WOODS NURSING AND I	REHAB			20 TOM HUNTER ROAD CHARLOTTE, NC 28256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	E ATE	(X5) COMPLETION DATE	
F 157	Continued From page	e 1	F	157			
	(D) A decision to trans resident from the facil §483.15(c)(1)(ii).						
	(14)(i) of this section, all pertinent information	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the					
		also promptly notify the lent representative, if any,					
	(A) A change in room as specified in §483.1	or roommate assignment I0(e)(6); or					
		ent rights under Federal or ns as specified in paragraph					
	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced	nailing and email) and resident representative(s).					
	practitioner and staff, record, the facility fail	with the physician, nurse and review of the medical ed to notify the physician of required surgical repair for 4 sampled residents			<ol> <li>Resident #5 was transferred to the hospital and discharged from the facility on 2/24/17.</li> <li>From 3/30/17-4/4/17, the Director Clinical Services (DCS) and Assistant</li> </ol>	у	
		n notification (Resident #5).			Director of Clinical Services (ADCS) completed a quality monitoring of residents who sustained a fall from		
	Resident #5 was adm 05/29/13. Diagnoses mental disorder, moo	included seizure disorder,			2/28/17-3/28/17 to validate that the residents' physician and/or nurse practitioner (NP) was notified at the tim of the fall. No discrepancies were	e	

Facility ID: 923058

If continuation sheet Page 2 of 23

OLIVILI	S FOR WEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	ATE SURVEY DMPLETED
		245202	R MINC			С
		345388	B. WING			03/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
HUNTER	WOODS NURSING AND	REHAB		620 TOM HUNTER ROAD CHARLOTTE, NC 28256		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPLETIO
F 157	Continued From page	e 2	F 15	57		
		eformity, history of falling		identified.		
	and multiple old skele			3. By 4/7/17, the DCS and	l/or ADCS	
				reeducated licensed nurses		
	Review of Resident #	≴5's annual Minimum Data		483.10(g)(14) regarding noti	•	
s s c c r c r r		Area Assessment dated		changes and Consulate Poli		
	5/3/16 and quarterly			Procedures N-105 "Change		
		nt with moderately impaired		Condition". Education includ		
		upervision of one staff		expectation of the licensed r		
		ility, transfers and activities		promptly notify the residents		
		and had no limitations with		and/or NP after a fall and to		
		M). A care plan updated		and document the residents	' clinical	
		notify the physician (MD) of		assessment including but, n		
	changes in condition.	• • • • •		vital signs, range of motion (		
				neurological changes and pa		
	Review of two of the	facility's reports, incident		hired licensed nurses will be	-	
	occurrence and Situa	· ·		upon hire.		
		view/Notify (SBAR), both		The licensed nurse are	to promptly	
		ded Resident #5 was noted		notify the residents' physicia		
		ative, lying on floor in front		after a fall and will communi		
		, clothes wet with urine, call		residents' clinical assessme	nt including	
	bell in reach, but not	in use, confused, and		but, not limited to, vital signs	s, range of	
	looking for a family m			motion (ROM)and neurologi	-	
	documented that the	re was no sign/symptom		Notification to be documented		
	(s/s) of injury, that the	e nurse practitioner (NP) was		SBAR (Situation Backgroun	d Appearance	
	notified on 1/20/17 at	t 1:45 PM and gave verbal		and Review) and physician a	and/or NP	
	telephone orders and	a message was left for the		recommendations implement	ited as	
	responsible party.			indicated. The DCS/Nurse S	•	
				review resident falls with the		
		ress note dated 01/23/17,		(Interdisciplinary Team) duri	ng the	
		5 was assessed by the MD		morning stand-up meeting		
		n mental status (MS) from		Mondays-Fridays and week		
		MD reviewed/assessed the		Falls Committee Meeting to		
		/17 - 1/22/17 by the NP and		compliance with timely phys		
		5. The progress note		NP notification of residents		
		nt #5 was seated at bedside		4. The DCS/Registered N		
		s, MS back to baseline,		Supervisor will conduct Qua		
	-	results were negative for a		Monitoring of 3 residents' me		
		(UTI), chest xray (CXR) and		to ensure that the residents'		
	dehydration, howeve	r, Resident #5 had an		and/or NP was promptly not	itied after a	

Facility ID: 923058

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	NO. 0938-039
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CO	MPLETED
						С
		345388	B. WING			03/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
HUNTER	WOODS NURSING AND	REHAB		620 TOM HUNTER ROAD CHARLOTTE, NC 28256		
				-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIOI DATE
F 157	Continued From page	e 3	F 15	.7		
	1.5	cell count (Leukocytosis),		fall at a frequency of 3 times	a week for 4	
		el with possible seizure		weeks, 1 time a week for 8 v		
	activity on 1/20/17. T	•		monthly . Schedule for QI m	•	
		ntinue the intravenous fluids		be modified based on finding	gs.	
		NP, continue the antibiotic				
	,	y the NP until repeated labs		The results of QI monitoring		
		esident #5 for a neurology		reported to the Quality Assu		
		progress note did not of, or an assessment specific		Performance Improvement ( monthly by the Administrato		
	to a fall on Friday, 1/2			designee. The Quality Assu		
				Performance Improvement (		
	Review of the SBAR	and hospital transfer		evaluate the effectiveness o		
	summary, both dated	1/24/17, revealed that on		monitoring/observation tools	for making	
		was transferred to the		changes to the corrective ac		
		er Resident #5 called 911		necessary to maintain subst		
	staff (EMS) take her	ve the emergency medical to her family.		compliance. The Quality As Improvement Committee me consist of, but not limited to,	embers	
		consultation report dated seizure		Administrator, Director of Cl Services, Medical Director, a	inical	
	activity, and a fall, with	th mild left hip pain. An Xray		three other members.		
		hospital course revealed a				
	displaced left femora repaired surgically at	I neck fracture that was the hospital.				
	An interview on 3/6/1	7 at 2:15 PM with nurse aide				
		e worked with Resident #5				
		P shift. NA #1 described				
	Resident #5 as alert/	oriented, normally				
		e, not typically combative,				
	-	L, and required set up help				
		at she found Resident #5 on				
		on 1/20/17, she did not recall tion of the resident's legs,				
	-	IA #1 stated Resident #5				
		Nurse #1 attempted to take				
		gns (VS). NA #1 stated				
	-	nbative, swinging at staff,				
	when she and NA #1	used a gait belt to assist				

If continuation sheet Page 4 of 23

DEPARTMENT OF HEAL CENTERS FOR MEDICA						FORM	D: 04/03/2017 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345388	B. WING				C 14/2017
NAME OF PROVIDER OR SUPPL	ER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		-
				620	0 TOM HUNTER ROAD		
HUNTER WOODS NURSING	AND	REHAB		СН	IARLOTTE, NC 28256		
PREFIX (EACH DEI	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
<ul> <li>NA #1 stated R pain and did not to her skin at the transfer to her w Resident #5 to</li> <li>An interview or revealed she w NA #1 asked for shift to transfer wc after a fall. I Resident #5 set front of her in a Resident #5 ex getting off the f cooperative init to transfer to he did not express observed. NA # time caring for</li> <li>An interview or revealed she w facility, but on f nurse on the flor residents on the 1/20/17, she w #5 and that the night clothes por refused assista planned to retu #1 stated NA # was on the floo 1/20/17. When room, she foun back, her legs w kicking/grabbin</li> </ul>	the fle esider of the fle esider of notic e time wc or v get dr of as in c or her a not her a no	bor to her wheel chair (wc). at #5 did not complain of the bruising/swelling/redness the of the fall, during the when NA #1 assisted tessed later in the shift. 7 at 2:35 PM with NA #2 orientation on 1/20/17 when assistance on the 7A - 3P ent #5 from the floor to her stated she observed in the floor with her legs in of urine. NA #2 stated ed she did not want help ind that the resident was not but then cooperated with staff NA #2 stated Resident #5 and no signs of injury was ed that was her first and only	F 15	7			

Facility ID: 923058

If continuation sheet Page 5 of 23

		MEDICAID SERVICES				<u>IO. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
			A. BUILDING	3		С
		345388	B. WING			3/14/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		5/14/2017
				620 TOM HUNTER ROAD		
HUNTER	WOODS NURSING AND	REHAB		CHARLOTTE, NC 28256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIOI DATE
F 157	Continued From page	e 5	F 15	57		
	#1 stated Resident #	5 did not complain of pain,				
		s unable to complete a full				
		ssess ROM or obtain VS				
		was not cooperative. Nurse ed Resident #5's ROM was				
		ved her arms/legs in all				
		dent #5 was combative and				
	"This was not like he	r." Nurse #1 stated she				
	called the NP and ad	vised of the resident's				
	-	ot of the fall, nor did she				
		ager (UM), write a nurse's				
		e fall on the 24 hour nursing				
	communication repor	. She noted the reason was				
		ing well on Friday, 1/20/17,				
		d did not know who replaced				
	-	that when she spoke to the				
	•	e received verbal orders				
		labs, a urinalysis, a CXR				
		#1 stated when she returned				
	•	1/23/17 she completed the				
		BAR, but that she did not 5 after the fall on 1/20/17 nor				
		was discharged to the				
		Nurse #1 stated she was not				
	-	#5 had a hip fracture. Nurse				
		ounseled for not notifying the				
		t documenting the fall in a				
	NN/24 hour commun	•				
	fall.	and notifying the UM of the				
		7 at 4:00 PM with Nurse #2				
		as needed on the 7A - 3P				
		nd had previously worked				
		rse #2 stated she worked Tuesday, 1/24/17 on the 3P -				
		sident #5 was transferred to				
	onne, uno day 100					

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · /		· · ·	<b>MPLETED</b>
						С
		345388	B. WING		0	3/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
HUNTER	WOODS NURSING AND	REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256			
				-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		EAPPROPRIATE	(X5) COMPLETIOI DATE
F 157	Continued From pag	e 6	F 15	7		
		was noted self propelling in	1 13	1		
	-	ple attempts to contact a				
	-	hone, cursing at staff and				
		tance with incontinence care.				
		behavior was unusual for				
		successful attempts were				
	made to assess the					
	Nurse #2 stated Res	ition due to non-compliance.				
		incident, denied pain when				
		esident eventually agreed to				
		care. Nurse #2 stated that				
	around 8:30 PM Res	ident #5 was witnessed to				
	-	ed EMS to take her to see a				
	-	e #2 stated EMS arrived				
	· ·	sisted Resident #5 with a				
		to the stretcher and that Resident #5 complained of				
		a routine complaint, but the				
		lined of pain that shift. Nurse				
		ot aware that Resident #5				
	sustained a fall on 1/	20/17 and that Nurse #2 did				
		#5 for any s/s of injury post				
	fall.					
	An interview on 3/6/1	17 at 4:50 PM with the MD via				
		assessed Resident #5 in the				
	<b>'</b>	/23/17 for altered mental				
		ID stated at the time of her				
		/17, she was not aware that				
		ed a fall on 1/20/17. The MD				
		e ordered by the NP because				
	-	nd possible seizure activity, . The MD stated that				
		show s/s of distress or pain,				
		specifically assess the				
		The MD stated she was				
	made aware of the h	ip fracture after Resident #5				

Facility ID: 923058

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FOI	ED: 04/03/2017 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345388	B. WING			0	C 3/14/2017
NAME OF P	ROVIDER OR SUPPLIER		1	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HUNTER	WOODS NURSING AND	REHAB					
					CHARLOTTE, NC 28256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 157	request assistance w authorization to surgin hip. The MD stated the possibly resulted from facility on 1/20/17 and expected MD/NP noti- resident experienced subsequent fracture of communication book at the next onsite visi- injury. An interview on 3/6/1 revealed she was in to 7A - 3P shift when Re- Nurse #1 was the hal- shift early because sh #1 stated she took ow day, but Nurse #1 did resident's fall, did not complete a NN, incide on the 24 hour report communication book. notified of the resider occurred. UM #1 state the fall when she revi- 1/23/17, but that the f fall until 1/25/17 wher facility and notified th- surgical repair of a hip An interview on 3/6/1 director of nursing (D made aware on Mono- #5 fell on Friday 1/20. Nurse #1 was the assist	contacted the facility to ith contacting the family for cally repair the resident's nat the hip fracture quite in the resident's fall in the d that she would have fication of a fall when a a change in MS and or documentation in the MD for the MD/NP to follow up t, if the fall did not result in 7 at 5:30 PM with UM #1 he facility on 1/20/17 on the esident #5 fell. UM #1 stated I nurse that day/shift and left ne was not feeling well. UM ver the medication cart that I not notify her of the notify the NP, did not ent report, document the fall or in the MD . UM #1 stated she was not it's fall on 1/20/17, the day it ed she was made aware of ewed the SBAR on Monday, MD was not notified of the in the hospital contacted the at Resident #5 required p fracture from a fall. 7 at 5:50 PM with the ON) revealed that she was day, 1/23/17 that Resident /17. The DON stated that signed nurse for Resident #5 ut she failed to notify the	F	157			

Facility ID: 923058

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						IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING	·		С
		345388	B. WING			
	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP COD		3/14/2017
	NOVIDEIN ON SOIT LIEN			620 TOM HUNTER ROAD	-	
HUNTER	WOODS NURSING AND	REHAB		CHARLOTTE, NC 28256		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 157	Continued From pag	e 8	F 15	7		
-		. The DON stated that	1.10			
		ly made aware of the				
	-	ision. The DON stated that				
	she conducted an inv					
	Resident #5's fall and					
	counseled regarding	the expectation to document				
		e MD communication book				
	and to report adverse	e events to staff. The DON				
	stated that when a re	sident fell, she expected the				
	nurse responsible for	the resident to				
		by documenting in the 24				
	-	complete an incident report,				
		the SBAR and in the MD				
		. The DON stated that if the				
		is physical injury, the MD/NP				
		erwise the fall would be				
	aocumented in the iv	ID communication book.				
		v was conducted on 3/13/17				
		NP. The NP stated she				
		I from the facility on Friday,				
		de aware of a change in				
	-	ing Resident #5, but that she t Resident #5 fell. The NP				
		that Resident #5 had an				
		el and possible infection and				
	gave verbal orders for	-				
		diately. The NP stated that				
		aware that Resident #5's				
	altered MS occurred	after a fall, she would have				
		dent's VS, neuro checks,				
	pain, deformities, and	d would have likely sent her				
	to the hospital for fur	ther evaluation of the				
		The NP stated that she				
	expects to be notified					
		ent experiences a change in				
		stated that it was possible				
		e occurred as a result of the				
		e would be inaccurate."				1

Facility ID: 923058

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FOF	ED: 04/03/2017 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		345388	B. WING		0	C 3/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
HUNTER	WOODS NURSING AND	REHAB		620 TOM HUNTER ROAD CHARLOTTE, NC 28256		
(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)	ACTION SHOULD BE COM D TO THE APPROPRIATE	
F 157	Continued From page	e 9	F 15	57		
	at 4:03 PM with Nurs Resident #5 on the 1 interview revealed sh which days/shifts she that she was not awa did she assess Resid fall. A telephone interview Nurse #4 revealed sh Resident #5 on the 3 Saturday 1/21/17 and the assigned nurse of stated she was also th Resident #5 on Mondon Nurse #4 stated Resid alert/oriented to self where needs known, an staff and refused meet worked with her all w 1/22/17), and on Mordon aware of the fall." Nu did not complain of le room short distances but was noted to stay more than usual and tired. Nurse #4 stated behavior for the resid fall had occurred on a notified, she would co with neuro checks/VS pain post fall for sever A telephone interview with Nurse #5 revealed	d Sunday 1/22/17, she was n the 11P - 7A shift. She the assigned nurse for day, 1/23/17, 3P - 11P shift. ident #5's baseline was with some confusion, made d at times she cursed at dications. Nurse #4 stated "I eekend (1/21/17 and nday (1/23/17), but I was not rse #4 stated Resident #5 eg/hip pain, ambulated in her as was her typical practice, in bed on 1/21/17 - 1/22/17 complained that she was d this was not unusual lent. Nurse #4 stated that if a a previous shift, and she was pontinue to monitor post fall S and ask the resident about				

Facility ID: 923058

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
		345388	B. WING		03	C 3/14/2017
AME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD		
	WOODS NURSING AND	REHAB		20 TOM HUNTER ROAD HARLOTTE, NC 28256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETIO
F 157	Continued From pag	ae 10	F 157			
		riented, had episodes of				
		s independent with ADL after				
	being set-up, receive	•				
		nally requested as needed on and ambulated short				
		n. Nurse #5 stated she was				
		dent #5 fell on Friday, 1/20/17				
		he resident for s/s of injury				
	post fall.					
	A telephone interviev	w occurred on 3/14/17 at				
		e #6 and revealed she				
		nt #5 on the 7A - 3P and the				
		aturday 1/21/17. Nurse #6				
		#5 was typically alert with endent with her ADL. Nurse				
		turday, 1/21/17 Resident #5				
	had increased confu	sion, was being treated for a				
		complained of generalized				
	•	ated with PRN pain meds . Nurse #6 stated she was				
		#5 fell and she did not assess				
	the resident for s/s o	f injury post fall.				
	Attempts to reach th	e nurse assigned to care for				
		ay, 1/20/17, 3P - 11P shift,				
	-	P - 11P shift, and multiple				
F 309	nurse aides were un 483 24 483 25(k)(l)	PROVIDE CARE/SERVICES	F 309			4/14/17
SS=G	FOR HIGHEST WEL		1 000			
	483.24 Quality of life	9				
	Quality of life is a fur	ndamental principle that				
		nd services provided to facility				
		ident must receive and the the necessary care and				
	services to attain or					

Facility ID: 923058

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345388	B. WING				_ 14/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HUNTER	WOODS NURSING AND I	REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 309	483.25 Quality of care Quality of care is a fu applies to all treatment facility residents. Bas assessment of a resid that residents receive accordance with profe practice, the compreh- care plan, and the residents but not limited to the fact (k) Pain Management The facility must ensu- provided to residents consistent with profess the comprehensive pot and the residents' goa (I) Dialysis. The facilit residents who require services, consistent w of practice, the compre- care plan, and the residents preferences. This REQUIREMENT by: Based on interviews practitioner and staff, record, the facility fail vital signs, neurologic motion after a fall that a hip fracture for 1 of	t with the resident's assent and plan of care. A mamental principle that and care provided to ed on the comprehensive dent, the facility must ensure t reatment and care in essional standards of tensive person-centered sidents' choices, including following: t. tre that pain management is who require such services, seional standards of practice, erson-centered care plan, als and preferences. ty must ensure that a dialysis receive such with professional standards rehensive person-centered sidents' goals and t is not met as evidenced with the physician, nurse and review of the medical ed to assess a resident's cal changes and range of t required surgical repair for	F	309	<ol> <li>Resident #5 was transferred to the hospital and discharged from the facilit on 2/24/17.</li> <li>From 3/30/17-4/4/17, the Director Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) completed a quality monitoring of residents who sustained a fall from</li> </ol>	у	
	The findings included	:			2/28/17-3/28/17 to validate that the licensed nurse completed and		

Event ID: QH0Z11

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						NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY
			A. BUILDING			С
		345388	B. WING			)3/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		JJ/14/2017
				620 TOM HUNTER ROAD		
HUNTER	WOODS NURSING AND	REHAB				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
<b>F</b> 000						
F 309			F 30			
		nitted to the facility on		documented a resident as		
		included seizure disorder,		include; vital signs, range		
	mental disorder, mod	-		(ROM) and neurological cl		
	and multiple old skel	leformity, history of falling		discrepancies were identif 3. By 4/7/17, the DCS at		
		etal fractures.		reeducated licensed nurse		
	Review of Resident #	≴5's annual Minimum Data		483.24, 483.25(k)(l) regard	•	
		Area Assessment (CAAs)		care/services for highest v	•	
		arterly MDS dated 1/19/17		Consulate Policies and Pr	•	
		5 with clear speech, able to		"Change in Resident Cond		
		nderstood, moderately		Toolkit". Education include		
	impaired cognition, re	equired supervision of one		expectation of the licensed	l nurse to	
	staff person with bed	mobility, transfers and		complete and document a	thorough	
	activities of daily livin	g (ADL), no limitations in		clinical assessment of a re	sident who falls	
		M) received scheduled pain		including but, not limited to	-	
		laints of pain in the previous		range of motion (ROM) an	-	
		The CAAs plan was to care		changes. Newly hired licer	nsed nurses will	
		chronic pain and her history		be educated upon hire.		
	of falls.			The licensed nurse ar		
				and document a comprehe		
		#5's care plan, updated		assessment of a resident		
		risk for alteration in pain and		including but, not limited to		
		c pain (bilateral lower		range of motion (ROM)and changes and pain. The cli	•	
		knees, shoulder and lower ure activity/falls, multiple		assessment will be docum		
		nfusion/dementia, poor		SBAR (Situation Backgrou		
		on-compliance and daily use		and Review) and commun		
	-	nterventions included to		24-Hour report for further t		
	monitor for signs/syn			necessary. The DCS/Nurs	•	
		petite, administer scheduled		review resident falls with the		
	pain medication as o	rdered, anticipate/assess		(Interdisciplinary Team)du	ring the Morning	
		r complaints of pain, and		Stand-up Meeting, Monda		
	notify the physician (	MD) of changes in condition.		weekly during the Falls Co		
				Meeting to ensure a comp		
		facility's reports, incident		assessment was complete		
	occurrence and Situa			who fall to provide care for		
		view/Notify (SBAR), both		being and Care Plan upda		
		ded Resident #5 was noted bative, lying on floor in front		4. The DCS/Registered Supervisor to conduct Qua		

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						8-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С		
		345388			03/14/201	17	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HUNTER	WOODS NURSING AND	REHAB		620 TOM HUNTER ROAD CHARLOTTE, NC 28256			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMP	X5) PLETIO ATE	
F 309			F 30				
	bell in reach, but not looking for a family m documented that their the nurse practitioner 1/20/17 at 1:45 PM a orders and a messag responsible party. Ne assessment of vital s pulse, respirations, te neurological (neuro) Further review of the there was no docume nurse's notes (NN) re an assessment of the or ROM related to a f the 11P - 7A shift on shift on 1/24/17. VS o as 98.9 (temperature (Respirations), 124/9 Review of MD teleph Resident #5 had the fall on 1/20/17 which ·1/20/17 - Chest Xray	re was no s/s of injury, that (NP) was notified on nd gave verbal telephone was left for the either report documented an igns (VS) (blood pressure, emperature), pain, evaluation or ROM. medical record revealed entation in the resident's egarding a fall on 1/20/17 or e resident's neuro changes fall. VS were documented for 1/21/17 through the 3P - 11P on 1/21/17 were documented ), 98 (pulse), 18 0 (blood pressure). one orders revealed that following new orders after a were ordered by the NP: / (CXR), STAT n level (a blood test that eizure activity), CBC		Monitoring of 3 residents' medic to ensure that residents who fal comprehensive assessment cor and documented at a frequency a week for 4 weeks, 1 time a we weeks, then monthly. Schedule monitoring to be modified based findings. The results of QI monitoring will reported to the Quality Assurant Performance Improvement Corn monthly by the Administrator an designee. The Quality Assurant Performance Improvement Corn evaluate the effectiveness of the monitoring/observation tools for changes to the corrective actior necessary to maintain substantic compliance. The Quality Assurant Improvement Committee memb consist of, but not limited to, the Administrator, Director of Clinica Services, Medical Director, and three other members.	I have a mpleted of 3 times eek for 8 for QI d on be ce mmittee d/or ce mmittee will e making if al ance ers		
	STAT ·1/21/17 - Start Leva mg daily for 10 days to a possible upper re urinary tract infection	abolic panel), and urinalysis, quin (antibiotic) (ABT) 500 as a prophylactic response espiratory infection (URI) or					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 04/03/2017 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION			LETED
		345388	B. WING					C 14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	ODE		
HUNTER	WOODS NURSING AND I	REHAB			20 TOM HUNTER ROAD HARLOTTE, NC 28256			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD B		(X5) COMPLETION DATE
F 309	mg now and continue mg at bedtime for a D may insert Mid Line o central catheter) Line Review of a MD progr revealed Resident #5 regarding altered mer Friday, 1/20/17. The N labs ordered on 1/20/ assessed Resident #6 documented Residen with no acute distress minimally verbal, urin negative, elevated wh (Leukocytosis), and a possible seizure activ to order additional lab metabolic panel), disc the ABT (Levaquin) u and refer for a neuro did not indicate notific specific to a fall on Fr A nurse's progress no midnight recorded Re due to complaints of p effective results. A nurse's progress no at 9:00 PM recorded f when asked and was hall repeatedly stating saying, "I don't want t note/SBAR document notified and an unsuc to notify the family. Re	in 100 mg capsule, give 300 same dose of Dilantin 300 bilantin level of 8.1 (Low); r PICC (peripherally inserted ress note dated 01/23/17, was assessed by the MD htal status (AMS) from MD reviewed/assessed the 17 - 1/22/17 by the NP and 5. The progress note t #5 was seated at bedside s, MS back to baseline, alysis/CXR/dehydration hite blood cell count low Dilantin level with ity on 1/20/17. The plan was ss (CBC, BMP (basic continue the IVF, continue ntil repeated labs returned consult. The progress note station of, or an assessment iday, 1/20/17.	F	309				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/03/2017 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345388	B. WING		_		C 14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
				620 TOM HUNTER ROAD			
HUNIER	WOODS NURSING AND F	REHAB		CHARLOTTE, NC 28256	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page take her to her family, transport and Resider of knee pain during tra (wc) to the stretcher. Review of the SBAR a summary, both dated 1/24/17, Resident #5 emergency room afte and requested to have staff (EMS) take her to Review of a hospital of 1/25/17 recorded Res activity, and a fall, wit completed during the displaced left femoral surgically at the hospital An interview on 3/6/12 (NA) #1 revealed she routinely on the 7A-3F Resident #5 as alert a cooperative with care independent with ADL only. NA #1 stated that the floor in her room of the time nor the positi and told Nurse #1. NA combative, swinging a used a gait belt to ass to her wc. NA #1 stated	e 15 EMS arrived at 9:30 PM for nt #5 was noted to complain ansfer from her wheel chair and hospital transfer 1/24/17, revealed that on was transferred to the r Resident #5 called 911 e the emergency medical o her family. consultation report dated ident #5 expressed seizure h mild left hip pain. An Xray hospital course revealed a neck fracture repaired ital. 7 at 2:15 PM with nurse aide worked with Resident #5 P shift. NA #1 described and oriented, normally , not typically combative, ., and required set up help at she found Resident #5 on on 1/20/17, she did not recall ron of the resident's legs, A#1 stated Resident #5 was a e #1 attempted to take the stated Resident #5 was at staff, when she and NA #1 sist Resident #5 did not did not notice	F 309				
	of the fall, during the t	ess to her skin at the time transfer to her wc or when ent #5 to get dressed later					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/03/2017 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345388	B. WING		_		C 14/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
				520 TOM HUNTER ROAD			
HUNIER	WOODS NURSING AND F	КЕНАВ		CHARLOTTE, NC 28256			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	2 16	F 309				
	revealed she was in or NA #1 asked for her a shift to transfer Resid wc after a fall. NA #2 Resident #5 seated of front of her in a pool of Resident #5 expresses getting off the floor an cooperative initially, b to transfer to her wc. I did not express pain a observed. NA #2 state time caring for Reside An interview on 3/6/17 revealed she was the facility, but on 1/20/17 nurse on the floor pro residents on the 7A - 1/20/17, she was the #5 and Resident #5 w clothes prior to her fal assistance with morni return to offer assistan NA #1 advised her tha floor in her room arou When Nurse #1 arrive she found the residen her legs were in front kicking/grabbing at sta and moving arms/ham #1 stated Resident #5	n the floor with her legs in of urine. NA #2 stated ed she did not want help not that the resident was not out then cooperated with staff NA #2 stated Resident #5 and no signs of injury was ed that was her first and only ent #5. 7 at 3:20 PM with Nurse #1 treatment nurse for the 7 she worked as a charge viding medications to 3P shift. Nurse #1 stated on nurse assigned to Resident vas in bed wearing her night II; Resident #5 had refused ing care and staff planned to nce again. Nurse #1 stated at Resident #5 was on the ind 11:30 AM on 1/20/17. ed to the resident's room, it on the floor on her back, of her, she was aff, kicking in all directions of sin all directions. Nurse 5 did not complain of pain, oble to complete a full body					
	because Resident #5 #1 stated she assume	was not cooperative. Nurse					

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(¥2) MULT	PLE CONSTRUCTION	OMB NO. 09 (X3) DATE SUF			
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		COMPLET			
					С			
		345388	B. WING		03/14/2	2017		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
HUNTER V	VOODS NURSING AND	REHAB		620 TOM HUNTER ROAD CHARLOTTE, NC 28256				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE CA	(X5) OMPLETIO DATE		
F 309	Continued From pag	e 17	F 3	09				
		ident #5 was combative and	_					
	"This was not like he	r." Nurse #1 stated she						
	called the NP and advised of the resident's AMS,							
		r did she advise the Unit						
	÷	a NN, record the fall on the munication report or in the						
	•	book. She noted the reason						
		t feeling well on Friday,						
	1/20/17, left her shift	early and did not know who						
	-	#1 stated that when she						
	•	he phone, she received						
	verbal orders from th	start PICC line with IVF.						
	•	in she returned to work on						
	Monday, 1/23/17 she	e completed the incident						
	•	t that she did not work with						
		lays after the fall on 1/20/17						
		nt was discharged to the Nurse #1 stated she was not						
	•	#5 had a hip fracture. Nurse						
		punseled for not notifying the						
		t documenting the fall in a						
	NN/24 hour commun	-						
	communication book fall.	and notifying the UM of the						
	iaii.							
	An interview on 3/6/1	7 at 4:00 PM with Nurse #2						
		as needed on the 7A - 3P						
		nd had previously worked						
		rse #2 stated she worked Tuesday, 1/24/17 on the 3P -						
		sident #5 was transferred to						
	-	2 stated during the shift on						
	1/24/17, Resident #5	was noted self propelling in						
		ble attempts to contact a						
		hone, cursing at staff and						
	retusing staff's assist	tance with incontinence care.						
	Nurse #2 stated this	behavior was unusual for						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/03/2017 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345388	B. WING				C / <b>14/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	WOODS NURSING AND I	REHAB			320 TOM HUNTER ROAD CHARLOTTE, NC 28256		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	AMS due to non-com Resident #5 took her incident, denied pain resident eventually ag incontinence care. N 8:30 PM on 1/24/17 F to call 911 and reques a family member. Nur around 9:00 PM, assi transfer from her wc t during this transfer, R knee pain which was first time she complai #2 stated she was no sustained a fall on 1/2 assessed Resident #8 fall. An interview on 3/6/1 <sup>*</sup> phone revealed she a facility on Monday, 1/2 stated at the time of h she was not aware th fall on 1/20/17. The M ordered by the NP be seizure activity, not be stated that Resident # distress or pain, but th assess the resident for she was made aware Resident #5 was trans 1/24/17 because the I to request assistance for authorization to su hip. The MD stated th	esident for pain and her pliance. Nurse #2 stated medications without when asked and that the greed to receive urse #2 stated that around Resident #5 was witnessed sted EMS to take her to see rse #2 stated EMS arrived sted Resident #5 with a o the stretcher and that esident #5 complained of a routine complaint, but the ned of pain that shift. Nurse t aware that Resident #5 20/17 and that she had not 5 for any s/s of injury post 7 at 4:50 PM with the MD via issessed Resident #5 in the 23/17 for AMS. The MD her assessment on 1/23/17, at Resident #5 sustained a ID stated that labs were cause of AMS and possible ecause of a fall. The MD	F	309			

Facility ID: 923058

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/03/2017 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		345388	B. WING		_	03/ <sup>-</sup>	_ 14/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			6	20 TOM HUNTER ROAD			
HUNTER	WOODS NURSING AND I	REHAB	C	CHARLOTTE, NC 28256	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	revealed she was in the TA - 3P shift when Revealed she was in the TA - 3P shift when Revealed she took ow day, but Nurse #1 was the hall shift early because she #1 stated she took ow day, but Nurse #1 did resident's fall, did not complete a NN, incide on the 24 hour report communication book. Notified of the resident occurred, and therefor assessed with VS, for integrity or in ROM powas made aware of the SBAR on Monday was not notified of the hospital contacted the Resident #5 required fracture. UM #1 stated were not made aware #5 post fall, over the vere not made aware at \$5 post fall, over the vere not made aware on Monday 1/20/Nurse #1 was the ass on Friday, 1/20/17, bu MD/NP, UM/oncoming continued monitoring. nursing staff were onlines the conducted an inv Resident #5's fall and counseled regarding the adverse events in the the staff.	7 at 5:30 PM with UM #1 he facility on 1/20/17 on the esident #5 fell. UM #1 stated I nurse that day/shift and left he was not feeling well. UM er the medication cart that not notify her of the notify the NP, did not ent report, document the fall or in the MD UM #1 stated she was not tt's fall on 1/20/17, the day it re Resident #5 was not r pain, changes in skin ost fall. UM #1 stated she he fall when she reviewed 7, 1/23/17, but that the MD e fall until 1/25/17 when the e facility and notified that surgical repair of a hip d the oncoming nursing staff e to monitor/assess Resident weekend. 7 at 5:50 PM with the ON) revealed that she was day, 1/23/17 that Resident 417. The DON stated that signed nurse for Resident #5 ut she failed to notify the g nurse of the fall for . The DON stated that y made aware of the sion. The DON stated that estigation regarding	F 309				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/03/2017 // APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345388	B. WING					C 14/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HUNTER	WOODS NURSING AND I	REHAB			620 TOM HUNTER ROAD CHARLOTTE, NC 28256			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD B		(X5) COMPLETION DATE
F 309	nurse responsible for communicate the fall hour reporting book, of document the fall on the communication book. fall resulted in obvious would be called, other documented in the MI DON also stated that expected nurses to m s/s of bruises, change mobility, complaints of checks/VS. If the nurse the DON expected the DON/MD. A telephone interview at 3:29 PM with the N received a phone call 1/20/17 and made aw MS/confusion regardi was not informed that stated she suspected elevated Dilantin leve gave verbal orders for with differential, CMP NP stated that had sh Resident #5's AMS of would have asked abo checks, pain, deformi sent her to the hospita the increased confusi that it was possible R occurred as a result of would be inaccurate."	sident fell, she expected the the resident to by documenting in the 24 complete an incident report, the SBAR and in the MD The DON stated that if the s physical injury, the MD/NP rwise the fall would be D communication book. The for the next 72 hours, she onitor the resident for any es in condition, changes in f pain and conduct neuro se identified any changes, e nurse to follow up with T. Was conducted on 3/13/17 P. The NP stated she from the facility on Friday, vare of a change in ng Resident #5, but that she c Resident #5 fell. The NP that Resident #5 had an I and possible infection and r labs (Dilantin level, CBC , urinalysis/CXR STAT). The been made aware that ccurred after a fall, she out the resident's VS, neuro ties, and would have likely al for further evaluation of on. The NP further stated esident #5's fracture if the fall, "To say otherwise	F	309				

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		MEDICAID SERVICES				<u>IO. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · · ·	TE SURVEY MPLETED
			A. BUILDING	3		
		345388	B. WING			С
		345366	B. WING			3/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
HUNTER	WOODS NURSING AND	REHAB		620 TOM HUNTER ROAD		
				CHARLOTTE, NC 28256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From pag	ie 21	F 30	9		
	· · · · · · · · · · · · · · · · ·	11P - 7A shift on 1/20/17. The	1 00			
		he did not recall specifically				
		e cared for Resident #5, but				
		are that Resident #5 fell nor				
	did she assess Resid	dent #5 post fall to look for				
	injury, or check VS, o	conduct safety checks/neuro				
	checks.					
		w on 3/13/17 at 4:09 PM with				
		he normally worked with				
	Resident #5 on the 3	d Sunday 1/22/17, she was				
	-	on the 11P - 7A shift. She				
		the assigned nurse for				
		day, 1/24/17, 3P - 11P shift.				
		ident #5's baseline was				
	alert/oriented to self	with some confusion, made				
	,	nd at times she cursed at				
		dications. Nurse #4 stated "I				
		veekend (1/21/17 and				
		nday (1/23/17), but I was not				
		urse #4 stated Resident #5				
	-	eg/hip pain, ambulated in her to stay in bed on 1/21/17 -				
		sual and complained that she				
		stated this was not unusual				
		dent. Nurse #4 stated that if a				
	fall had occurred on	a previous shift, and she was				
	notified, she would c	ontinue to monitor post fall				
		S and ask the resident about				
	pain post fall for seve	eral days.				
		Mon 3/11/17 at 12:21 DM				
		<i>w</i> on 3/14/17 at 12:31 PM led she was the assigned				
		5 on Monday, 1/23/17 on the				
		#5 stated Resident #5's				
		riented, had episodes of				
		s independent with ADL after				
						1

Facility ID: 923058

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/03/2017 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345388	B. WING					C 14/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
HUNTER	WOODS NURSING AND I	REHAB			620 TOM HUNTER ROAD			
	0.000				CHARLOTTE, NC 28256			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 309	medication, occasion medication as needed short distances in her was not aware that R 1/20/17. Nurse #5 sta resident post fall was conduct neuro checks 72 hours post fall to s A telephone interview 12:49 PM with Nurse worked with Resident 3P - 11P shifts on Sat stated that Resident astated that Resident confusion and indepe #5 stated that on Satu had increased confus AMS/UTI, complained was medicated with F results. Nurse #6 stat Resident #5 fell and t post fall assessment assessments of pain, frequent monitoring.	ally requested pain d (PRN) and ambulated r room. Nurse #5 stated she esident #5 fell on Friday, ated the routine practice for a to assess the resident's VS, s, assess for pain/injury for see if any changes occurred. v occurred on 3/14/17 at #6 and revealed she t #5 on the 7A - 3P and the turday 1/21/17. Nurse #6 was typically alert with endent with her ADL. Nurse urday, 1/21/17 Resident #5 sion, was being treated for d of generalized pain and PRN pain meds with effective ted she was not aware hat she did not complete a which would have included ROM, neuro checks and	F	309				

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