DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	-			OMB NO	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		E CONSTRUCTION	COMF	SURVEY PLETED
		345388	B. WING				C 1 <b>3/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	WOODS NURSING AND I	REHAB		6	20 TOM HUNTER ROAD		
HORTER				C	CHARLOTTE, NC 28213		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	survey was conducted 12/07/23. The survey to validate the credibl plan. Therefore, the 12/13/23. The followin NC00209788 and res	site complaint investigation d from 12/06/23 through / team returned on 12/13/23 e allegation of IJ removal exit date was changed to ing intake was investigated sulted in immediate jeopardy. plaint allegations resulted in was identified at:					
	CFR 483.10 at tag F5 J. CFR 483.15 at tag F6 J.	580 at a scope and severity 520 at a scope and severity 760 at a scope and severity					
	The tag F760 constitu Care.	uted Substandard Quality of					
F 580 SS=J		jury/Decline/Room, etc.)	F	580			
	consult with the residu consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc	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; ge in the resident's physical,					
LABORATORY I	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

**Electronically Signed** 

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.

12/31/2023

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HUNTER	WOODS NURSING AND I	REHAB			20 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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	clinical complications (C) A need to alter tree a need to discontinue treatment due to adve commence a new form (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must at resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configurat locations that comprise part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by:	reatening conditions or ); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in 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 dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident posite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations	F	580	Past noncompliance: no plan of		
	Based on record revi	iews and responsible party,			Past noncompliance: no plan of		

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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		
		345388	B. WING _				C 13/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	WOODS NURSING AND F	REHAB		62	20 TOM HUNTER ROAD			
				С	HARLOTTE, 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 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	failed to notify Resider (RP) that Resident #1 from insulin administra- discontinued on 07/21 prescribed for Person admission from the sa- with same first and las Resident #1's RP stat July about the admini- would have asked to sa and the Medical Direct Resident #1 did not he Had Resident's #1's F the high likelihood fur errors would not have This deficient practice residents reviewed for The findings included Resident #1 was adm 07/17/23. Resident #1's diagnos FL-2 form (state form medical condition and when placed in a facil doctor at the discharg and dated 07/05/23 in neurological condition disturbance, non-Alzh malnutrition, stage IV long-term drug therap	ector interviews, the facility int #1's responsible party had low blood sugar levels ation and the insulin was 1/23. The insulin was #2 (potential new ame skilled nursing facility st name as Resident #1). ted if he had been notified in stration of the insulin he speak to the Administrator stor and informed them ave a diagnosis of diabetes. RP been notified there was ther significant medication e occurred until September. e occurred for 1 of 2 r notification of change. : : itted to the facility on ses according to his correct that describes a patient's the amount of care needed ity) signed by the medical jing skilled nursing facility neluded progressive a, dementia with behavioral neimer's dementia, pressure ulcer and by.	F 5	580	correction required.			
	Person #2's medication entered for Resident #	y. on orders which were						

Facility ID: 923058

If continuation sheet Page 3 of 60

TAG       REGULTORY OR LSC DENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       DATE         F 580       Continued From page 3       F 580       <		-	ID HUMAN SERVICES				FORM	M APPROVED
AND PLAN OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING     COMPLETED       345388     B. WING     C       TAGE OF PROVIDER OR SUPPLIER       HUNTER WOODS NURSING AND REHAB       (XI) ID PREFIX     STREET ADDRESS, CITY, STATE, ZIP CODE       COMPLETE HUNTER WOODS NURSING AND REHAB       (XI) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH ORFICETIVE AND OF CORRECTION REGULATORY OR LSC DENTIFYING INFORMATION)       TAG       PROVIDERS PLAN OF CORRECTION (EACH ORFICETIVE AND OF CORRECTION SHOULD BE (EACH ORFICETIVE AND OF CORRECTIVE AND OF CORRECTION SHOULD BE (EACH ORFICETIVE AND OF CORRECTIVE AND OF CORRECTION SHOULD BE (EACH ORFICETIVE AND OF CORRECTIVE AND				(X2) MUL	TIPL	LE CONSTRUCTION		
12/13/2023       NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       620 TOM HUNTER ROAD       MUNTER WOODS NURSING AND REHAB       SUMMARY STREMENT OF DEFICIENCIES       VALUE OF PROVIDER'S FLAN OF CORRECTION     CONCRECTIVE ACTION SHOULD BE       VARE OF CARLOTTE, NC 22213     CONCRECTIVE ACTION SHOULD BE     CONCRECTIVE ACTION SHOULD BE       VALUE OF CARLOTTE, NC 2213     CONCRECTIVE ACTION SHOULD BE     CONCRECTIVE ACTION SHOULD BE     CONCRECTIVE ACTION SHOULD BE       VALUE OF CONTROL TELEVISION OF LISC IDENTIFYING INFORMATION)     PRETIX     TAG     EACH ORDER THAN OF CORRECTIVE ACTION SHOULD BE     CONSERTING       F 580     Continued From page 3     F 580     F 580     F 580     F 580       I A Lantus (Iong-acting insulin) Subcutaneous     Solution 100 units/millimeter (insulin Glargine) inject 55 units     subcutaneously two times a day for hypertension.     I Lantus (Iong-acting insulin) Subcutaneous     Solution 100 units/millimeter (insulin Glargine) inject 50 units     Subtractaneously two times a day for hypertension.     I Lantus (Iong-acting insulin) Subcutaneous       Solution 100 units/millimeter (insulin Glargine) inject 50 units     Subtractaneously two times a day for hypertension.     I Lantus (Iong-acting insulin) Subcutaneous       Solution 100 units/millimeter (insulin Glargine) inject 50 units     Subtractaneously two times a day for Hypertension.     I Lantus (Iong-ac	AND PLAN OF	FCORRECTION						
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       HUNTER WOODS NURSING AND REHAB     STREET ADDRESS, CITY, STATE, ZIP CODE       Image: Control of the state of								С
BUNDER WOODS NURSING AND REHAB       Continued From page 3       TAG     D (MA) 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION)     D (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION)     D (PREFIX TAG     PROVIDER'S PLAN OF CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     O(MA) (MA) 10 (EACH DETICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION)     D (PACH DETICENCY MUST BE PRECEDED BY TAG     D (PREFIX CONSTRUCTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     O(MA) (MA) 10 (EACH DETICENCY MUST BE PRECEDED BY DEFICIENCY)     O(MA) (MA) 10 (EACH DETICENCY MUST BE PRECEDED BY DEFICIENCY)     O(MA) (MA) 10 (EACH DETICENCY MUST BE PRECEDED BY DEFICIENCY)     O(MA) (MA) 10 (EACH DETICENCY MUST BE PRECED BY DEFICIENCY)     O(MA) (MA) 10 (EACH DETICENCY MUST BE ADD DEFICIENCY)     PROVIDENT BY DEFICIENCY     O(MA) 10 (MA) 10 (EACH DETICENCY MUST BE ADD DEFICIENCY)     O(MA) 10 (MA) 10 (EACH DETICENCY MUST BE ADD DEFICIENCY)     PROVIDENT BY DEFICIENCY     O(MA) 10 (MA) 10			345388	B. WING			12/	/13/2023
HUNTER WOODS NURSING AND REHAB       CHARLOTTE, NC 28213       Image: Colspan="2">SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST PROFERENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)     Ip (EACH DEFICIENCY WIST TAG     PROVIDER'S PLAN OF CORRECTION SHOULD BE (CACORRECTIVE ACTOR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OWNED (CACH DEFICIENCY)       F 580     Continued From page 3     F 580       1. Aspirin oral tablet chewable 81 milligram (mg) tablet - give 1 tablet by mouth daily for hypertension.     F 580       2. Eliquis oral tablet 5 mg - give 1 tablet by mouth two times a day for aphasia.     F 580       3. Furosemide oral tablet 40 mg - give 1 tablet by mouth one time a day for hypertension.     F 4. Lantus (Iong-acting insulin) Subcutaneous Solution 100 units/millimeter (insulin Clargine) inject 55 units subcutaneously two times a day for diabetes mellitus.       5. Synthroid oral tablet 50 micrograms (mcg) (Levothyroxine Sodium) - give 1 tablet by mouth in the morning for thyoid.       Resident #1's medication orders effective 09/16/23 included in part:       1. Brimonidine Tartate Ophthalmic Solution 0.2% - instill 1 drop in both eyes three times a day.       2. Dorzolamide HCI Ophthalmic Solution 2% - instill 1 drop in bet yes two it as aday.       3. Flomax Oral Capsule 0.4 mg - give 1 capsule	NAME OF PI	ROVIDER OR SUPPLIER						
Preferx TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       COMPLET DATE         F 580       Continued From page 3       F 580         1.       Aspirin oral tablet chewable 81 milligram (mg) tablet - give 1 tablet by mouth daily for hypertension.       F 580         2.       Eliquis oral tablet 5 mg - give 1 tablet by mouth two times a day for aphasia.       F 580         3.       F cross-mide oral tablet 40 mg - give 1 tablet by mouth one time a day for hypertension.       A.         4.       Lantus (long-acting insulin) Subcutaneous Solution 100 units/millimeter (insulin) Galrgine) inject 55 units subcutaneously two times a day for diabetes mellitus.       S.         5.       Synthroid oral tablet 50 micrograms (mcg) (Levothyroxine Sodium) - give 1 tablet by mouth in the morning for thyroid.       Resident #1's medication orders effective 09/16/23 included in part:         1.       Brimonidine Tartrate Ophthalmic Solution 0.2% - instill 1 drop in both eyes three times a day.       C.         2.       Dorzolarmide HCI Ophthalmic Solution 2% - instill 1 drop in left eye two times a day.       Sie 1 capsule 0.4 mg - give 1 capsule	HUNTER	WOODS NURSING AND I	REHAB					
<ul> <li>Aspirin oral tablet chewable 81 milligram (mg) tablet - give 1 tablet by mouth daily for hypertension.</li> <li>Eliquis oral tablet 5 mg - give 1 tablet by mouth two times a day for aphasia.</li> <li>Furosemide oral tablet 40 mg - give 1 tablet by mouth one time a day for hypertension.</li> <li>Lantus (long-acting insulin) Subcutaneous Solution 100 units/millimeter (insulin Glargine) inject 55 units subcutaneously two times a day for diabetes mellitus.</li> <li>Synthroid oral tablet 50 micrograms (mcg) (Levothyroxine Sodium) - give 1 tablet by mouth in the morning for thyroid.</li> <li>Resident #1's medication orders effective 09/16/23 included in part:</li> <li>Brimonidine Tartrate Ophthalmic Solution 0.2% - instill 1 drop in both eyes three times a day.</li> <li>Dorzolamide HCl Ophthalmic Solution 2% - instill 1 drop in left eye two times a day.</li> <li>Flomax Oral Capsule 0.4 mg - give 1 capsule</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
<ul> <li>by mouth at bedtime for BPH.</li> <li>4. Folic Acid Oral Tablet - give 1 tablet by mouth one time a day for malnutrition/weight loss.</li> <li>5. Melatonin Oral Tablet - give 1 tablet by mouth at bedtime for insomnia.</li> <li>6. Vitamin B-1 Tablet 100 mg - give 1 tablet by mouth one time a day for risk for malnutrition/weight loss.</li> <li>7. Vitamin B-12 ER Oral Tablet Extended Release 1000 mcg - give 1 tablet by mouth one time a day for risk for malnutrition/weight loss.</li> <li>Resident #1's admission nursing assessment dated 07/17/23 revealed he was alert and</li> </ul>	F 580	<ol> <li>Aspirin oral table tablet - give 1 tablet b hypertension.</li> <li>Eliquis oral tablet mouth two times a da</li> <li>Furosemide oral by mouth one time a da</li> <li>Furosemide oral by mouth one time a da</li> <li>Lantus (long-acti Solution 100 units/mili inject 55 units sub for diabetes mellitus.</li> <li>Synthroid oral tal (Levothyroxine Sodiu in the morning for Resident #1's medica 09/16/23 included in p</li> <li>Brimonidine Tartr 0.2% - instill 1 drop in day.</li> <li>Dorzolamide HCI instill 1 drop in left ey</li> <li>Flomax Oral Cap by mouth at bedtime f</li> <li>Folic Acid Oral Ta one time a day for ma</li> <li>Melatonin Oral Ta at bedtime for insomr</li> <li>Vitamin B-1 Table mouth one time a day malnutrition/weight lo</li> <li>Vitamin B-12 ER Release 1000 mcg - g time a day for risk</li> </ol>	et chewable 81 milligram (mg) by mouth daily for t 5 mg - give 1 tablet by hy for aphasia. tablet 40 mg - give 1 tablet day for hypertension. ing insulin) Subcutaneous llimeter (insulin Glargine) boutaneously two times a day blet 50 micrograms (mcg) m) - give 1 tablet by mouth thyroid. ation orders effective part: rate Ophthalmic Solution n both eyes three times a I Ophthalmic Solution 2% - e two times a day. osule 0.4 mg - give 1 capsule for BPH. ablet - give 1 tablet by mouth alnutrition/weight loss. ablet - give 1 tablet by mouth nia. et 100 mg - give 1 tablet by mouth nia. et 100 mg - give 1 tablet by / for risk for ss. C Oral Tablet Extended give 1 tablet by mouth one for malnutrition/weight loss.	F	580			

Facility ID: 923058

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/08/2024 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345388	B. WING			( 12/	C 13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
				20 TOM HUNTER ROAD			
HUNIER	WOODS NURSING AND F	КЕЛАВ		CHARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 580	party. Review of Resident # Medication Administra following: On 07/19/23 an order Director (MD) to chec meals and at bedtime at 6:00 PM on 07/19/2 On 07/19/23 at 11:02 blood sugar level of 6 The Nurse Practitione Resident was alert an symptoms of distress given orange juice an Resident #1's blood s documented by Nurse On 07/20/23 at 5:55 A sugar level of 64. He shake to drink. There anyone was notified of by Nurse #4 in the pro Review of a lab repor 6:53 AM a lab drawn a blood sugar level of indication on the lab t reviewed by staff. Th in the nursing progres	as his own responsible 1's progress notes and ation Record revealed the was written by the Medical k blood sugar levels before for hypoglycemia to begin 23. AM Resident #1 had a 5 and his insulin was held. er was made aware. d had no signs or noted. Resident #1 was d a snack. At 11:30 AM ugar level went up to 104 e #2. AM Resident #1 had a blood was given a 120 ml health e was no documentation that of the blood sugar level of 64	F 580		CIENCY)		
	-	e made to contact Nurse #4 for Resident #1 on the 7:00 /ithout success.					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 01/08/2024 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345388	B. WING			_	( 12/	C 13/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	,	
	WOODS NURSING AND F			62	20 TOM HUNTER ROAD			
HUNTER	WOODS NURSING AND P	(ERAB		С	HARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	5	F	580				
	Resident #1 had Lant due to low blood suga His blood sugar level was 91. A telephone interview with Nurse #2 reveale #1 and taking care of usually the nurse on t 7:00 PM shift. He cor the resident on 07/20, being documented on stated Resident #1 wo tell you he was not dia been on insulin. Nurs remember if Resident levels or not but said the physician were us and high blood sugar a blood sugar level of called the provider for recall knowing Reside level of less than 40. not remember if he ca responsible party (RP blood sugar levels on but said if he had he v	hat hall on the 7:00 AM to firmed he had taken care of (23 based on his initials the MAR for that shift. He build not have been able to abetic and should not have the #2 stated he couldn't #1 had low blood sugar the parameters for notifying ually on the orders for low levels. He further stated for less than 40 he would have further orders but did not ent #1 had a blood sugar Nurse #2 indicated he could						
	Resident #1 had a blo was no documentatio notes that the MD or I was placed in the MD	AM Nurse #4 documented bod sugar level of 71. There n in the nursing progress NP was notified but a note communication book and a the responsible party (RP)						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345388	B. WING				C 13/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 580	Continued From page	96	F	580			
	-	e made to contact Nurse #4 for Resident #1 on the 7:00 vithout success.					
	was discontinued for Director (MD) but the	PM the Lantus insulin order Resident #1 by the Medical before meals and at s continued until 09/15/23.					
	revealed no indication had been notified of h blood sugar levels on was 64, on 07/20/23 a sugar level which was	1's nursing progress notes n his responsible party (RP) nis low and critically low 07/20/23 at 5:44 AM which at 6:53 lab drawn blood s less than 40 (critically low) r level on 07/21/23 at 6:03					
	(MDS) assessment da was severely cognitiv	ion Minimum Data Set ated 07/31/23 revealed he ely impaired, non-verbal, re assistance of 1-2 staff vities of daily living.					
	Social Worker revealed Manager had attempt for his care plan meet became apparent to the resident was alert and and was unable to tal after the meeting she discharging skilled nut the responsible party number and had update record with the inform stated she notified the	ted to interview the resident ting on 07/19/23 and it hem during the meeting the d oriented to person only k with them. She stated had called the SW at the ursing facility and obtained					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>			(X3) DATE	E SURVEY PLETED
		345388	B. WING				C / <b>13/2023</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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 OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	that had been entered medical record. She Coordinator #1 called until she finally reache came into the facility of #1's admission paper sometime in Septemb attention the facility he diagnoses, and medic #1, so she called the facility and obtained the facility and be facility and be	ent #1's responsible party d in the resident's electronic further stated Admissions the responsible party (RP) ed him on 07/24/23 and he on 07/24/23 to sign Resident work. The SW explained ber it was brought to her ad the wrong date of birth, cation orders for Resident discharging skilled nursing he correct information from that facility and said the tained hard copies of the om the discharging skilled 5/23 at 3:14 PM with the trevealed she was familiar remembered that course of his stay they had he incorrect demographic nich resulted in him not nedications or having the mented at the facility. She stered insulin, but it was 23 when she realized his the not consistent with facility obtained Resident phics, diagnoses, and arging skilled nursing facility further stated she began responsible party on ble to leave a message due uil but said she finally none on 09/19/23 to inform in his diagnoses, orders, and accived from the discharging	F	580			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY	
		345388	B. WING				C 1 <b>3/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
HUNTER	WOODS NURSING AND	REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213 IENCIES ID PROVIDER'S PLAN OF CORRECTION					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		x		BE	(X5) COMPLETION DATE	
F 580	Continued From page	8	F	580				
	with Resident #1's RI notified by anyone at had received the wro of his stay at the facil the facility had called him they had stopped and said if they had h needed to "meet with medical director beca been a diabetic a day stated they had not n the low blood sugar la Resident #1 on 07/24 admission paperwork was not told about ott had received and had receiving the medicat aware the facility had Resident #1 until Hos date of birth on 09/15 conversation. He sai Resident #1 had received for 2 months and had Medical Director that medications." The R was because Residen Hospice, they were a An interview on 12/07 Assistant Director of I she had served as the about 6 weeks from 0 The ADON indicated Resident #1's low and levels but said their n been to notify the Me	The RP also stated he ner medications Resident #1 I not had diagnoses for ions. The RP was not the wrong date of birth for pice had asked about his /23 during a telephone d he was not aware ived the wrong medications only been told by the they were "adjusting his P indicated he assumed it nt #1 had been placed on						

Facility ID: 923058

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345388	B. WING				C 13/2023
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 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	levels, document the resident's guardian, re and notify them of the the holding of his insu- notification. The ADC documented in the nu- would have to assum- been notified of the lo could not explain why An interview on 12/06 Director of Nursing (D Consultant revealed that the correct conta- #1's RP to notify him discontinued or that he levels. They both exp information listed him party with no telephor the Nurse Consultant #1's RP had not been low blood sugar levels obtained the RP's nar from the discharging so 07/19/23 or why he w had visited Resident a his admission paperw A follow up interview of the Director of Nursin Consultant with the Ar revealed the DON, Ac Consultant knew why been notified of the lo insulin being discontin had visited Resident a his admission paperw Consultant stated the	notification and contact the esponsible party or family e low blood sugar levels and ulin and document the DN said if it was not ursing progress notes she e Resident #1's RP had not w blood sugar levels and the had not been notified. 5/23 at 5:00 PM with the DON) and the Nurse he nurses would not have ct information for Resident of the insulin being e had low blood sugar blained Person #2's as his own responsible ne number. The DON nor could answer why Resident notified of the insulin and s after the facility had me and telephone number skilled nursing facility on as not informed when he #1 on 07/24/23 at 4:45 PM with g (DON), and Nurse	F	580			

Facility ID: 923058

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMF	E SURVEY PLETED
		345388	B. WING				C / <b>13/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	RP about the insulin a on 07/24/23 and it shu documented. The DC with notification was f their own responsible Power of Attorney to I any changes with a re Nurse Consultant furt notified on 09/19/23 b mix-up with his medic stated the RP had no information. They sai notifying Resident #11 tried to contact the so finally got to speak with The Administrator wa jeopardy on 12/07/23 The facility provided to action plan with a corr As a result of the definisecuring accurate pat #1 received medication #2. Medications inclue Acting) insulin. Reside and had not been pre Resident #1's response that Resident #1 had sugar readings as a re the insulin being disco time of the occurrence his own responsible preceived from the disc belonged to Resident had not yet discovere	and low blood sugar levels ould have been DN stated the expectation for the resident (if they are party), family, guardian, or be notified within 24 hours of esident. The DON and ther stated the RP had been by the Medical Director of the cations and said the MD concerns regarding the id there was a delay in 's RP because the MD had on for several days and the him on 09/19/23. s notified of immediate at 5:15 PM. the following corrective npletion date of 09/29/23: cient practice of not tient information, Resident ded 3 doses of Lantus (Long ent #1 was not a diabetic escribed insulin. sible party was not notified three critical low blood esult of receiving insulin and ontinued on 7/21/23. At the e Resident #1 was listed as party based on information	F	580			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY
			A. BUILDI	NG _			C
		345388	B. WING				/13/2023
NAME OF PI	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From page	e 11	F	580			
	the contact number lis Admission Record, the reached back out to the Social Worker on 7/19 facility's Social Worker information for Reside Admissions made seven number with no succe until the morning of 7/ Director. The admissi completed by the Director. The admissions afternoon on 7/24/23 responsible party. Re was not informed of the insulin being discontine All residents residing potential to be affected On 9/28/23, the Admi Admissions Coordinal current resident recorr and responsible party information was accu- identified were correct On 9/21/23, a Root C completed by the Director rel determined Resident not notified of critical being discontinued as correct information for party.	eral attempts were made to sted on Resident #2's the Director of Admissions the discharging facility's 9/23. The discharging er provided new contact ent #1. The Director of veral attempts using the new ess. Contact was not made /24/23 by the Admissions on agreement was actor of Admissions in the with Resident #1's sident #1's responsible party the low blood sugars or nued on 7/24/23. in the facility have the ed by the deficient practice. ssions Director and tor completed a review of rds to verify dates of birth //emergency contact rate. Any discrepancies ted. ause Analysis was actor of Nursing and lated to notification. It was #1's responsible party was low blood sugars and insulin a result of not having the r Resident #1's responsible					
		utive Director educated the and Admissions Coordinator					

Facility ID: 923058

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
					620 TOM HUNTER ROAD		
HUNIER	WOODS NURSING AND I	КЕНАВ			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 580	on ensuring responsil information for newly entered into the electra accurate. Prior to adm Admissions or Admiss validate contact inforr responsible parties ar through verbal auther Admissions Director of will be educated durin by the Executive Director ha responsibility. On 9/21/23, the Direct education to licensed condition/notification to "Family/Responsi "Physician Notifica "Physician order ( "Appropriate docu "If more than 3 att responsible party the Director of Nursing/ar "Reviewed situation notification to include: o an accident invol results in injury and h physician intervention o a significant char mental, or psychosoc deterioration in health status in either life-thr clinical complications. o A need to alter tra	ble party/emergency contact admitted residents is ronic medical record and is hission The Director of sions Coordinator will nation for residents, hd/or emergency contact nitication. The newly hired or Admissions Coordinator og the Orientation process ctor, going forward. The s been notified of this tor of Nursing initiated nurses related to change in to include: ble Party Notification ation if indicated) imentation sempts are made to notify the nurses must notify the nd or Unit Manager. ons that would require the potential for requiring the resident which as the potential for requiring the asthe potential for requiring the asthe potential for requiring the asthe potential for requiring the asthe potential for	F	58			

Facility ID: 923058

If continuation sheet Page 13 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345388	B. WING				C /13/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	education prior to wor shift), regarding chan include notifying resp to Director of Nursing information is not pre- responsible party is n attempts. The Director responsible for trackin 9/21/23. In the event nursing, the contracter the Director of Nursin assignment. On 9/21 assigned a designee Administrative Team t weekend Licensed Nu- the start of their shift. Nurses and will be ed Orientation process b going forward. The Di- notified of this respon Starting on 9/28/23 th designee to complete monitoring for Notifica MD/NP/Responsible I residents have emerg party listed with corre completed by 12/21/2 to be completed by 3/ The Director of Nursir introduced the plan of Assurance Performar on 9/28/23. The Director for implementing this reviewed by QAPI con-	not educated will receive this rking their next scheduled ge in condition/notification to onsible party and notification when the contact sent/no longer accurate or ot able to be reached after 3 r of Nursing will be ng nurses not educated on the facility must use contract ed nurse will be educated by g prior to the start of their /23, the Director of Nursing from the Nursing to ensure evening and urses were educated prior to Newly hired Licensed ucated during the y the Director of Nursing, rector of Nursing has been sibility. e Executive Director and/or Quality Improvement ation of Changes to Party and to ensure newly gency contact/responsible ct telephone number to be twelve weeks to be 3 and monthly for 3 months 21/24. ng and Executive Director f correction to the Quality the Improvement Committee stor of Nursing is responsible plan. Findings will be mmittee monthly and Quality dated if changes are needed	F	580			

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					). 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	SURVEY
AND I LAN OF	CONTRECTION	BENTI IOATION NOMBER.	A. BUILDI	NG	i		
							C
		345388	B. WING			12/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					620 TOM HUNTER ROAD		
HUNTER	WOODS NURSING AND F	REHAB			CHARLOTTE, NC 28213		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	Х	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	DATE
			_				
F 580	Continued From page	e 14	F	580	0		
	Performance Improve	ement Committee consists					
	of but not limited to th	e Executive Director,					
	Director of Nursing, A	ssistant Director of Nursing,					
	Social Services Mana	iger, Business Office					
	Manager, Activities D	irector, Human Resources,					
	Pharmacist, Medical I	Director, CNA, Dietary					
	Manager, Maintenand	ce Director, Housekeeping					
		ns, Medical Records, and					
	MDS Nurse. The Qua	lity Assurance Performance					
		tee meets monthly and					
	quarterly at a minimu	m.					
	Compliance date: 09						
	The facility's correctiv	e action plan was validated					
	by the following:						
	" On 12/13/23 the	facility's plan of correction					
	was validated upon re	eview of the sign-in sheets					
	for in-service education	on provided to the					
	admissions staff and	business office staff on the					
	admissions policy, ve	rifying demographic					
	information, and how	to verify correct information					
	by reviewing two form	ns of identification of					
	residents, one includi	ng a photograph. Review of					
	the monitoring audits	revealed no concerns					
	identified. Interviews	conducted with the					
	Business Office Mana	ager and the Assistant					
	Business Office Mana	ager and Admissions staff					
		eived education on the					
	admissions policy and	-					
		ent's correct information					
	-	eing admitted to the facility.					
		pled residents recently					
	admitted revealed no						
	" In addition, the p	lan of correction was					
	validated upon review	/ of the sign-in sheets for					
	in-service education p	provided to all licensed					
	nurses on notification	of change in condition					
	policy, admissions po	licy, discharge policy,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
			A. BUILDI	ING _			C
		345388	B. WING			12/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580 F 620 SS=J	the electronic medica Review of the monitor were no concerns ide conducted with the lic revealed they had rec notification and docur for any change condit residents. Record rew who recently had chat treatment revealed no The facility's complian validated. Admissions Policy CFR(s): 483.15(a)(1)- §483.15(a) Admission §483.15(a)(1) The fac implement an admissi §483.15(a)(2) The fac (i) Not request or requires idents to waive the subpart and in applica- licensing or certification limited to their rights t (ii) Not request or requires are not eligible for, or or Medicaid benefits. (iii) Not request or requires are not eligible for, or or Medicaid benefits. (iii) Not request or requires are not eligible for, or or Medicaid benefits. (iii) Not request or requires are not eligible for, or or S483.15(a)(3) The fac	A change in condition mentation of notification in l record (EMR) on 09/21/23. ring audits revealed there ntified. Interviews sensed nursing staff seived education on mentation of the notification tion or treatment for view of sampled residents nges in condition or o concerns. the date of 9/29/23 was (7) hs policy. cility must establish and ions policy. cility must- uire residents or potential eir rights as set forth in this able state, federal or local on laws, including but not o Medicare or Medicaid; and uire oral or written ints or potential residents will not apply for, Medicare quire residents or potential tential facility liability for		620			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/08/2024 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE : COMPL	_ETED
		345388	B. WING		_	( 12/1	,  3/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HUNTER	WOODS NURSING AND I	REHAB		620 TOM HUNTER ROAD CHARLOTTE, NC 28213	3		
(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 BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 620	admission, or continu However, the facility r resident representative resident's income or r for facility care to sign incurring personal fina facility payment from resources. §483.15(a)(4) In the con- Medicaid, a nursing facility solicit, accept, or rece amount otherwise reconstruction State plan, any gift, m consideration as a pro- expedited admission facility. However,- (i) A nursing facility m eligible for Medicaid f resident has requested not specified in the St term "nursing facility s facility gives proper n cost of these services condition the resident stay on the request for additional services; and (ii) A nursing facility m a charitable, religious contribution from an of person unrelated to a potential resident, but contribution is not a c expedited admission, facility for a Medicaid	of admission or expedited ed stay in the facility. may request and require a ve who has legal access to a resources available to pay in a contract, without ancial liability, to provide the resident's income or case of a person eligible for acility must not charge, eive, in addition to any pured to be paid under the noney, donation, or other econdition of admission, or continued stay in the ay charge a resident who is or items and services the ed and received, and that are tate plan as included in the services'' so long as the otice of the availability and as to residents and does not 's admission or continued or and receipt of such and hay solicit, accept, or receive , or philanthropic organization or from a Medicaid eligible resident or a only to the extent that the ondition of admission, or continued stay in the	F 62				

Facility ID: 923058

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	WOODS NURSING AND I	REHAB		6 C			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 620	apply stricter admission or local laws than are prohibit discrimination to Medicaid. §483.15(a)(6) A nursi provide to a resident time of admission, no characteristics or serv §483.15(a)(7) A nursi composite distinct paid disclose in its admiss configuration, includin comprise the compose specify the policies the between its different I (c)(9) of this section. This REQUIREMENT by: Based on record revit facility failed to impleted and Procedure and vec cognitively impaired r admitted to the facility discharging skilled nut (potential new admisses name as Resident #1 who did not have a di administered 3 doses experienced 3 three la the insulin was discor Resident #1 received diuretic, and a medica hypothyroidism from 0 prescribed for Person occurred for 1 of 2 res	ons standards under State specified in this section, to a against individuals entitled and facility must disclose and or potential resident prior to tice of special vice limitations of the facility. In facility that is a rt as defined in §483.5 must ion agreement its physical og the various locations that ite distinct part, and must at apply to room changes ocations under paragraph is not met as evidenced ews and staff interviews, the ment their Admissions Policy erify the identity of a esident when he was with paperwork from the rsing facility for Person #2 sion with same first and last ). As a result, Resident #1, agnosis of diabetes, was of long-acting insulin, and by blood sugar levels before ation used to treat 07/17/23 until 09/15/23 #2. This deficient practice sidents reviewed for I had a high likelihood of	F	620	Past noncompliance: no plan of correction required.		

Facility ID: 923058

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345388	B. WING				C 13/2023	
NAME OF PI	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
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 OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 620	Continued From page	e 18	F	620				
	The findings included	:						
	The Admissions Polic facility dated 08/19/20 in part: "The Marketing Coord Coordinator will: - Copy all insurance, cards, and attach cop verification, i.e.: Med Medicaid eligibility, et obtained, copies MUS electronic medical red attempts to obtain the the admission checkli over to the Business - Complete all docum	ey and Procedure for the D18, under Procedure read dinator or Admissions Medicare, and Medicaid bies of all applicable payor icare eligibility verification, c. When documents are ST be scanned into the cord. There must be 3 ese copies documented on ist before this can be turned Office Manager. ents listed on Admissions by State specific forms not						
	FL-2 form (state form medical condition and when placed in a facil doctor at the discharg and dated 07/05/23 in neurological condition disturbance, non-Alzh malnutrition, stage IV long-term drug therap Resident #1's admiss dated 07/17/23 revea oriented to person on	n, dementia with behavioral neimer's dementia, pressure ulcer and by. ion nursing assessment						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
		345388	B. WING				C / <b>13/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		•	Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 620	<ul> <li>party. This assessme #3.</li> <li>Several attempts wer who was the admitting without success.</li> <li>Person #2's medicating entered for Resident is Admissions Coordina 1. Aspirin oral table (mg) tablet - give 1 ta hypertension.</li> <li>2. Eliquis oral table mouth two times a da 3. Furosemide (diur 1 tablet by mouth one hypertension.</li> <li>4. Lantus (long-acti solution 100 units/mill inject 55 units subcut for diabetes mellitus. check blood sugar ind 5. Synthroid oral tal (Levothyroxine Sodiu in the morning for thy Review of Resident # orders received from nursing facility on 09/ Medical Director at th included the following 1. Brimonidine Tartr 0.2% - instill 1 drop in for glaucoma.</li> <li>2. Dorzolamide HC instill 1 drop in left ey glaucoma.</li> </ul>	ent was entered by Nurse e made to contact Nurse #3 g nurse for Resident #1 on orders which were #1 on 07/17/23 by tor #1 included: t chewable 81 milligrams blet by mouth daily for t 5 mg - give 1 tablet by y for aphasia. retic) oral tablet 40 mg - give e time a day for ng insulin) subcutaneous limeter (insulin Glargine) aneously two times a day There were no orders to cluded in these orders. blet 50 micrograms (mcg) m) - give 1 tablet by mouth roid. 1's correct medication the discharging skilled 15/23 and verified by the e facility on 09/16/23 crate Ophthalmic Solution both eyes three times a day	F	620			

Facility ID: 923058

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		MEDICAID SERVICES		PLE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	MPLETED		
			A. BUILDING			С		
		345388	B. WING					
	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP CODI		2/13/2023		
NAME OF F	ROVIDER OR SOFFLIER			620 TOM HUNTER ROAD				
HUNTER	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	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE		
F 620	Continued From pag	e 20	F 62	20				
1 020			F 02	20				
	by mouth at bedtime							
		Tablet 1 mg - give 1 tablet by						
		y for malnutrition/weight loss.						
		let 100 mg - give 1 tablet by y for malnutrition/weight loss.						
		R Oral Tablet Extended						
	-	grams (mcg) - give 1 tablet						
	-							
	by mouth one time a day for risk for malnutrition/weight loss.							
	An interview on 12/0	6/23 at 11:47 AM with the						
	Social Worker reveal	led she and the Unit						
	Manager had attemp	ted to interview the resident						
		eting on 07/19/23 and it						
	became apparent to	them during the meeting the						
	resident was alert an	d oriented to person only						
	and was unable to ta	lk with them. She stated						
	after the meeting she	e had called the SW at the						
	discharging facility a	nd obtained the responsible						
	party name and telep	phone number and had						
	updated the resident	's medical record with the						
		. The SW stated she notified						
		dinator #1 and the Business						
		e updated information on						
		nsible party that had been						
		nt's medical record. She						
		missions Coordinator #1						
	-	e party (RP) until she finally						
		4/23 and he came into the						
	facility on 07/24/23 to	k. The SW explained						
		ber it was brought to her						
		had the wrong date of birth,						
	-	ications for Resident #1, so						
		arging skilled nursing facility						
		rect information from the						
	Social Worker at that							
		-						
	Marketing Director of	btained hard copies of the						

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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:			E CONSTRUCTION	(X3) DATE	
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				e	620 TOM HUNTER ROAD		
	WOODS NURSING AND I	REHAB		0	CHARLOTTE, NC 28213		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 620	Business Office Mana she received a teleph Nurse who informed H date of birth for Resid responsible party (RP The Hospice Nurse re Office Manager the co Resident #1 and the H notified the facility So Resident #1's date of Worker reached out b the discharging skilled obtained the correct in #1's correct FL-2 (sta patient's medical con- care needed when pla medication orders. An interview on 12/06 Marketing Coordinato referrals and goes to evaluate residents for admission to the facilit received a telephone skilled nursing facility evaluate Resident #1 exact date) for possib She further stated she had interviewed Resid seen him and looked and agreed to take hi Coordinator said the S discharging skilled nur information and given that day (could not re	6/23 at 11:55 AM with the ager, revealed on 09/15/23 one call from the Hospice her the facility had the wrong lent #1 according to the P) who was a family member. eported to the Business prect date of birth for Business Office Manager cial Worker of the error with birth. The facility Social by telephone to the SW at d nursing facility and information and Resident te form that describes a dition and the amount of aced in a facility) and 6/23 at 5:20 PM with the or revealed she received hospitals and facilities to possible transfer and ity. She stated she had call from the discharging and went to the facility to (could not remember the ble admission to the facility. e could not remember if she dent #1 but said she had over his paperwork provided m. The Marketing Social Worker at the trsing facility had printed out to her in an envelope on member what day) and she	F	620			
	that day (could not re						

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			()(0)			0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE S COMPLI			
			A. BUILDING	<u> </u>				
		345388	B. WING		C			
		345388	B. WING	12/13/20				
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE			
	WOODS NURSING AND	REHAB		620 TOM HUNTER ROAD				
				CHARLOTTE, NC 28213				
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE		
F 620	Continued From pag	e 22	E 62	20				
1 020			F 62	20				
		lent #1 that they were						
	-	ty. She indicated they had						
		sident that she had evaluated						
		d received the wrong						
		ith the wrong medication						
		the Marketing Coordinator,						
	-	nformation was received						
		skilled nursing facility when						
		esident #1, the wrong						
		n uploaded by Admissions						
		s computer profile at the						
	-	ng Coordinator said at the						
		Resident #1 she was not						
		o residents with the same						
		at the discharging skilled						
		ter learned there were, and						
	-	the wrong information for the						
		ne typical packet consisted of						
		heet, discharge summary						
	-	none of which had pictures						
	of the resident on the	-						
		he couldn't remember if she						
		ation prior to it being entered						
	-	ad no reason to believe it						
		nformation for Resident #1.						
		dinator indicated Admissions						
		d have been responsible for						
		I's information through rtals. Once the documents						
		missions Coordinator #1, she						
	-	ion into the resident's						
		ofile. According to the						
	-	or, since the issue with						
		dmitted from another facility						
		orders, and medication						
	last name as Reside	(who had the same first and						
	LIAST DATE AS RESIDE							
	changed their proces							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345388	B. WING				C 1 <b>3/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE		
					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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 620	card, and social secur the electronic medica resident was unable t packet with the Admis responsible party was process. She stated trained for her position obtain copies of cards the information but sa the cards prior to the prior to admission now responsible party, gua must provide two form one must include a ph Admissions Coordina interview. Admissions Coordina the facility at the time An interview on 12/07 Director of Nursing (D Nurse Consultant reve Resident #1 had beer for which he didn't ha were following the ord discharging skilled nut they were not aware of #1 and his orders unt Hospice on 09/15/23 had for the resident w Consultant stated ond birth was incorrect, th skilled nursing facility information and the co	<ul> <li>identification, Medicare</li> <li>rity card and scan them into</li> <li>I record. If the admitting</li> <li>o complete the admission</li> <li>asions Coordinator, then the</li> <li>a contacted to complete the</li> <li>when she was initially</li> <li>n, she was not trained to</li> <li>a and relied on portals for</li> <li>aid now they obtain copies of</li> <li>resident being admitted and</li> <li>w resident's or their</li> <li>ardian, or power of attorney</li> <li>ns of identification of which</li> <li>notograph of the resident.</li> </ul> tor #1 was not available for tor #2 was not employed by <ul> <li>of the error.</li> </ul> 7/23 at 4:45 PM with the DON), Administrator, and ealed they were aware <ul> <li>n administered medications</li> <li>ve diagnoses but said they</li> <li>ders provided by the</li> <li>ursing facility. They all said</li> <li>of any issues with Resident</li> <li>il they were notified by</li> <li>that the date of birth they</li> <li>vas not correct. The Nurse</li> <li>they learned the date of</li> <li>ey called the discharging</li> <li>and obtained the correct</li> </ul>	F	620			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
		IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
			A. BUILDING	G		0
		345388	B. WING			С
		545566				2/13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	1	
	WOODS NURSING AND	REHAB		620 TOM HUNTER ROAD		
-				CHARLOTTE, NC 28213		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 620	Continued From pag	e 24		20		
1 020			F 62	20		
	ordered and they init					
		tments for the resident. The				
		d DON stated the original				
		sheet) created on admission				
		not be reviewed because				
		new profile for Resident #1				
	-	ne current profile for the				
		information had been erased				
		se Consultant further stated				
	-	ated a new profile for the				
		prrecting the old profile so				
	•	uld be visible but said that				
		missions Coordinator #1 had				
	done with Resident #	i s mormauon.				
	An intonviow on 12/1	1/23 at 10:46 AM was				
		al Worker (SW) #2 from the				
		ursing facility. The interview				
		ng Coordinator from the				
		e and assessed both				
		son #2 (who had the same				
		on 07/12/23 and was handed				
		arge packets in two different				
	envelopes with the fa					
	-	FL-2 for each resident in the				
	envelope. SW #2 fur					
	· ·	or left the facility Person #2				
	-	nt to discharge so she let the				
		or know on 07/14/23 that				
	-	e coming; however, Person				
		main at their facility and not				
		view further revealed at				
	-	Resident #1 was sent to the				
	-	a second discharge packet				
		edications, face sheet,				
		es, history and physical,				
		dietary considerations. SW				
	#2 stated after the di	-				
		scharde she was contacted				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	0: 01/08/2024 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345388	B. WING				( 12/ <sup>-</sup>	C 13/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
HUNTER	WOODS NURSING AND F	REHAB			20 TOM HUNTER ROAD HARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 620	facility stating they ha and needed Resident stated the Marketing O discharging skilled nu handed the informatio Marketing Coordinato been given both Resid packets when she cou the discharging skilled The Administrator was jeopardy on 12/07/23 The facility provided t action plan with a con The facility failed to en from a significant med #1 was administered Person #2. Resident # edications: " Lantus " Eliquis " Synthroid " Lasix " Aspirin Prior to Resident #1's the Director of Admiss assessment. When le skilled nursing facility Social Worker provide Person #2's North Ca Form (FL-2) with a da medication list for Res also admitted to the fa	d mixed up the residents #1's records again. SW #2 Coordinator came to the rsing facility and was in in person. She stated the r acknowledged she had dent #1's and Person #2's mpleted the assessments at d nursing facility. Is notified of immediate at 5:15 PM. The following corrective hpletion date of 09/29/23: Insure Resident #1 was free dication error when Resident medications prescribed for #1 received the following admission to our facility, sions conducted a bedside aving the discharging the discharging facility's ed physical copies of the rolina Long Term Care te of birth of 1/16/56 and sident #2. Resident #1 was acility with Person #2's date b), medical information, and	F	520				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345388	B. WING				C / <b>13/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HUNTER	WOODS NURSING AND F	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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 620	Upon arrival on 7/17/2 person with confusion The FL2 received pro- information. Person # the discharging facility own responsible party On 7/19/23 a care con- with Resident #1 led B Director. During the c was observed to have impairment, congruer symptoms of possible listed as his own resp was unable to actively After realizing Reside impairment, and seve the contact number lis Admission Record, the reached back out to the Social Worker on 7/19 facility's Social Worke information for Reside Admissions made seven umber with no succe until the morning of 7/ Director. The admissi completed by the Direct afternoon on 7/24/23 responsible party. On 9/15/23, during a between the Resident our hospice partner, a information via teleph the date of birth we w discharging facility did	23, Resident #1 was alert to a and memory impairment. vided no relative or contact 2's admission record from y listed the resident as his /. nference meeting was held by the Social Services are conference, Resident #1 e notable cognitive at with the signs and e dementia. Resident #1 was onsible party. Resident #1 y participate. nt #1's cognitive ral attempts were made to sted on Resident #2's e Director of Admissions he discharging facility's 2/23. The discharging er provided new contact ent #1. The Director of /eral attempts using the new ess. Contact was not made /24/23 by the Admissions on agreement was ector of Admissions in the with Resident #1's phone conversation t #1 responsible party and and while verifying one, it was discovered that	F	620			

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If continuation sheet Page 27 of 60

INTERMENT OF DEFICIENCIES AND PLAY OF CORRECTION         (N) IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345388         (2) MALTIPLE CONSTRUCTION A. BUILDING 		-	ID HUMAN SERVICES				FORM	): 01/08/2024 APPROVED 0. 0938-0391
142132023       NMEE OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, JP CODE       CODE NURSING AND REHAB       OPENDING SANDAWE SYSTEMM OF DESCRIPTIONS PROVIDER OF NUMBER AND REMATION       OPENDING SANDAWE SYSTEMM OF DESCRIPTIONS PROVIDER OF NUMBER AND REMATION       OPENDING SANDAWE SYSTEMM OF DESCRIPTIONS PROVIDER OF NUMBER AND REMATION       OPENDING SANDAWE SYSTEMM OF DESCRIPTIONS PROVIDER OF NUMBER AND REMATION       OPENDING SANDAWE SYSTEMM OF DESCRIPTIONS PROVIDER OF NUMBER AND REMATION       OPENDING SANDAWE SYSTEM OF DESCRIPTIONS PROVIDER OF NUMBER AND REMATION       STATE STATE ADDRESS CITY, STATE, JP CODE       SECONDER TO SANDAWE SYSTEMM OF DESCRIPTION OF D	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY LETED
INMARE OF PROVIDER OR SUPPLIER     STREET ADDRESS. OTTY, STATE, ZIP CODE       HUNTER WOODS NURSING AND REHAB     STREET ADDRESS. OTTY, STATE, ZIP CODE       IPAL     IPAL OF CONSTRUCT AND STATE ENHANCE OF DEFICIENCIES.     IPAL OF CONFECTION       IPAL OF CONFECTION WIST OF DEFICIENCIES.     IPAL OF CONFECTION WIST OF DEFICIENCE OF UTLL     IPAL OF CONFECTION ADDRESS OF THE ADDRESS. OTTY, STATE, ZIP CODE       IPAL OF THE STATE ADDRESS.     IPAL OF CONFECTION ADDRESS OF THE ADDRESS. OTTY, STATE, ZIP CODE     IPAL OF CONFECTION       IPAL OF THE STATE ADDRESS.     IPAL OF CONFECTION ADDRESS OF THE ADDRESS. OTTY STATE, ZIP CODE     IPAL OF CONFECTION       IPAL OF CONFECTION ADDRESS OF THE ADDRESS.     IPAL OF CONFECTION     IPAL OF CONFECTION       IPAL OF CONFECTION ADDRESS OF THE ADDRESS.     IPAL OF CONFECTION     IPAL OF CONFECTION       IPAL OF CONFECTION ADDRESS OF THE ADDRESS.     IPAL OF CONFECTION     IPAL OF CONFECTION       IPAL OF CONFECTION ADDRESS OF THE ADDRESS.     IPAL OF CONFECTION     IPAL OF CONFECTION       IPAL OF CONFECTION OF LIST OF CONFECTION OF CONFECTION     IPAL OF CONFECTION OF CONFECTION     IPAL OF CONFECTION OF CONFECTION OF CONFECTION       IPAL OF CONFECTION OF			345388	B. WING		_		
HUTTER WOODS NURSING AND REHAB       CHARLOTTE, NC 28213         (M) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MOST BE PRECEDED BY FULL REOULTORY OR LSC DENTERVING INFORMATION)       D PREFIX TAG       PROVIDENTERVING NUMBER AND RECEDED BY FULL REOULTORY OR LSC DENTERVING INFORMATION)       D PREFIX TAG       PROVIDENTERVIS NUMBER RECEDENT NUMBER AND RECEDED BY FULL REOULTORY OR LSC DENTERVING INFORMATION)       D PREFIX TAG       PROVIDENTERVIS NUMBER RECEDENT NUMBER AND RECEDED BY FULL RECOVERS THE ADDRESS OF THE APPROPRIATE       O PROVIDENT NUMBER AND RECEDED BY FULL RECOVERS THE ADDRESS OF THE APPROPRIATE DEFICIENCY       O PROVIDENT NUMBER AND RECEDED BY FULL RECOVERS THE ADDRESS OF THE APPROPRIATE       O PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER AND RECEDED BY FULL RECOVERS THE ADDRESS OF THE APPROPRIATE DEFICIENCY       O PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER DEFICIENCY       D PROVIDENT NUMBER PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER DEFICIENCY       D PROVIDENT NUMBER PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER PROVIDENT NUMBER CONSTRUCTION PROVIDENT NUMBER PROVIDENT NUMBER AND NUMBER PROVIDENT NUMBER PROVIDENT NUMBER PROVIDENT NUMBER AND NUMBER PROVIDENT NUMBER AND NUMBER AND NUMBER PROVIDENT NUMBER AND NUMBER AND NUMBER AND NUMBER PROVIDENT NUMBER AND N	NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
Precipin TAG         REGULATORY OR LSC IDENTIFYING NFORMATION)         PRETX TAG         C(EACH ORPRECTIVE ACTION SHOULD BE CROSS-REFERENCES)         COMPLET DEFICIENCY           F 620         Continued From page 27 that the initial information received from the discharging facility was that of Person #2 who was also a resident of the discharging facility with the same name as Resident #1.         F 620           · On 9/15/23 the correct information, including medication orders for Resident #1.         F 620           · On 9/15/23 the correct information, including medication orders for Resident #1. The discontinued.         F 620           · On 9/15/23 the Director of Nursing completed a medication error report for Resident #1.         F 620           · On 9/15/23 the Director of Nursing completed a medication error report for Resident #1.         F 7 Critical medications received in error were Insulin, Eliquis and Synthroid, Lasix and Aspirin. The Insulin Ad previously been discontinued on 7/21/23, prior to this discovery due to low blood sugar levels.         F The Eliquis, Synthroid, Aspirin, and Lasix were discontinued on Friday, 9/15/23. Labs ordered were Thyroid Stimulating Hormone (TSH), Complete Metabolic Panel (CBP), Complete Blood Count (CBC) with differential.         F On 9/22/23 and 9/25/23 lab results (TSH, CBC with diff, and CMP) were reviewed by the Medical Director and determined there were no adverse reactions suffered, and Resident #1 was not at risk for any other adverse reactions because of this indicent. Resident #1 was and at risk for any other adverse reactions	HUNTER V	VOODS NURSING AND F	REHAB			3		
<ul> <li>that the initial information received from the discharging facility was that of Person #2 who was also a resident of the discharging facility with the same name as Resident #1.</li> <li>* On 9/15/23 the correct information, including medication orders for Resident #1 was obtained. Resident #1 was evaluated by the facility Medical Director. Upon review of Resident #1 medications and orders, all unnecessary medications were discontinued.</li> <li>* On 9/15/23 the Director of Nursing completed a medication error report for Resident #1.</li> <li>* On 9/15/23 the Director of Nursing completed a medications received in error by Resident #1.</li> <li>* On 9/15/23 the Director of Nursing completed for the medication error report was completed for the medications received in error were Insulin, Eliquis and Synthroid, Lasix and Aspirin. The insulin had previously been discontinued on 7/21/23, prior to this discovery due to low blood sugar levels.</li> <li>* The Eliquis, Synthroid, Aspirin, and Lasix were discontinued on Friday, 9/15/23 Labs ordered were Thyroid Stimulating Hormone (TSH), Complete Metabolic Panel (CBP), Complete Blood Count (CBC) with differential.</li> <li>* On 9/22/23 and 9/25/23 lab results (TSH, CBC with diff, and CMP) were reviewed by the Medical Director and determined there were no adverse reactions uffered, and Resident #1 was not at risk for any other adverse reactions because of this incident. Resident #1 was as not at risk for any other adverse reactions</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B		COMPLETION
seen and monitored throughout the weekend by the facility Nurse Practitioner. " The facility's Medical Director made multiple	F 620	that the initial informa discharging facility was was also a resident of the same name as Ref " On 9/15/23 the co- medication orders for Resident #1 was eval Director. Upon review and orders, all unnece discontinued. " On 9/15/23 the D a medication error rep medication error repo medication error repo medication error repo medication s received " Critical medicatio Insulin, Eliquis and Sy The insulin had previo 7/21/23, prior to this of sugar levels. " The Eliquis, Synt were discontinued on ordered were Thyroid (TSH), Complete Met Complete Blood Cour " On 9/22/23 and 9 CBC with diff, and CM Medical Director and adverse reactions suf not at risk for any othe because of this incide seen and monitored th the facility Nurse Prace	tion received from the as that of Person #2 who f the discharging facility with esident #1. orrect information, including Resident #1 was obtained. uated by the facility Medical of Resident #1 medications essary medications were birector of Nursing completed bort for Resident #1. The rt was completed for the in error by Resident #1. ons received in error were ynthroid, Lasix and Aspirin. ously been discontinued on discovery due to low blood hroid, Aspirin, and Lasix Friday, 9/15/23. Labs Stimulating Hormone abolic Panel (CBP), nt (CBC) with differential. 0/25/23 lab results (TSH, MP) were reviewed by the determined there were no fered, and Resident #1 was er adverse reactions ent. Resident #1 was also hroughout the weekend by ctitioner.	F 62	0			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345388	B. WING				_ 13/2023
NAME OF P	ROVIDER OR SUPPLIER	1		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 620	attempts to reach Res by phone starting on a leave a message due Medical Director spok responsible party on a the incident. Resident understood and had r incident. To help ensure the de reoccur, a chart audit since 5/17/2023 was Office Manager and A 9/28/23 to ensure infor residents' medical reo belonged to the residi included verifying the demographic sheet, th and financial informat discrepancies were co On 9/21/23, a Root C completed by the Director. In failed to validate Resi upon admission on 7/ The Executive Director. In failed to validate Resi upon admission on 7/ The Executive Director Coordinator, Business Assistant Business O accurate documentati had been obtained pr Accurate information information, financial	sident #1's responsible party 9/15/23 but was unable to to full voice mailbox. The we with the Resident #1's 9/21/23 and advised him of t #1's responsible party no adverse response to the efficient practice does not of all residents admitted conducted by Business admissions Coordinator on ormation filed in the cord was accurate and ing resident. This audit resident information on the he resident's photograph, tion was accurate. Any orrected. ause Analysis was ector of Nursing and o conclusion, the facility ident #1 medical information (17/23. b) completed education on ty's admissions team, which of Admissions, Admission s Office Manager to ensure ion for admitting residents ior to entering the facility. would include demographic information, and a tissions team was also required information,	F	620			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				6	20 TOM HUNTER ROAD		
HUNTER	WOODS NURSING AND I	REHAB		C	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 620	documentation, media received from a disch and belonged to the a Authentication will be facility's appointed rep Business Office Manag Office Manager were Executive Director on information, which ind Security Number, Dat information and policy admitting resident. Th and Admissions and/o the newly admitted re- authentication. Auther newly admitted resider information, including name, date of birth, a the resident is unable the Director of Admiss Coordinator will have power of attorney or a authenticate the newl identity. Authentication admitted resident's gu appointed person to v including, but not limit date of birth, and soci Prior to admission, ne- their responsible party two forms of identifica- include Medicare and When documents are scanned into the resider record. There must b copies documented o	cation list, and FL-2s arging facility were accurate admitting resident. verified by the discharging presentative. The facility ager and Assistant Business also educated by the ensuring required cludes the residents' Social te of Birth, insurance card y information belong to the ne Director of Admissions or Coordinator will validate sidents' identity by verbal ntication will require the ent to verbally provide , but not limited to their nd social security number. If to provide this information, sions and/or Admissions the resident's guardian, appointed person verbally y admitted resident's n will require the newly uardian, power of attorney or verbally provide information, ted to the resident's name, ial security number.	F	620			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 620	Office personnel will the during new hire orient during new hire orient "Starting on 9/28/23 the designee to complete monitoring for Admissi forms of identification a photograph, copy or review admission pace for twelve weeks and Weekly monitoring will Monthly monitoring will Monthly monitoring will monthly monitoring will monthly monitoring will a surface Performance on 9/28/23. The Exect for implementing this reviewed by QAPI commonitoring (audit) upor based on findings. The Performance Improvers of but not limited to the Director of Nursing, A Social Services Mana Manager, Activities D Pharmacist, Medical I Manager, Maintenand Supervisor, Admission MDS Nurse. The Qual Improvement Commit quarterly at a minimute Completion date: 09/2	d Admissions or Business be educated on this process fation. The Executive Director and/or Quality Improvement fion Process to include two of which one must include f insurance cards, and tket to be completed weekly monthly for 3 months. If be completed by 12/21/23. If be completed by 3/21/24. Ing and Executive Director f correction to the Quality fice Improvement Committee utive Director is responsible plan. Findings will be mmittee monthly and Quality dated if changes are needed the Quality Assurance ment Committee consists e Executive Director, ssistant Director of Nursing, nger, Business Office irector, Human Resources, Director, Housekeeping ns, Medical Records, and ulity Assurance Performance the meets monthly and m.	F	620			

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED C
		345388	B. WING		12	2/13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 620	Continued From page	9 31	F 6	20		
F 760 SS=J	validated upon review in-service education p staff and business off policy, verifying demo how to verify correct i forms of identification a photograph. Review revealed no concerns conducted with the Bu the Assistant Busines Admissions staff reve education on the admi importance of confirm information prior to th the facility. Record rev recently admitted reve facility's completion d validated. Residents are Free of CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on record revi staff, Nurse Practition interviews, the facility medication errors who administered medicat #2 (potential new adm last name as Resider information and medic for Resident #1 in error	f Significant Med Errors The that its- nts are free of any significant is not met as evidenced ews and family member, er and Medical Director failed to prevent significant en a. Resident #1 was ions prescribed for Person nission with same first and	F 7	60 Past noncompliance: no plan of correction required.		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345388	B. WING				C / <b>13/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	had three low blood s insulin was discontinu Resident #1 was adm aspirin, diuretic, and a hypothyroidism for wh treat. b. In addition, R two eye drops prescri glaucoma from 07/17, deficient practice occur reviewed for medicati likelihood for serious Example b. was cited severity of D. The findings included 1. a. Resident #1 was 07/17/23. Resident #1's diagnos FL-2 form (state form medical condition and when placed in a facil doctor at the discharg and dated 07/05/23 in neurological condition disturbance, non-Alzh malnutrition, stage IV long-term drug therap Resident #1's admiss dated 07/17/23 revea oriented to person on needs but was listed a party. The resident's	<ul> <li>iabetes and was</li> <li>of long-acting insulin and sugar levels before the led on 07/21/23. In addition, inistered an anticoagulant, a medication used to treat nich he had no diagnoses to resident #1 did not receive bed for his diagnosis of /23 through 09/15/23. This urred for 1 of 2 residents on errors and had a high harm.</li> <li>at a lower scope and</li> <li>admitted to the facility on</li> <li>ses according to his correct that describes a patient's a the amount of care needed ity) signed by the medical ping skilled nursing facility neuronal dementia, pressure ulcer and by.</li> </ul>	F	76			

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DEPARTMENT OF HEALTH AND						FORM	01/08/2024 APPROVED
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
	345388	B. WING			_		C 13/2023
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	12/	10,2020
				20 TOM HUNTER ROAD			
HUNTER WOODS NURSING AND R	EHAB			HARLOTTE, NC 28213	3		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
<ul> <li>who was the admitting without success.</li> <li>Person #2's medication entered for Resident # Admissions Coordinate 1. Aspirin oral tablet (mg) tablet - give 1 tab hypertension.</li> <li>2. Eliquis oral tablet mouth two times a day 3. Furosemide (diure 1 tablet by mouth one hypertension.</li> <li>4. Lantus (long-actin solution 100 units/millini inject 55 units subor for diabetes mellitus. Check blood sugar incl 5. Synthroid oral table (Levothyroxine Sodium in the morning for the Review of the Medicati (MAR) for Resident #1 following medications p from 07/17/23 to 09/15 of Resident #1 on the 1. Aspirin 58 d 2. Eliquis 117 3. Furosemide 58 d 4. Lantus insulin 07/21/23)</li> <li>5. Synthroid 60 d</li> </ul>	the resident. made to contact Nurse #3 nurse for Resident #1 n orders which were 1 on 07/17/23 by the or #1 and included: chewable 81 milligrams let by mouth daily for 5 mg - give 1 tablet by for aphasia. etic) oral tablet 40 mg - give time a day for g insulin) subcutaneous meter (insulin Glargine) cutaneously two times a day There were no orders to uded in these orders. let 50 micrograms (mcg) n) - give 1 tablet by mouth hyroid. ion Administration Records revealed he received the prescribed for Person #2 i/23. There was a picture MAR: loses doses	F	760		)EFICIENCY)		

Facility ID: 923058

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345388	B. WING				C / <b>13/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	orders received from 09/15/23 and verified the facility on 09/16/2 1. Brimonodine Tart 0.2% - instill 1 drop in for glaucoma. 2. Dorzolamide HC instill 1 drop in left ey glaucoma. 3. Flomax Oral Cap by mouth at bedtime f 4. Folic Acid Oral Ta mouth one time a day 5. Vitamin B-1 Table mouth one time a day 6. Vitamin B-12 ER Release 1000 microg by mouth one time a malnutrition/weig Review of Resident # Medication Administra following: On 07/18/23 at 9:00 A Lantus insulin 55 unit administered by Nurs MAR. On 07/18/23 at 9:00 F receive Lantus insulin documented as refusa On 07/19/23 an order sugars before meals a hypoglycemia to begit the MAR	<ul> <li>the discharging facility on by the Medical Director at 3 included the following: trate Ophthalmic Solution a both eyes three times a day</li> <li>I Ophthalmic Solution 2% - e two times a day for</li> <li>I Ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e two times a day for</li> <li>I ophthalmic Solution 2% - e trans (mcg) - give 1 tablet day for risk for</li> <li>I ophthalt Extended</li> <li>I ophthalt</li></ul>	F	760			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345388	B. WING				C 13/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
HUNTER	VOODS 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 760	sugar reading of 64. and a snack documer nursing progress note On 07/20/23 at 6:53 A glucose reading revea of less than 40 accord On 07/20/23 at 9:00 A insulin held due to low AM of 64. The blood 10:24 AM and it was #2. On 07/21/23 at 6:03 A sugar reading of 71. and a snack documer On 07/21/23 at 9:00 A Lantus insulin 55 unit administered by Nurs On 07/21/23 at 1:29 F was discontinued for meals and at bedtime until they were discon according to the MAR Several attempts were by telephone without Review of Resident # Data Set (MDS) asse	s subcutaneously e #2 on the MAR. AM Resident #1 had a blood He was given orange juice need by Nurse #4 in the es. AM a lab drawn blood aled a blood sugar reading ding to the lab. AM Resident #1 had Lantus v blood sugar level at 5:55 sugar was rechecked at 91 documented by Nurse AM Resident #1 had a blood He was given orange juice need by Nurse #4. AM Resident #1 received s subcutaneously e #2 according to the MAR. PM the Lantus insulin order Resident #1 but the before e blood sugars continued ntinued on 09/15/23 c. e made to contact Nurse #4 success. 1's admission Minimum ssment dated 07/31/23	F	760	,		
		erely cognitively impaired, red extensive assistance of					

Facility ID: 923058

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/08/2024 MAPPROVED ). 0938-0391
STATEMENT OF DEFIC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345388	B. WING		_		C 13/2023
NAME OF PROVIDER	R OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			6	20 TOM HUNTER ROAD			
HUNTER WOODS	NURSING AND F	REHAB	c	CHARLOTTE, NC 28213	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
1-2 st A tele with N Resid care o was n verba insulin them She s Medic mark, insulin had n receiv ordero transo pictur stateo could being She s MAR the m A tele with N #1 an usual #1 wo not di insulin Resid said t were sugar	phone interview Jurse #1 revealed ent #1 and vague of him but not an ion-verbal and w lize to them he was haid if her initials cation Administra- she would have n as prescribed a o way of knowin re insulin or any ed if it was in his cribed on the MA e of the resident d she cared for the n't remember ex- reassigned to the tated if the pictures addictions as or phone interview Jurse #2 revealed d taking care of by the nurse on to build not have be abetic and shou n. Nurse #2 state ent #1 had low here usually on the o levels. He furth	<ul> <li>a 36</li> <li>as of daily living (ADL).</li> <li>on 12/07/23 at 11:39 AM</li> <li>d she remembered</li> <li>all remembered taking</li> <li>y details. She stated he</li> <li>y details. Nurse #1</li> <li>he resident a few times but</li> <li>actly what days before</li> <li>he other unit at the facility.</li> <li>re of the resident on the</li> <li>ident in the bed, they gave</li> <li>dered by the physician.</li> <li>on 12/07/23 at 12:57 PM</li> <li>d he remembered Resident</li> <li>him and said he was</li> <li>hat hall. He stated Resident</li> <li>him and said he was</li> <li>hat hall. He stated Resident</li> <li>him and said he was</li> <li>hat hall. He stated Resident</li> <li>him and said he was</li> <li>hat hall. He stated Resident</li> <li>him and said he was</li> <li>hat hall. He stated Resident</li> <li>him and said he was</li> <li>hat hall. He stated Resident</li> <li>him and said he was</li> <li>hat hall. He stated Resident</li> <li>him and said he was</li> <li>hat hall. He stated Resident</li> <li>him and said he was</li> <li>hat</li></ul>	F 760		JEFICIENCY)		

Facility ID: 923058

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345388	B. WING				C /13/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	checked to be sure the picture of the resident medications. A physician order was consult Hospice due to condition (advanceme intermittent refusal to An interview on 12/06 Business Office Manas she received a teleph Nurse who informed H date of birth for Reside responsible party (RF The Hospice Nurse re Office Manager the co Resident #1 and the H notified the facility So Resident #1's date of Worker reached out be the discharging facility information and Reside form that describes a and the amount of ca facility) and medication A review of Resident revealed a note writted the Director of Nursin "Resident #1 admitted facility on 07/17/23. I the orders received a for another resident - name residing at the Medical Director was situation, order received discontinue all medical	te resident matched the t on the MAR before giving a written on 09/13/23 to to a decline in Resident #1's ent of dementia and eat and drink). 5/23 at 11:55 AM with the ager, revealed on 09/15/23 ione call from the Hospice her the facility had the wrong lent #1 according to the P) who was a family member. eported to the Business orrect date of birth for Business Office Manager cial Worker of the error with birth. The facility Social by telephone to the SW at y and obtained the correct dent #1's correct FL-2 (state patient's medical condition re needed when placed in a on orders. #1's progress notes en on 09/15/23 at 9:28 PM by g (DON) that read: d to the facility from another t was discovered today that t the time of admission were Person #2 with the same transferring facility. The made aware of the	F	76			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/08/2024 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
	WOODS NURSING AND F	DEHAR		62	0 TOM HUNTER ROAD		
HONTER				CH	HARLOTTE, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page they were reviewed w		F 7	60			
	Medical Director."	in and vermed by the					
	Medical Director (MD) with Resident #1 and somewhere along the discovered they had t information on him wh being on the correct m right diagnoses docur stated he was adminis stopped on 07/21/23 s ugars were not cons so it was discontinued continued with blood a bedtime. The MD furf recall all the medication administered in error discontinued on 09/15 obtained his correct d and orders from the d indicated Resident #1 underlying comorbidit on admission and the of his medical history updated and correct in 09/15/23. The MD fur-	course of his stay they had he incorrect demographic nich resulted in him not nedications or having the nented at the facility. She stered insulin, but it was when she realized his blood istent with needing insulin, d but the resident had sugars before meals and at ther stated she couldn't ons he had been but said they were all 5/23 when the facility had emographics, diagnoses, ischarging facility. She was very frail and his ies had not been revealed y didn't have a true picture until they had received nformation on him on rther indicated that while it					
	wrong medications fo seen any adverse effe wrong medications be she had ordered labs count (CBC), complet and thyroid stimulating the labs were all within resident.	t Resident #1 received the r 2 months, they had not ects of the resident from the eing administered. She said including a complete blood e metabolic panel (CMP), g hormone (TSH) level and n normal limits for the					

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · · ·	MPLETED
			A. BUILDING	<u> </u>		0
		245200				С
		345388	B. WING			2/13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
	WOODS NURSING AND	DEHAR		620 TOM HUNTER ROAD		
HONTER	NOODS NONSING AND	REHAD		CHARLOTTE, NC 28213		
(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)	I SHOULD BE	(X5) COMPLETION DATE
F 760	O	- 00				
F 760			F 76	50		
	Director of Nursing (I					
		Resident #1 was discharged				
		nursing facility on 7/17/23				
	and they had receive					
		and medication orders for				
		N stated it was not until				
		n on 09/15/23 that they were				
	aware there was a p	roblem with Resident #1's				
	date of birth. She fu	rther stated it wasn't until				
	they reached the disc	charging facility on 09/15/23				
	that they discovered	they also had incorrect				
	diagnoses and medie	cations for Resident #1. She				
	explained their norm	al admitting procedure was				
	for the Admission Co	ordinator and the Business				
	Office Manager or As	ssistant to verify insurance				
	through the various of	computer portals. Once the				
	information was verif					
	medications were pa	ssed to the admitting nurse				
	or Unit Manager and	they verified the information				
	for medications and	orders was entered correctly				
	once they received th	he orders. The DON further				
	explained the nurses	s would have no way of				
	knowing the informat	tion they received regarding				
	diagnoses, orders, a	nd medications was not				
	correct for Resident	#1 since he could not verify				
		self. She continued to explain				
	that once his blood s	ugar levels appeared to				
	remain low, the Med					
		ulin so he only received 3				
	doses but said they l	nad continued with blood				
		e meals and at bedtime				
		e was diabetic. The DON				
		covered the error on 09/15/23				
		nt #1 were discontinued and				
	the Marketing Coord	inator obtained the correct				
	information for Resid	lent #1. He was seen by the				
		were written for the right				
		-	1			1
	medications to be giv	ven. She further stated				

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					PRINTED: 01/08/2024 FORM APPROVED OMB NO. 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>′</i>	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	345388	B. WING		_	C 12/13/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
HUNTER WOODS NURSING AND RE			620 TOM HUNTER ROAD		
HUNTER WOODS NORSING AND RE	NAD		CHARLOTTE, NC 28213	3	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	DATE
receiving the wrong med explained the nurses veresident on the MAR with to be sure they are giving the right resident. An interview on 12/07/22 Unit Manager for North and 300 halls revealed s employed as the Unit M stated she recalled hear and the mix-up with his know any of the details stated typically the Nurs name prior to giving medication further stated there was would have known they medications to Resident unable to verbalize and those medications. She knowledge he had not c identification and so the the orders prescribed by	tained and said the MD adverse effects from him dications. The DON erified the picture of the th the resident in the bed og the right medications to 3 at 11:26 AM with the which included 100, 200 she had only been anager for 90 days. She ring about Resident #1 medications but didn't about the situation. She ses verified the resident's dications but was not esidents their date of birth hs. The Unit Manager really no way the Nurses were giving the wrong t #1 because he was tell them he was not on e indicated to her some in with a picture Nurses were carrying out y the Medical Director f knowing the medications it Manager further with the same name fiers such as name and tre to ensure the right he right medications. anager all residents' admission to use as an and staff at the facility. 3 at 11:34 AM with the	F 76	0		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		345388	B. WING			C 12/13/2023		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
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	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 760	she had served as the about 6 weeks from 0 She stated she remen mix-up with his medic stated she remember but not oriented and w his dementia was adw have been able to tell supposed to receive i medications he was p have been prescribed indicated he would no validating his date of to his name being cal answer questions about medications. A follow up telephone 3:00 PM with the Mar she had gone to the t 09/15/23 and obtaine #1 which included his nursing progress note order summary and d as his FL-2. The Mar she handed the inforr Coordinator #1 who e electronic medical rec because that was the b. Resident #1 did no his glaucoma from 7/ eye drops were presc 1. Brimonidine Tartr 0.2% - instill 1 drop in for glaucoma.	e Unit Manager for North for 6/20/23 through 07/31/23. mbered Resident #1 and the ations. The ADON further ed Resident #1 was alert vas non-verbal. She said vanced and he would not the Nurses he was not nsulin, or any of the prescribed that should not I for him. The ADON of have been capable of birth and could only respond led but was not reliable to but diagnoses or interview on 12/07/23 at keting Coordinator revealed ransferring facility on d information for Resident medications, face sheet, es, history and physical, ietary considerations as well keting Coordinator stated nation to the Admissions intered the information in the cord for Resident #1 ir process at the time. t receive 2 eye drops to treat 17/23 through 9/15/23. The tribed as follows: rate Ophthalmic Solution both eyes three times a day	F	760				

Facility ID: 923058

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345388	B. WING			C 12/13/2023		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HUNTER	WOODS NURSING AND I	REHAB			20 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 760	Continued From page	÷ 42	F	760				
	Medical Director (MD with Resident #1 and somewhere along the discovered they had t information on him we being on the correct r right diagnoses docur stated that while he s medications for which not seen any adverse receiving those medic drops for his glaucom The Administrator, DC Regional Vice Preside notified of immediate 5:15 PM. The facility provided t action plan with a corr The facility failed to e from a significant med #1 was administered Person #2. Resident # medications: " Lantus " Eliquis " Synthroid " Lasix " Aspirin Prior to Resident #1's the Director of Admiss assessment. When le skilled nursing facility Social Worker provide	<ul> <li>course of his stay they had he incorrect demographic nich resulted in him not nedications or having the mented at the facility. She hould have received other a he had diagnoses; she had effects from his not cations particularly the eye a.</li> <li>DN, Nurse Consultant and ent of Operations were jeopardy on 12/07/23 at</li> <li>he following corrective npletion date of 09/29/23.</li> <li>ensure Resident #1 was free dication error when Resident medications prescribed for #1 received the following</li> <li>admission to our facility, sions conducted a bedside</li> </ul>						

Facility ID: 923058

If continuation sheet Page 43 of 60

		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/08/2024 MAPPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE COMP	SURVEY LETED
		345388	B. WING				( 12/	) 13/2023
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HUNTER W	VOODS NURSING AND F	REHAB			20 TOM HUNTER ROAD CHARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 760	medication list for Per also admitted to the fa of birth (DOB: 1/16/56 medication orders on Upon arrival on 7/17/2 person with confusion The FL2 received pro- information. Person # the discharging facility own responsible party On 7/19/23 a care cor with Resident #1 led b Director. During the ca was observed to have impairment, congruent symptoms of possible listed as his own resp was unable to actively After realizing Reside impairment, and seve the contact number lis Admission Record, th reached back out to th Social Worker on 7/19 facility's Social Worke information for Reside Admissions made seve number with no succe until the morning of 7/ Director. The admission completed by the Dire afternoon on 7/24/23 responsible party.	te of birth of 1/16/56 and son #2. Resident #1 was acility with Person #2's date b), medical information, and 7/17/23. 23, Resident #1 was alert to and memory impairment. vided no relative or contact 2's admission record from y listed the resident as his y. ofference meeting was held by the Social Services are conference, Resident #1 e notable cognitive it with the signs and dementia. Resident #1 was onsible party. Resident #1 y participate. Int #1's cognitive ral attempts were made to sted on Person #2's e Director of Admissions he discharging facility's 20/23. The discharging r provided new contact ent #1. The Director of veral attempts using the new ess. Contact was not made 24/23 by the Admissions ion agreement was ector of Admissions in the with Resident #1's obone conversation	F	760				
		#1 responsible party and						

Facility ID: 923058

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345388	B. WING				C / <b>13/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	I		:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HUNTER	WOODS NURSING AND	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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 760	our hospice partner, a information via teleph the date of birth we w discharging facility die Upon further investiga that the initial informat discharging facility wa was also a resident o the same name as Re "On 9/15/23 the corre medication orders for Resident #1 was eval Director. Upon review and orders, all unnec discontinued. "On 9/15/23 the Director medication error repor medication error repor medications received "Critical medications of Insulin, Eliquis and Sy The insulin had previo 7/21/23, prior to this of sugar levels. "The Eliquis, Synthroi discontinued on Frida were Thyroid Stimula Complete Metabolic F Blood Count (CBC) w "On 9/22/23 and 9/25 with diff, and CMP) w Director and determin reactions suffered, ar	and while verifying tone, it was discovered that there provided by the d not match Resident #1. ation, it was also discovered tition received from the as that of Person #2 who f the discharging facility with esident #1. ect information, including Resident #1 was obtained. Juated by the facility Medical v of Resident #1 medications essary medications were ector of Nursing completed a ort for Resident #1. The ort was completed for the in error by Resident #1. received in error were ynthroid, Lasix and Aspirin. ously been discontinued on discovery due to low blood id, Aspirin, and Lasix were by, 9/15/23. Labs ordered ting Hormone (TSH), Panel (CBP), Complete	F	760			

Facility ID: 923058

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		345388	B. WING				C /13/2023
NAME OF PF	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER V	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	monitored throughout Nurse Practitioner. "The facility's Medical attempts to reach Res by phone starting on a leave a message due Medical Director spok responsible party on a the incident. Resident understood and had r incident. To help ensure the de reoccur, a chart audit since 5/17/2023 was Office Manager and A 9/28/23 to ensure infor residents' medical reo belonged to the residi included verifying the demographic sheet, ti and financial informat discrepancies were co On 9/21/23, a Root C completed by the Director Executive Director. In failed to validate Resi upon admission on 7/ The Executive Director Coordinator, Business Assistant Business O	t #1 was also seen and t the weekend by the facility I Director made multiple sident #1's responsible party 9/15/23 but was unable to to full voice mailbox. The se with the Resident #1's 9/21/23 and advised him of t #1's responsible party no adverse response to the efficient practice does not of all residents admitted conducted by Business Admissions Coordinator on ormation filed in the cord was accurate and ing resident. This audit resident information on the he resident's photograph, tion was accurate. Any orrected. ause Analysis was ector of Nursing and conclusion, the facility ident #1 medical information 17/23. br completed education on ty's admissions team, which of Admissions, Admission s Office Manager and ffice Manager to ensure	F	760			
	Assistant Business O						

Facility ID: 923058

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SU COMPLE C         NAME OF PROVIDER OR SUPPLIER       345388       B. WING       12/13         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER ROAD CHARLOTTE, NC 28213       620 TOM HUNTER ROAD CHARLOTTE, NC 28213       12/13			ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 01/08/2024 ORM APPROVED 3 NO. 0938-0391
345388         D. WING         12/13           NAME OF PROVIDER OR SUPPLIER           STREET ADDRESS, CITY, STATE, ZP CODE           MUNTER WOODS NURSING AND REHAB           OTH UNITER TO DE REFORMACES           MUNTER WOODS NURSING AND REHAB           DECOMPTION OF DESTIMATION           MERCENDER OF DESTIMATION           MERCENDER OF DESTIMATION           MERCENDER OF DESTIMATION           PROVIDER OF DESTIMATION           PROVIDER OF DESTIMATION OF DESTIMATION            <	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		(X3)	DATE SURVEY COMPLETED
HUNTER WOODS NURSING AND REHAB         Base of the second sec			345388	B. WING _			C 12/13/2023
HUNTER WOODS NURSING AND REHAB       CHARLOTTE, NC 2213         Image: Construction of the constend the construction of the construction of	NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE	, ZIP CODE	
CHARLOTTE, INC 2213           IMMERY TAO         SUMMARY STATEMENT OF DEFICIENCIES (EAC) DEFICIENCY MUST DE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFX TAG         PROVIDER'S FUN OF CORRECTION (EAC) CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OF TO THE APPROPRIATE DEFICIENCY)           F 760         Continued From page 46 had been obtained prior to entering the facility. Accurate information, mancial information, and a photograph. The admissions team was also reeducated to ensure required information, including but not limited to, clinical documentation, medication list, and FL-28 received from a discharging facility were accurate and belonged to the admitting resident. Authentication will be verified by the discharging facility's appointed representative. The facility Business Office Manager and Assistant Business Office Manager were also educated by the Executive Director on ensuring required information, which includes the resident's Social Security Number, Date of Birth, insurance card and Admissions and/or Coordinator will require the newly admitted resident to verbally provide information, including, but not limited to their name, date of birth, and social security number. If the resident to urehally provide information, including, but not limited to their name, date of birth, and social security number. If the resident to verbally provide information, including, but not limited to their name, date of birth, and social security number. If the resident to verbally provide information, including, but not limited to their name, date of birth, and social security number. If the resident to verbally provide information, including, but not limited to their name, date of birth, and social security number.           Prior to admission, newly admitted resident's identify. Authentication will require the newly admitted resident's quardian, power of					620 TOM HUNTER ROAD		
PREFIX TAG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION)         PREFIX TAG         (EACH CORRECTIVE ACTION SHOULD BE CROSHEPERFECTED TO THE APPROPRIATE DEFICIENCY)           F 760         Continued From page 46         F 760           had been obtained prior to entering the facility, Accurate information, financial information, and a photograph. The admissions team was also reeducated to ensure required information, including but not limited to, clinical documentation, medication list, and FL-2s received from a discharging facility were accurate and belonged to the admitting resident. Authentication will be verified by the discharging facility's appointed representative. The facility Business Office Manager and Assistant Business Office Manager were also educated by the Executive Director on ensuring required information, which includes the resident's Social Security Number, Date of Birth, insurance card information and policy information belong to the admitting resident. The Director of Admissions and Admissions and/or Coordinator will validate the newly admitted resident's identity by verbal authentication. Authentication will require the newly admitted resident's identity purched information, including, but not limited to their name, date of birth, and social security number. If the resident is unable to provide the information, and adord Admissions Coordinator will require the newly admitted resident's jurvide information, including, but not limited to their name, date of birth, and social security number. If the resident is unable to provide this information, the Director of Admissions and/or Admissions Coordinator will require the newly admitted resident's quardian, power of attorney or appointed person to verbally provide information, including, but not limited to the resident's identity. Authentication will require tho newly admitted reside	HUNTER	WOODS NORSING AND	RENAD		CHARLOTTE, NC 28213		
had been obtained prior to entering the facility. Accurate information would include demographic information, financial information, and a photograph. The admissions team was also reeducated to ensure required information, including but not limited to, clinical documentation, medication list, and FL-2s received from a discharging facility were accurate and belonged to the admitting resident. Authentication will be verified by the discharging facility's appointed representative. The facility Business Office Manager and Assistant Business Office Manager were also educated by the Executive Director on ensuring required information, which includes the residents' Social Security Number, Date of Birth, insurance card information a policy information belong to the admitting resident. The Director of Admissions and Admissions and/or Coordinator will validate the newly admitted residents' locatily yoverbal authentication. Authentication will require the newly admitted resident to verbally provide information, including, but not limited to their name, date of birth, and social security number. If the resident is unable to provide this information, the Director of Admissions Coordinator will have the resident's guardian, power of attomey or appointed person verbally authenticate the newly admitted resident's clorents, power of attomey or appointed person verbally admitted resident's guardian, power of attomey or appointed person verbally admitted resident's guardian, power of attomey or appointed person verbally admitted resident's guardian, power of attomey or appointed person verbally admitted resident's guardian, provide information, including, but not limited to the resident's name, date of birth, and social security number.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIV CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIATE	(X5) COMPLETION DATE
date of birth, and social security number. Prior to admission, newly admitted residents or their responsible party will be required to provide	F 760	had been obtained pr Accurate information information, financial photograph. The adm reeducated to ensure including but not limit documentation, medi received from a disch and belonged to the a Authentication will be facility's appointed re Business Office Manager Office Manager were Executive Director or information, which ind Security Number, Da information and polic admitting resident. Th and Admissions and/ the newly admitted re authentication. Authe newly admitted reside information, including name, date of birth, a the resident is unable the Director of Admis Coordinator will have power of attorney or authenticate the newl identity. Authentication admitted resident's g appointed person to	rior to entering the facility. would include demographic information, and a hissions team was also required information, ed to, clinical cation list, and FL-2s harging facility were accurate admitting resident. • verified by the discharging presentative. The facility ager and Assistant Business also educated by the nensuring required cludes the residents' Social te of Birth, insurance card y information belong to the ne Director of Admissions or Coordinator will validate esidents' identity by verbal intication will require the ent to verbally provide to provide this information, sions and/or Admissions the resident's guardian, appointed person verbally by admitted resident's on will require the newly uardian, power of attorney or verbally provide information,	F 7			
include a photograph. Copy all insurance cards to		date of birth, and soc Prior to admission, ne their responsible part two forms of identifica	ial security number. ewly admitted residents or y will be required to provide ation, of which one must				

Facility ID: 923058

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/08/2024 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345388	B. WING			( 12/ <sup>-</sup>	C 13/2023
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE	E, ZIP CODE		
			6	20 TOM HUNTER ROAD			
HUNTER	WOODS NURSING AND F	REHAB	0	CHARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 760	scanned into the resid record. There must b copies documented o before turning them o Manager. Newly hire Office personnel will b during new hire orient "Starting on 9/28/23 th designee to complete monitoring for Admiss forms of identification a photograph, copy of review admission pac for twelve weeks and Weekly monitoring wi Monthly monitoring wi "The Director of Nursi introduced the plan of Assurance Performan on 9/28/23. The Exec for implementing this reviewed by QAPI con monitoring (audit) upo based on findings. Th Performance Improve of but not limited to th Director of Nursing, A Social Services Mana Manager, Activities D Pharmacist, Medical I Manager, Maintenano Supervisor, Admission MDS Nurse. The Qua	Medicaid if available. obtained, copies must be dent's electronic medical e 3 attempts to obtain these in the admission checklist ver to the Business Office d Admissions or Business be educated on this process tation. The Executive Director and/or Quality Improvement ion Process to include two of which one must include f insurance cards, and ket to be completed weekly monthly for 3 months. If be completed by 12/21/23. If be completed by 3/21/24. Ing and Executive Director f correction to the Quality ince Improvement Committee utive Director is responsible plan. Findings will be mmittee monthly and Quality lated if changes are needed e Quality Assurance ment Committee consists e Executive Director, ssistant Director of Nursing, iger, Business Office irector, Human Resources, Director, CNA, Dietary the Director, Housekeeping ins, Medical Records, and lity Assurance Performance tee meets monthly and Quality and lity Assurance tee meets monthly and Quality and the cord of the completed is the completed for the consists office the consists office the consists office the constant the consists office the constant	F 760				

Facility ID: 923058

If continuation sheet Page 48 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	RM APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345388	B. WING _		1	2/13/2023
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	WOODS NURSING AND	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 PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	Continued From page	e 48	F 7	760		
	Completion date: 09/2	29/2023				
	The facility's correctiv by the following:	re action plan was validated				
F 867 SS=D	validated upon review in-service education p staff and business off policy, verifying demo how to verify correct i forms of identification a photograph. Review revealed no concerns conducted with the Bi the Assistant Busines Admissions staff reve education on the adm importance of confirm information prior to th the facility. Record re recently admitted reve facility's completion d validated. QAPI/QAA Improvem CFR(s): 483.75(c)(d)( §483.75(c) Program f monitoring. A facility must establis policies and procedur collections systems, a adverse event monitor	ent Activities	F 8	867		12/14/23

Event ID: S3HS11

Facility ID: 923058

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING				C / <b>13/2023</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	systems to obtain and from direct care staff, resident representativ information will be use are high risk, high vol opportunities for impr §483.75(c)(2) Facility systems to identify, co information from all do not limited to the facil §483.70(e) and include will be used to develop indicators. §483.75(c)(3) Facility and evaluation of per- including the methods development, monitor §483.75(c)(4) Facility including the methods systematically identify analyze and use data adverse events in the facility will use the da prevent adverse ever §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance	maintenance of effective d use of feedback and input other staff, residents, and ves, including how such ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective oblect, and use data and epartments, including but ity assessment required at ding how such information up and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will v, report, track, investigate, and information relating to facility, including how the ta to develop activities to its. systematic analysis and clility must take actions e improvement and, after ctions, measure its success, e to ensure that	F	867	7		

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CENTER STATEMENT (	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		CONSTRUCTION		FORM OMB NC (X3) DATE	0: 01/08/2024 1 APPROVED 0: 0938-0391 SURVEY LETED
		345388	B. WING					C 13/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	ODE	1 12/	13/2023
					20 TOM HUNTER ROAD			
HUNTER	WOODS NURSING AND F	REHAB			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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BI		(X5) COMPLETION DATE
F 867	determine underlying impacting larger syste (ii) How they will develow will be designed to eff level to prevent qualit safety problems; and (iii) How the facility wi of its performance imp ensure that improvem §483.75(e) Program a §483.75(e)(1) The face performance improve high-risk, high-volume consider the incidence of problems in those a outcomes, resident sa resident choice, and c §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activities distinct performance i number and frequenc conducted by the faci and complexity of the	cility will develop and dressing: a systematic approach to causes of problems ems; elop corrective actions that feet change at the systems y of care, quality of life, or II monitor the effectiveness provement activities to tents are sustained. activities. cility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. hance improvement hedical errors and adverse vze their causes, and actions and mechanisms and learning throughout the of their performance s, the facility must conduct mprovement projects. The y of improvement projects and as reflected in the facility	F	867				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	WOODS NURSING AND I	REHAB			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 PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 867	Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sect §483.75(g) Quality as §483.75(g) Quality as §483.75(g)(2) The quassurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under to resulting from drug re available data to mak This REQUIREMENT by: Based on observation interviews, the facility Assurance (QAA) Con implemented procedu interventions the com a recertification and co 08/31/21. The area of prevention was origin recertification and cor 08/31/21. The area w during the onsite revisi dated 12/13/23. The of facility during two fed	a must include at least t focuses on high risk or identified through the data s described in paragraphs tion. sessment and assurance. ality assessment and reports to the facility's esignated person(s) ming body regarding its uplementation of the QAPI er paragraphs (a) through e committee must: ement appropriate plans of ified quality deficiencies; and analyze data, including he QAPI program and data gimen reviews, and act on e improvements. is not met as evidenced ms, record review, and staff 's Quality Assessment and mmittee failed to maintain res and monitor mittee put in place following omplaint survey dated infection control and ally cited during a mplaint survey dated as subsequently recited sit and complaint survey continued failure of the eral surveys of record shows y's inability to sustain an	F	867	On 12/13/23, The Executive Director H an Ad Hoc Quality Assurance and Performance Improvement meeting wit the facility Interdisciplinary Team. Members of the committee included the Director of Clinical Services, Social Services, Dietary Manager, Admission Director, Minimum Data Set Coordinate Activities Director, Medical Records Director, Dietary Manager, Environmer Service Manager, and Business Office Manager. During this meeting, the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the Qual	th e s or, ntal	

Facility ID: 923058

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/08/2024 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING				C / <b>13/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	WOODS NURSING AND	REHAB			20 TOM HUNTER ROAD HARLOTTE, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 867	Continued From page	ə 52	F	867			
	The findings included	ŀ			Assurance process to include identific correcting, and monitoring of identified	-	
	The tag is cross refer				deficiencies to ensure compliance ar quality are maintained. Additionally,	nd	
	F880- Based on obse			Hoc meeting focused on F880 and Infection Control. The discussion inc	luded		
	staff interviews, the fattheir hand hygiene policy when the			hand hygiene, hand hygiene before, during and after patient care, donnin and doffing of personal protective	g,		
	perform hand hygien	ne Treatment Nurse did not			equipment, and the understanding or	F	
		o donning gloves to remove			Transmission Based Precautions. Th		
		drainage from several			facility Quality Assurance reviewed fa		
		t's (Resident #9) left leg and			findings and developed a new plan o	-	
	foot wound, and right	inner thigh wound. The			correction for maintaining compliance	e in	
	Treatment Nurse dof	fed her gloves after			these areas.		
	-	gs and donned new gloves					
		hands and proceeded to			To help assist with the deficient prac		
		o the wounds and covered			from reoccurring, on 12/6/23, the fac		
		ze dressings. This occurred			infection preventionist began reeduc	•	
	for 1 of 2 residents re	eviewed for wound care.			facility staff on the facility Infection C policies and procedures which include		
	During the recertifica	tion and complaint survey			but were not limited to, hand hygiene		
		acility failed to implement			hand hygiene before, during and after		
		nission Based Precautions			patient care, hand hygiene after		
		hallway when 1 of 1 staff			performing non- patient care tasks,		
		ove gown before exiting			donning, and doffing of personal		
		to wear gloves to deliver			protective equipment, and the		
		se of them in the room and			understanding of Transmission Base		
	perform hand hygien				Precautions. Staff members reeduca		
	observed for infectior	i control.			included nursing staff, administrative		
	An intonvious with the	Director of Nursing (DON)			dietary staff environmental services s and therapy staff. Education will be	siaii,	
		Director of Nursing (DON), Irse Consultant on 12/13/23			completed by 12/14/23. Any newly h	ired	
		monthly Quality Assurance			staff will be educated during new hire		
		held to review measures put			orientation or prior to the start of their		
		ed with the Medical Director			shift.		
		ts for their response and					
	feedback to issues id	entified. When issues were			The facility infection preventionist als		
	identified a review an	d corrective action plan was			began conducting clean dressing cha	ange	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/08/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HUNTER	NOODS NURSING AND	REHAB			20 TOM HUNTER ROAD HARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	the QA committee rev Administrator felt inte were beginning to aid deficiencies but need committee to ensure areas. The Nurse Co QA for infection contr new citation was und broad heading. The in would be providing st	nere was no improvement, visited it. The DON and rventions put into place	F	867	competencies with all Licensed Nursii Staff and Nurse Aide II Staff on 12/6/2 Clean dressing change assessments included verbal understanding and discussion of the competency, direct observation and return demonstration clean dressing change competencies Licensed Nursing Staff and Nurse Aid Staff will be completed by 12/14/23. A newly hired Licensed Nursing Staff or newly hired Nurse Aide II staff will be educated on clean dressing change during new hire orientation or prior to start of their first shift. Completion dat these observations will be May of 202 The Director of Nursing and/or Nursin designee will randomly perform Quali Observations with five randomly select facility staff members twice weekly for weeks on hand hygiene, hand hygien before, during and after patient care, hygiene after performing non- patient tasks, donning, and doffing of persons protective equipment, and the understanding of Transmission Based Precautions. Staff members observed include nursing staff, administrative s dietary staff, environmental services s and therapy staff. Thereafter, observations with five randomly select staff members once weekly for two months, and then with five staff memto once monthly for three months. The Director of Nursing and/or Nursing designee will randomly perform Quali Observations with Licensed Nursing s and Nurse Aide II personnel to ensure proper clean dressing changes with fa	All with e II ny the e for 4. g y ted four e nand care al will aff, taff, ted pers	

Event ID: S3HS11

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/08/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345388	B. WING		C 12/13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	WOODS NURSING AND F	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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 867 F 880 SS=D	CFR(s): 483.80(a)(1)( §483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and tran diseases and infection	& Control (2)(4)(e)(f) htrol blish and maintain an nd control program a safe, sanitary and hent and to help prevent the hsmission of communicable	F 86	<ul> <li>residents. The Director of Nursing Nursing designee will observe three randomly selected Licensed Nurse Nurse Aide II perform clean dressin changes twice weekly for four wee Thereafter, clean dressing change observations with 3 Licensed Nurse Nurse Aide II will be conducted one weekly for two months, and with 3 Licensed Nurses or Nurse Aide II of monthly for three months.</li> <li>The QAPI Committee will evaluate effectiveness and amend as neede Executive Director is responsible for implementing this plan and will rep the results of the quality Monitoring (audits) to the Quality Assurance Performance Improvement Commit monthly. The Regional Director of Services will attend the Quality Ass Performance Improvement meeting four months for validation.</li> <li>Date of Completion for this plan of correction is 12/14/2023</li> </ul>	ee es or ng eks. ees or ce once e the ed. The or oort on g ittee Clinical surance g for
	7(02-99) Previous Versions Obs	olete Event ID: S3HS1		Eacility ID: 923058	ontinuation sheet Page 55 of 6

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Event ID: S3HS11

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345388	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	WOODS NURSING AND F	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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	and control program ( a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services und arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how isco resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possible circumstances. (v) The circumstances	blish an infection prevention IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other in possible incidents of se or infections should be esmission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable cin lesions from direct	F	880			

Facility ID: 923058

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I					FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
	345388	B. WING_			( 12/ <sup>-</sup>	C 13/2023
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
			62	20 TOM HUNTER ROAD		
HUNTER WOODS NURSING AND F	REHAB		С	HARLOTTE, NC 28213		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
by staff involved in dir §483.80(a)(4) A syster identified under the facorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will conduced IPCP and update their This REQUIREMENT by: Based on observation interviews, the facility hand hygiene policy a control policy when the perform hand hygiened treatments, or prior to soiled coverings with wounds on a resident foot wound, and right Treatment Nurse doffer removing the covering without sanitizing her apply the treatment to them with border gaus for 1 of 2 residents ref The findings included The facility's policy er	he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of view. ct an annual review of its r program, as necessary. is not met as evidenced n, record review and staff failed to implement their as part of their infection he Treatment Nurse did not e prior to beginning o donning gloves to remove drainage from several 's (Resident #9) left leg and inner thigh wound. The ed her gloves after gs and donned new gloves hands and proceeded to the wounds and covered ze dressings. This occurred viewed for wound care. : tittled Hand Hygiene which on Control Policies and	F	880	The treatment nurse failed to perform hand hygiene prior to beginning treatm or prior to donning gloves to remove soiled coverings with drainage from several wounds on Resident #9. The treatment nurse was reeducated by the facility Infection Preventionist on hand hygiene before, during, and after woun care and as needed during patient care (12/6/23). The Infection Preventionist a educated the treatment nurse on donni and doffing personal protective equipm (12/6/23). Additionally, a review of precautions, including but not limited to barrier and enhanced barrier precautio use of gloves, and the use of hand sanitizer was also discussed (12/6/23). Residents currently residing in the facil have the potential to be affected.	e d e ilso ing ient o, ns,	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/0 FORM APPR OMB NO. 0938	ROVE
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345388	B. WING		12/13/202	3
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HUNTER V	WOODS NURSING AND	REHAB		320 TOM HUNTER ROAD 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPL	(5) LETIO ATE
F 880	Continued From page	e 57	F 880			
	"Process" read in par	t:		To help assist with the deficient from reoccurring, the facility inf preventionist began conducting	ection	
	<ul><li>Before initiating a</li><li>Before and after</li></ul>	a clean procedure		dressing change competencies Licensed Nursing Staff and Nu Staff on 12/6/23. Clean dressin	s with all rse Aide II	
	excretions, mucous r or wound dressings " After glove	nembranes, non-intact skin, removal"		assessments included verbal understanding and discussion competency, direct observation	n and return	
	11:00 AM on Resider	was made on 12/06/23 at ht #9 with the Treatment		demonstration. All clean dressi competencies with Licensed N and Nurse Aide II Staff will be c	ursing Staff completed	
	supplies and placed t the overbed table. T	nt Nurse gathered her them on a clean surface on he Treatment Nurse donned		by 12/14/23. Any newly hired L Nursing Staff or newly hired Nu staff will be educated on clean	urse Aide II dressing	
		nd removed the el from the resident's left		change during new hire orienta to the start of their first shift.		
	doffed her gloves after without sanitizing her	aced after her shower). She er removing the towel and hands, donned new gloves		The Director of Nursing and/or designee will randomly perform Observations with Licensed Nu	n Quality ursing staff	
	wound bed that had t assistant. The Treat	-honey treatment to the been cleaned by her ment Nurse then applied the ing to the lower leg wound,		and Nurse Aide II personnel to proper clean dressing changes residents. The Director of Nurs Nursing designee will observe	with facility ing and/or	
	doffed her gloves, an Resident #9 complair	nd washed her hands. The of knee pain, so the sped her treatment of		randomly selected Licensed No Nurse Aide II perform clean dre	urses or essing	
	wounds to get the res	sident pain medication.		changes twice weekly for four v Thereafter, clean dressing cha observations with 3 Licensed N	nge Iurses or	
	continued with the Tr #9. Resident #9 had	PM the wound observation eatment Nurse on Resident been medicated for her ne medication was effective.		Nurse Aide II will be conducted weekly for two months, and wit Licensed Nurses or Nurse Aide monthly for three months.	h 3	
	The Treatment Nurse	e placed a drape on the floor			hold to	
	clean gloves without her hands and remov	#9's feet. She donned first washing or sanitizing /ed the gauze squares from ner thigh wound. The		An Ad Hoc QAPI meeting was discuss the findings, root cause of action for the deficient practi (12/13/23). The Executive Dire	e and plan ice	

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING		C	
		345388	B. WING		12/1	3/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	WOODS NURSING AND	REHAB		620 TOM HUNTER ROAD 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 58	F 88			
	without sanitizing her to clean the wound w cleaning the wound a the Treatment Nurse the wound bed and a the thigh wound. Sh- without sanitizing her and cleaned the left f gloves again and with donned new gloves a The Treatment Nurse and with the same gl wounds, applied hydr foot, calcium alginate ankle and Medi-hone then with the same g supplies, using her so calcium alginate tube to clean and dress th left foot. After putting	n doffed her gloves and hands donned clean gloves with wound cleanser. After and with the same gloves on, applied calcium alginate to upplied a clean dressing to e then doffed her gloves and hands, donned new gloves foot wound, doffed her nout sanitizing her hands and cleaned the toe wound. e after cleaning the wounds, oves on she had cleaned the rogel with gauze to the left e on the left heel and left ey on the left lateral foot. She loves on gathered her cissors and touching the e with the same gloves used e 3 wounds on the resident's g her supplies away, the fed her gloves and washed and water.		responsible for implementing th will report on the results of the of monitoring (audits) to the Qualit Assurance Performance Improvied Committee (QAPI). The Quality Assurance Performance Improvied Committee Members include, b limited to the Executive Director of Nursing, Assistant Director of Social Services, Medical Direct Manager, and Minimum Data S and a minimum of one direct car The findings will be reviewed an monthly for a minimum of three the QAPI Committee. Date of Completion for this plan correction will be 12/14/2023	quality ty vement vement ut are not r, Director f Nursing, or, Dietary et Nurse are giver. nd reported months to	
	Treatment Nurse reversible didn't sanitize her her gloves to begin tr and that she had not every time she had d she was new in her r being watched while Resident #9. She sta mistake after the treat	5/23 at 2:00 PM with the ealed she was aware that in hands before she donned reatments on Resident #9 sanitized her hands after offed her gloves. She stated ole and was nervous about she provided care to ated she had realized her itment had been completed. 5/23 at 5:00 PM with the				

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/08/202 FORM APPROVE OMB NO. 0938-039
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345388	B. WING		_	C 12/13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
HUNTER	WOODS NURSING AND I	REHAB		620 TOM HUNTER ROAD CHARLOTTE, NC 28213	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	
F 880	about proper hand wa treatments. She state Treatment Nurse was watched and was ner	ashing while providing ed she felt like the a nervous about being vous because this was her someone from an agency	F 88			

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