STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 7/30/24 to conduct a complaint investigation survey and exited on 7/30/24. Additional information was obtained offsite on 7/31/24 through 8/9/24. Therefore, the exit date was changed to 8/9/24. Event ID# 790X12. Intakes NC00218725, NC00219252, and NC00220087 were investigated. One (1) of the six allegations resulted in a deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and Resident interviews the facility failed to protect a resident's right to be free from abuse for 1 of 3 residents reviewed for abuse (Resident #8). Resident #8 reported Resident #7 slapped Resident #8's face with his open hand, continued slapping at her face multiple times and "hit her like a girl" while yelling at her when Resident #7 exited the	F 600	F600 Resident #8 was observed in the resident room on 7/30/2024 and Resident #8 denied any harm, concern, or fear from Resident #7. Resident #7 was sent to the Emergency Room for evaluation of behaviors on	9/4/24

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

Electronically Signed | 08/28/2024

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F 600	Continued From page 1 smoking courtyard and Resident #8 entered. The findings included: Resident #8 was admitted to the facility on 4/17/24 with essential primary hypertension, and fracture of unspecified part of neck of neck femur. Review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated 6/11/24 revealed Resident #8 was cognitively intact and required set up to extensive assistance from staff for her activities of daily living and utilized a wheelchair for mobility. Resident #7 was admitted to the facility on 01/19/24 with diagnoses that included diabetes mellitus, acute kidney failure, and schizophrenia. Review of Resident #7's Discharge, Return Anticipated Minimum Data Set (MDS) assessment dated 5/30/24 revealed he was cognitively intact, exhibited verbal behavioral symptoms directed towards others 1-3 days a week. The MDS also indicated Resident #7 required set up to dependent assistance from staff for his activities of daily living and utilized a wheelchair for mobility. The care plan revised 6/3/24 revealed Resident #7 had an ADL self-care deficit performance related to the disease process of schizophrenia and impaired balance and neuropathy related to diabetes mellitus. The care plan also revealed Resident #7 had behaviors related to the disease process of schizophrenia often refused care, yelled and cursed at staff, and was verbally aggressive toward staff.	F 600	6/27/2024. A 24 hour report completed and sent to the state agency on 8/21/2024. Adult Protective Services was notified on 8/21/2024. Resident #7 and all current residents were audited for any concerns around the topic of Abuse and Neglect and Exploitation by the Executive Director or designee on 7/31/2024. From 6/27/2024 to 7/03/2024 skin assessments were completed. No issues noted. On 7/31/24 the Executive Director (Abuse Coordinator) initiated staff education to all departments in the building to cover Freedom from Abuse and Neglect of residents. The facility will educate all new employees on hire and as needed will continue training with staff. The Executive Director (Abuse Coordinator) and/or designee will conduct random audits related to Freedom from Abuse, Neglect, and Exploitation four times a week for four weeks then twice a week for four weeks and then weekly for four weeks. The Quality Assurance Performance improvement committee members consist of but not limited to Executive Director, Director of Nursing, Unit Managers, Social Services, Medical director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum data Set Nurse and a minimum of one direct care giver.	

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F 600	Continued From page 2 A review of a Psychiatric Mental Health (PMH) Nurse Practitioner follow up note dated 6/10/24 revealed Resident #7 recently was prescribed new medications at bedtime. The note indicated Resident #7 did not exhibit any combativeness or aggression and it was suggested to continue current prescribed medications. An interview with Resident #8 on 7/30/24 at 1:20 PM revealed she entered the smoking courtyard on 6/27/24 as Resident #7 exited. When their wheelchairs were next to each other as they passed through the entrance to the courtyard, Resident #7 slapped Resident #8's face with his open hand, continued slapping at her face multiple times and "hit her like a girl" while yelling. She could not recall what Resident #7 said. She further explained that other residents intervened, and she moved her chair away from Resident #7 and came back inside the facility and told Nurse #1 about the incident. Resident #8 confirmed she was not injured just upset. She believed another resident alerted the Unit Manager about the incident, but she was unsure who it was. Resident #8 explained the Unit Manager called law enforcement, but she declined to press charges when law enforcement arrived at the facility and spoke to her. Resident #8 stated Resident #7 typically yelled at staff and annoyed other residents on the smoking courtyard and in the halls, but she had not had an altercation with him before or after the incident on 6/27/24. Review of a nurse progress note written by Nurse #1 dated 6/27/24 at 1:20 PM revealed Resident #8 was physically assaulted by Resident #7. Resident #8 was in stable condition, sustained no injuries and was in no distress. Nurse #1	F 600	The Executive Director/designee will report findings to the Quality Assurance Performance Improvement meeting monthly for three months. The findings of the monitoring tool will be discussed/reviewed in Quality Assurance Performance Improvement meeting. Completion Date: 09/04/2024	

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F 600	Continued From page 3	F 600		

indicated Resident #8's pain score was zero and an unsuccessful attempt was made to contact the provider, and a message was left.

A phone interview was conducted with Nurse #1 on 7/31/24 at 3:18 PM and revealed she was unsure of what initiated the incident on 6/27/24 as the incident was not witnessed by staff. Nurse #1 stated after lunch on 6/27/24 Resident #8 was crying and reported to her that Resident #7 yelled at Resident #8 and hit her face with an opened hand, like a slap and pulled her hair. She noted Resident #8 sustained no injuries and there was no redness or swelling present. Nurse #1 recalled that she alerted her Unit Manager. Resident #7 was sent to the hospital for evaluation that afternoon and returned that night. She stated law enforcement came to the facility, but she was not able to recall who called them. Nurse #1 further stated Resident #8 was mad that Resident #7 was allowed to return to the facility after his hospital evaluation. Nurse # 1 was not able to recall if any other residents were involved.

A nursing progress note written by the Unit Manager on 6/27/24 at 1:30 PM revealed Resident #7 smacked and grabbed Resident #8's hair, verbally assaulted her and became more aggressive. The note explained both residents were separated.

An additional nursing progress note written by the Unit Manager on 6/27/24 at 12:41 PM revealed a psychological evaluation was ordered for Resident #7 due to physical contact incident.

A review of the police report dated 6/27/24 at 1:41 PM revealed the Unit Manager filed the report of

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simple assault on 6/27/24 at 1:30 PM between Resident #7 and Resident #8 and Resident #8 declined to press charges.

Multiple attempts were made to interview the Unit Manager over the phone and were unsuccessful.

A review of a Social Work progress note on 6/27/24 at 4:52 PM revealed the Social Worker (SW) and Activity Director were informed by Resident #8 that she was hit by Resident #7 in the facility. The note further revealed law enforcement was called, and an ambulance took Resident #7 to the hospital for evaluation. Resident #8 stated she was ok and did not want to press charges. The Director of Nursing (DON) and Administrator were informed.

A review of a Psychiatric Mental Health (PMH) Nurse Practitioner note dated 6/27/24 was reviewed. It revealed Resident #7 was visited in the facility per staff request due to an incident of Resident #7 physical aggression by grabbing the hair of a female resident and was verbal aggressive to staff and other residents in the facility. The note included an order to send Resident #7 to the hospital for psychiatric evaluation for aggression towards others.

A progress note written by Nurse #1 dated 6/27/24 at 10:17 PM indicated Resident #7 returned from the hospital after being cleared from a psychological evaluation.

An interview with the SW on 7/30/24 at 3:00 PM revealed Resident #8 reported to her after lunch on 6/27/24 that Resident #7 took his open hand and hit her in the head and yelled at her. She explained Resident #8 reported she was fine, and

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she did not want to press charges. The SW explained she did not call law enforcement as Resident #8 stated she did not want them called but another staff member did, but she could not remember who. She explained Resident #8 first reported the incident to the Unit Manager and then she and the Activity Director spoke to her about the incident.

An interview with the Activity Director on 7/30/24 at 2:22 PM revealed she did not witness the incident in the smoking courtyard between Resident #7 and Resident #8 on 6/27/24. She stated Resident #7 was often agitated and exhibited verbal behaviors in the common areas of the facility. She stated that other residents were annoyed by his behaviors but could not speak to the incident on 6/27/24. She stated Resident #8 was upset after the incident but did not want to press charges.

Multiple attempts were made to interview Resident #7 on 7/30/24 and were unsuccessful as he was not able to be interviewed.

Multiple attempts were made to interview the DON over phone and were unsuccessful as she was not in the facility during the survey and did not return any calls.

A phone interview with the former Administrator was conducted on 7/30/24 at 3:27 PM. He confirmed he was the Administrator at the time of the incident on 627/24 between Resident #7 and Resident #8. He explained on 6/27/24, he was contacted by the Unit Manager and told that Resident #7 moved his wheelchair by Resident #8 and hit her on the shoulder. He stated nursing staff evaluated Resident #8, but there was no

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F 600	Continued From page 6 harm done. He could not recall if Resident #7 was sent for evaluation. The Administrator met with Resident #8, and she wanted to make sure Resident #7 was not around her going forward. The former Administrator stated that neither resident was harmed, so he did not think it qualified as a reportable incident or something which required a protection plan per the facility's policy. The former Administrator stated he did not know of any other time that Resident #7 was physically abusive to others, but he was often verbally abusive to staff.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of	F 607		9/4/24

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F 607	Continued From page 7 employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to implement their abuse policy in the areas of reporting, investigating, and protection following an allegation of resident to resident abuse. The allegation was not reported to the state or Adult Protective Services (APS), an investigation was not conducted, and protection was not implemented to prevent further potential abuse. This deficient practice was for 1 of 3 residents (Resident #8) reviewed for abuse. Findings included: A review of the facility's abuse policy entitled Abuse, Neglect, Exploitation, and Misappropriation, last revised 11/16/22 revealed the Abuse Coordinator (Executive Director) or his/her designee would investigate all reports of allegations of abuse, neglect, misappropriation and exploitation. The Abuse Coordinator and/or Director of Nursing would take statements from the victim and suspects and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she would secure all physical evidence. Upon completion of the investigation, a detailed report would be prepared. For protection, the resident will be evaluated for any signs of injury, including a physical exam, and/or psychosocial assessment, increased supervision of the alleged victim and	F 607	F607 Company policy was reviewed on abuse, neglect, and exploitation and misappropriation and reporting requirements on 7/31/24. A 24 hour report completed and sent to the state agency on 8/21/2024. Adult Protective Services was notified on 8/21/2024. Resident #7 and all current residents were audited for any concerns around topic of abuse and safety by the Executive Director (Abuse Coordinator) or designee on 7/31/24. From 6/27/2024 to 7/03/2024 skin assessments were completed. No issues noted. On 7/31/24 the Executive Director (Abuse Coordinator) and the Director of Clinical Services were provided education on company policy for reporting incidents by the Regional Director of Clinical Services. The Executive Director (Abuse Coordinator) or designee will complete education on 7/31/24 to current staff and departments concerning on reportable events and safety and security for all residents. The facility will educate all new employees on hire. As needed training	

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F 607	Continued From page 8 residents, room or staffing changes if needed to protect the resident(s) from the alleged perpetrator, provide the resident with emotional support and counseling during and after the investigation period. Resident #8 was admitted to the facility on 4/17/24. The quarterly Minimum Data Set (MDS) dated 6/11/24 revealed Resident #8 was cognitively intact. A phone interview was conducted with Nurse #1 on 7/31/24 at 3:18 PM and revealed she was unsure of what initiated the incident on 6/27/24 as the incident was not witnessed by staff. Nurse #1 stated after lunch on 6/27/24 Resident #8 was crying and reported to her that Resident #7 yelled at Resident #8 and hit her face with an opened hand, like a slap and pulled her hair. She noted Resident #8 sustained no injuries and there was no redness or swelling present. Nurse # 1 was not able to recall if any other residents were involved. Nurse #1 recalled that she alerted her Unit Manager. She stated law enforcement came to the facility, but she was not able to recall who called them. Nurse #1 further stated Resident #8 was mad that Resident #7 was allowed to return to the facility after his hospital evaluation. The interview further revealed Resident #7 was readmitted to the facility later that evening on 6/27/24, and she could not recall any measures put into place to supervise Resident #7 or protect Resident #8 and she received no instructions from management moving forward. A review of a progress note written by the Unit Manager dated 6/27/24 at 1:30 PM read in part,	F 607	will continue with all staff. The Executive Director (Abuse Coordinator) and/or designee will conduct audits related to incidents in facility that needs to be reported to the State and Adult Protective Services. Audits to be completed five times a week for four weeks then three times a week for four weeks and as needed. The Quality Assurance Performance improvement committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical director, maintenance Director, Housekeeping Services, dietary Manager, and Minimum data Set Nurse and minimum of one direct care giver. The Executive Director/designee will report findings to the Quality Assurance Performance Improvement meeting monthly for three months. The findings of the monitoring tool will be discussed/reviewed in Quality Assurance Performance Improvement meeting. Completion Date:09/04/2024	

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Resident #7 grabbed and smacked Resident #8's hair and verbally assaulted her and became more aggressive. Residents were separated.

A review of the law enforcement report dated 6/27/24 at 1:41 PM revealed Resident #8 declined to press charges for simple assault by Resident #7. The Unit Manager was listed as the reporting person.

Multiple attempts to contact the Unit Manager by phone were unsuccessful during the survey.

A progress note written by the Social Worker (SW) on 6/27/24 at 4:52 PM revealed Resident #8 reported to her and the Activity Director that she was hit by Resident #7 in the facility. She stated law enforcement was called and Resident #7 was taken to the hospital for evaluation. The note further revealed Resident #8 stated she was ok and did not want to press charges. Administrator and Director of Nursing (DON) were made aware of the incident.

A progress note written by Nurse #1 dated 6/27/24 at 10:17 PM indicated Resident #7 returned from the hospital after being cleared from a psychological evaluation.

There was no evidence that this resident to resident abuse incident was reported to the state agency and Adult Protective Services (APS).

An interview with Resident #8 on 7/20/24 at 1:20 PM revealed she has not had any more incidents with Resident #7 but stated he moved around the facility and was often in the same common areas she was.

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An interview with the SW on 7/30/24 at 3:00 PM revealed she was aware of the incident that occurred on 6/27/24. She revealed she was not aware of any investigation or protection plan put into place by management after the incident on 6/27/24. She stated she was not aware of any other incidents regarding Resident #7 and another resident.

Multiple attempts were made to contact the DON during the survey and were unsuccessful.

A phone interview with the former Administrator was conducted on 7/30/24 at 3:27 PM. He stated he was aware of the 6/27/24 incident but could not remember who informed him. He revealed he did not report the incident because Resident #8 was not harmed. He stated the nursing staff evaluated Resident #8 and found no injuries. The perpetrator, Resident #7, was not physically abusive to others before, just verbally abusive to staff. The former Administrator further stated that neither resident was harmed, so he did not think it qualified as a reportable incident or something which required a protection plan per the facility's policy.

A phone interview with the current Administrator was conducted on 7/31/24 at 1:15 PM. He stated he started working at the facility recently and was not aware of an investigation or any protection plan put into place because of the alleged abuse incident on 6/27/24. He was not aware of any incidents involving Resident #7 with another resident. He stated the incident should have been reported and investigated per their policy.