STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redwood Health & Rehab	5939 Reddman Road Charlotte, NC 28212

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interviews, the facility failed to treat Resident #1 with dignity and respect when Nurse #1 engaged in a verbal argument with Resident #1 utilizing profanity and yelling at Resident #1. This deficient practice affected 1 of 3 residents reviewed for dignity (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses which included heart failure, absence of right leg above knee, and unspecified arthritis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #1 was cognitively intact and was not coded for behaviors. Resident #1's active care plan, last revised on 4/1/26, had a focus area regarding Resident #1 having behaviors of rejecting care and services. The goal included Resident #1's behaviors will not cause her or other residents any distress through the review period. Interventions included approaching with a calm quiet voice, diverting attention, and removing Resident #1 from the situation and taking her to an alternative location as needed, explaining all procedures to Resident #1 before starting and allowing her time to adjust to changes, and monitoring behavior episodes and attempting to determine the underlying cause with consideration to location, time of day, and persons involved. An Investigation Report dated 6/3/26 and sent to the Division of Health Service Regulation (DHSR) indicated that Resident #1 reported on 5/28/26 at approximately 5:30 PM that Nurse #1 alleged that on the evening of 5/27/26, Nurse #1 who was responsible for her care was verbally abusive toward her when she requested her pain medication. Resident #1 reported that Nurse #1 used derogatory and insulting statements, spoke to her in a scolding manner, and entered her personal space by getting close to her face during the interaction in front of other residents and staff. The Investigation Report revealed Resident #1 claimed she was upset but did not have mental anguish due to the altercation. Another resident's family member was listed as the witness and the Investigation Report additionally revealed Nurse #1 was reported to Board of Nursing in North Carolina and was immediately suspended pending investigation. The allegation of abuse was substantiated, and Nurse #1 was terminated on 6/1/26. The Investigation Report indicated all employees at the facility received abuse training. The Investigation Report was signed by the Administrator on 6/3/26. A written statement from Family Member #1 dated 5/27/26 at 5:17 PM revealed he witnessed Resident #1 following Nurse #1 in the hallway while yelling and making inappropriate, offensive, and racially derogatory comments towards Nurse #1 to include black b**** and dirty black b****. The statement indicated Nurse #1 initially attempted to disengage from Resident #1 and walked away but Resident #1 continued yelling and following Nurse #1 and Nurse #1 became visibly upset and began verbally engaging with and cursing at Resident #1. Family Member #1's statement included that Nurse #1 stated something to the effect of take your one-legged a** back to your room. You don't need to be out here. Call whoever the f*** you want, I don't f****** care. The statement indicated Resident #1 stated she wanted to beat up the nurse and Nurse #1 moved closer to Resident #1 and stated Let's do this. You can't get out of your f****** chair, you one-legged b****, so you can't do anything. Family Member #1 reported Nurse #1 was in Resident #1's face while yelling and cursing. He reported in his statement that Resident #1's behavior was inappropriate and offensive, however, Nurse #2's response (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	escalating the situation and she could not get away from her. Nurse #1 stated she had a couple of other residents that she needed to monitor closely due to condition changes and Resident #1 was preventing her from completing her tasks. Nurse #1 stated after more than an hour of Resident #1 being relentless, Nurse #1 stated she was irritated and gave Resident #1 her medications. Nurse #1 stated she had been a nurse for 30 years and had a bad day and she lost it with Resident #1. A statement from Nurse # 2 dated 5/28/26 revealed she heard Nurse #1 call Resident #1 a one-legged b**** and that she didn't give a f*** about being fired. Nurse #2 revealed in her statement that Nurse #1 stated Resident #1 was a drug addict and she didn't give a f*** who the Administrator was and that she would walk out of this b**** right now. Nurse #2's statement indicated Family Member #1 and other residents heard the altercation and that Family Member #1 told her he was scared to have his loved one cared for by Nurse #2. Nurse #2 continued that Resident #1 was distressed and Nurse #2 convinced her not to call the police. A telephone interview with Nurse #2 on 6/16/26 at 2:59 PM revealed she was working on the other unit on the evening of 5/27/26 when the incident between Resident #1 and Nurse #1 occurred. She stated a few residents came and got her on the unit and when she arrived at the other unit, she heard Nurse #1 and Resident #1 cursing each other out. She stated she removed Resident #1 from the unit and Resident #1 stated she was going to call the Administrator on her phone. Nurse #2 stated she saw Resident #1 speaking to the Administrator on the phone, but she did not know which details she shared with him. A telephone interview with the Director of Nursing (DON) was conducted on 6/18/26 at 10:20 AM. She stated she was made aware of the 5/27/26 incident between Nurse #1 and Resident #1 on 5/28/26. She understood that Nurse #1 made some inappropriate statements toward Resident #1 after she asked for her medications early in the evening of 5/27/26. The DON stated she had the expectation that all staff would notify either herself or the Administrator of any type of abuse and that Nurse #1 should have let Resident #1 know of the medication timeframe and continued her medication pass. The DON stated that nurses had to follow the provider's orders for scheduled medications. A telephone interview with the Administrator on 6/23/26 at 4:13 PM revealed he left the faciity on 5/27/26 and then received a phone call from Nurse #2 that Resident #1 was upset, and she wanted to speak to him. He stated Resident #1 told him another resident called her a one-legged white t**** wh***. The Administrator stated Resident #1 did not get along with the other resident and it was not unusual for them to get upset with each other. He asked Resident #1 what she wanted him to do and she stated she was going to go to her room for the evening. The next day, he followed with the other resident who did not mention the incident and in the evening when he was ready to leave for the day, he found a statement under his door from Nurse #2 explaining the incident on 5/27/26 between Resident #1 and Nurse #1. The Administrator stated he expected the Nurse #1 to walk off the unit and disengage during the altercation with Resident #1 and that did not happen. He indicated the entire incident could have all been avoided if Nurse #1 had just walked away from Resident #1.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, Pulmonologist Office Receptionist, Nurse Practitioner (NP) and staff interviews the facility failed to ensure a resident attended a scheduled pulmonary follow-up visit with the pulmonologist for 1 of 1 resident reviewed for quality of care (Resident #2). The findings included:Resident #2 was admitted to the facility on [DATE]. His diagnoses included acute respiratory failure with hypoxia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact. A review of resident #2's Electronic Medical Record (EMR) revealed a scheduled pulmonologist appointment on 6/9/26 at 1:20 PM. An interview with Resident #2 on 6/16/26 at 2:29 PM revealed he had a follow-up appointment with the pulmonologist on 6/9/26 from his hospitalization earlier in the year and no one from the facility took him to the appointment that the NP ordered because no one at the facility knew anything about it. He stated he hadn't been anywhere out of the facility for a while and was unaware if the appointment had been rescheduled. An interview with the Medical Transporter on 6/16/26 at 2:41 PM revealed she had been employed at the facility since the beginning of March 2026. She stated the Nurse Practitioner (NP) requested a follow-up appointment on 4/24/26 with the pulmonologist for Resident #2, but she was on medical leave and was unaware of the appointment request. The Medical Transporter stated typically when nursing received an order for a new doctor's appointment, the nurse on duty approved it and a copy of the appointment would be given to her, and another copy would be given to the Receptionist at the front desk. She stated she set up all appointments she knew about before her medical leave and was not aware of any other staff member covering her job duties while she was gone. The Medical Transporter stated after Resident #2 missed his appointment, she was made aware by the Director of Nursing (DON) on 6/10/26 and she rescheduled the appointment for 7/23/26. A telephone interview with the Pulmonologist Office Receptionist occurred on 6/17/26 at 11:02 AM. She revealed Resident #2 was a no-show for his appointment on 6/9/26 and confirmed Resident #2 had an appointment on their schedule for 7/23/26 and it was scheduled by the facility on 6/10/26. A telephone interview with the NP on 6/17/26 at 11:13 AM revealed Resident #2's pulmonologist appointment was a follow up from a hospitalization earlier in the year. He stated Resident #2 had some respiratory concerns including pneumonia and a pleural effusion earlier in the year and the pulmonologist wanted these concerns monitored after the hospitalization. The NP stated when he ordered a medical appointment for any resident, he would fill out a communication log sheet with the resident's name and consultation information, and he would put the communication log sheet in the box to communicate with the Medical Transporter. He stated he had the expectation that the DON or nursing staff would communicate with the Receptionist at the front desk or the Medical Transporter as well. The NP stated he understood that during the Medical Transporter's absence, new consults were getting scheduled and some appointments were missed. He stated all nursing staff should communicate with the Receptionist and the Medical Transporter when processing a medical appointment order. He stated he spoke with the DON a week ago and asked her to streamline the communication process with nursing staff for medical appointments. A telephone interview with the Receptionist occurred on 6/17/26 at 1:45 PM and revealed she was not aware of an appointment for Resident #2 on 6/9/26. She stated all appointments were scheduled and coordinated with outside transportation before the Medical Transporter went out on medical leave. The Receptionist stated she typically received a list of medical transports daily, some were driven by the Medical Transporter, and some were driven by a contracted wheelchair transport company. A telephone interview with the DON on 6/18/26 at 10:20AM revealed Resident #2's pulmonologist appointment on 6/9/26 was on the book for an outside wheelchair transport company because Resident #2 had to be transported in a reclining wheelchair. She stated the wheelchair transport company was supposed to pick up Resident #2 and they did not. The DON stated she called the wheelchair transport company, and they did not have (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transportation available for Resident #2. She stated a new appointment for Resident #2 was scheduled for 7/23/26. The DON stated that when a medical provider in the facility ordered a medical consult appointment, nursing staff reviewed the order and then a printed form for the appointment would be filled out and given to the Medical Transporter to put in the transportation book. She stated the Receptionist was covering for the Medical Transporter while she was out on leave and the DON was sure there was a transport communication request given to the outside wheelchair transportation company to request a ride for Resident #2. A review of a facility transportation request sheet dated 4/27/26 at 1:30 PM revealed an email request for wheelchair transportation for Resident #2 on 6/9/26 for a 1:20 PM appointment at the pulmonologist office location. The form indicated it had been scanned to email but did not contain an email from the facility to the wheelchair transportation company or a response from the wheelchair transportation company confirming the appointment. A telephone interview with the Wheelchair Transportation Company Owner was attempted on 6/23/26 at 10:13 AM but he refused to provide any information regarding Resident #2's medical transportation request for a pulmonology appointment on 6/9/26. A telephone interview with the Administrator on 6/23/26 at 4:13 PM revealed Resident #2 did miss his appointment on 6/9/26 and he did not find out about the missed appointment until the following day when Resident #2's Responsible Party (RP) contacted him. The Administrator stated the Medical Transporter was out on medical leave when the order was made and the facility started reviewing all medical appointments for residents since 6/9/26 to ensure there were no more missed appointments. He stated Resident #2 had a rescheduled pulmonologist appointment in July.