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	05/11/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to discard dented canned goods stored for use, failed to dry divided plates prior to stacking, and failed to discard a wet cardboard box of pound cakes covered in frozen condensation. These practices occurred in 1 of 1 walk-in freezer, 1 of 1 dishwashing area, and 1 of 1 dry storage area and had the potential to affect food served to residents. The findings included:An initial tour of the main kitchen occurred on 5/4/26 at 9:58 AM with the Dietary Manager. The following concerns were identified:-A 108 ounce (oz.) can of applesauce with a large dent on the rim and side, a 6.62 pound (lb.) can of mandarin oranges with a small dent on rim, and a 7 lb. can of vanilla pudding with a small dent on the rim were stored in the dry storage area for use.-A cardboard box containing 12-pound cakes was stored under the main cooling fan in the walk-in freezer; the box was dark in appearance and covered in frozen condensation.-Six divided plates were stacked wet (wet-nested) in the dishwasher area.An interview with the Dietary Manager on 5/7/26 at 2:05 PM revealed she in-serviced the kitchen staff on proper drying of dining supplies, inspecting cans for dents, and proper storage in the freezer. The Dietary Manager stated the staff sometimes would not pay attention and would forget correct kitchen practices. She stated the cardboard box in the walk-in freezer belonged to the Activities department and she found sometimes those boxes were not placed in the right spot in the walk-in freezer to prevent the condensation from dripping on the box. The Dietary Manager stated Activity staff had access to the freezer and the box was placed in the incorrect spot on the shelf. She stated she wanted dented cans to be pulled from rotation to send back to the distributer for credit. An interview with the Administrator on 5/7/26 at 2:50 PM revealed he had the expectation for staff to properly store items in the walk-in freezer and divided plates needed to be stored correctly. He indicated kitchen staff who assist with unloading the food distribution truck would be educated on proper can storage in the dry storage area.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 observations, record review, and Nurse Practitioner, resident and staff interviews, the facility failed to provide clinical assessment and treatment when a resident first reported that he was burned after he accidentally spilled his cup of hot noodles on himself for 1 of 3 residents reviewed for quality of care (Resident #70). Findings included: Resident #70 was admitted to the facility on [DATE] and readmission on [DATE] with diagnosis that included multiple sclerosis, paraplegia, muscle weakness, and contracture of muscles to lower extremities. Review of physician order dated 7/25/24 revealed Hydrocodone (pain reliever used to treat moderate to severe pain) 5-325 milligrams (MG) one (1) tablet by mouth every 12 hours as needed for pain. Review of annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 was cognitively intact and had been assessed as being independent for eating, personal hygiene, mobility, and transfers. Resident #70 also required minimal assistance for toileting, supervision assistance for dressing, and partial assistance for showering. Resident #70 was also as coded as use of manual wheelchair for mobility. An interview with Resident #70 on 5/06/26 at 2:15 PM revealed on the evening of 4/30/26 sometime after supper probably between 6:00 PM to 7:00 PM he was putting his fork into a cup of hot noodles, and his hand accidentally hit the cup and spilled the cup of noodles onto him. He stated he immediately started to clean himself up, removed his wet clothes, dried himself off and draped a gown over himself. He revealed at first he could tell his skin on the lower right side of his stomach and his right upper thigh appeared red but then a few minutes later the areas appeared more irritated and were burning a little, so he went out to the hall and found Medication Aide #1 on the medication cart. Resident #70 stated that he told Medication Aide #1 about what had happened and that he had burned himself and she asked him why he did not tell the first shift nurse and that he should have told them and that he could tell the second shift nurse (Nurse #4) who was covering both halls. He revealed he then asked for his as needed pain medication due to the pain from his burn being a level 8 out of 10 (numeric scale for pain with 0 being no pain and 10 being the worst pain) and Medication Aide #1 administered him his pain medication which helped with the pain. He stated later that evening he spoke with Nurse #4 and told her about what had happened and that he had been burned, and she also asked him why he did not notify the first shift nurse and that he should have notified the first shift nurse and then walked away. Resident #70 stated at first he was shocked Nurse #4 had not even asked to look at his burns but his pain medication had started working, and he was not feeling any pain or discomfort from his burns, so he did not mention it again until he notified the first shift nurse (Nurse #3) the following morning on 5/01/26. He revealed once he told Nurse #3 about what had happened and about the burns, Nurse #3 immediately assessed his burns, contacted the NP and provided treatment. Resident #70 stated the NP followed up with him later that same day and continued with his same treatment, instructed him to notify staff if he saw any signs of drainage or infection, and reminded him if he was feeling any pain to request his pain medication as needed. An interview conducted with Nurse Aide (NA) #2 on 5/06/26 at 3:15 PM revealed he typically worked second shift (3:00 PM to 11:00 PM), had been scheduled to work second shift on the evening of 4/30/26, and was assigned to Resident #70's hall. NA #2 stated he did not recall Resident #70 telling him during his rounds that night about him spilling his noodles or about the burns and if Resident #70 had told him he would have notified the nurse. An interview with Medication Aide #1 on 5/06/26 at 3:25 PM revealed she typically worked second shift (3:00 PM to 11:00 PM) and was scheduled on the evening of 4/30/26 and assigned to work the medication cart for Resident #70's hall. She stated on the evening of 4/30/26 sometime between 7:00 PM and 8:00 PM while working the medication cart, Resident #70 approached her and stated that earlier he had gotten burned when he accidentally spilled his cup of hot soup noodles on himself. She revealed she asked him if he had told the first shift nurse what happened and Resident #70 stated no, the first shift nurse had already left by the time he had got everything cleaned up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Aide #1 stated that she told him he should have notified the first shift nurse and that the second shift nurse on the 200 hall was also covering his hall and for him to tell her. She revealed Resident #70 had an order for as needed pain medication due to his medical conditions and requested his pain medication for a pain level of 8 out of 10 due to burning himself. She stated that she administered Resident #70 his pain medication. Medication Aide #1 revealed she never assessed or provided treatment for Resident #70's burns that night and did not recall whether she informed Nurse #4 about the burns. She stated she did recall seeing Resident #70 speaking with Nurse #4 later that evening but could not hear what they were speaking about and was never told that night of any new orders for medications or treatments. Medication Aide #1 revealed she remembered completing rounds on Resident #70 later that evening and he stated his pain was good and the medication was effective. Review of the April 2026 Medication Administration Record (MAR) revealed on 4/30/26 at 8:38 PM Resident #70 was administered Hydrocodone 5-325 MG 1 tablet by mouth every 12 hours as needed for pain by Medication Aide #1 for a pain level of 8 out of 10. Pain medication was effective. A telephone interview conducted with Nurse #4 on 5/11/26 at 2:30 PM revealed she typically worked as a second shift nurse (7:00 PM to 7:00AM) and was scheduled to work on the night of 4/30/26. She stated she was scheduled as the nurse and working the cart on the 200 halls but was overseeing Medication Aide #1 who was working Resident #70's hall. She revealed she was familiar with Resident #70 and might have spoken to him that night but did not recall him ever telling her about him accidentally spilling his cup of hot soup noodles onto himself causing him to get burned. She stated she believed that had she been told she would have assessed Resident #70, called the physician, and documented the incident. Nurse #4 revealed she spoke with Medication Aide #1 that night about resident blood sugars but never about Resident #70 getting burned. Review of nursing progress note written by Nurse #3 dated 5/01/26 revealed Resident #70 showed Nurse #3 scald wounds sustained previous night when hot soup noodles accidentally spilled onto his right thigh (8 inch by 3-inch wound and a 3 inch by 1-inch wound) and lower right side of abdomen (6 inch by 2-inch wound). Nurse #3 notified NP and wound nurse and received treatment orders. Nurse #3 thoroughly washed wound and applied new treatment orders. Review of incident report written by Nurse #3 dated 5/01/26 revealed Resident #70 showed Nurse #3 scald wounds sustained previous night when hot soup noodles accidentally spilled to his right thigh (8 inch by 3-inch wound and a 3 inch by 1-inch wound) and lower right side of abdomen (6 inch by 2-inch wound). Nurse #3 notified NP and wound nurse and received treatment orders. Nurse #3 thoroughly washed wound and applied new treatment orders. An interview with Nurse #3 on 5/06/26 at 3:35 PM revealed he typically worked first shift (7:00 AM to 7:00 PM) and was scheduled to work on the morning of 5/01/26 and assigned to Resident #70's hall. He stated on the morning of 5/01/26 sometime between 8:00 AM and 9:00 AM he was administering Resident #70 his morning medications when Resident #70 informed him that the previous evening he was attempting to eat a cup of hot soup noodles and accidentally hit the cup with his hand and spilled the hot soup noodles onto himself and had gotten burned. He revealed Resident #70 stated that after he cleaned himself up, he went to the second shift Medication Aide #1 and informed her what had happened and that he had gotten burned and that she asked Resident #70 why he didn't tell the first shift nurse before they left and that he would need to tell the second shift nurse. He revealed Resident #70 requested his as needed pain medication for the pain from his burns and Medication Aide #1 administered the medication and it was successful. Nurse #3 stated Resident #70 later informed the second shift nurse (Nurse #4) who was covering that hall and that she also asked why he did not inform the first shift nurse what happened and that he should have informed first shift but that she never physically assessed him or treated the burns or contacted the physician. Nurse #3 revealed after hearing this he immediately assessed Resident #70 and found that he had a burn to his lower right abdomen that was red and appeared as if a blister had popped and what he believed to be two wounds to his right upper thigh that appeared the same. He stated he immediately notified the NP and received new treatment orders. He revealed he then washed Resident #70's wounds, applied the new (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatments, administered his as needed pain medication for a pain level of 5 out of 10, entered treatment orders into system, completed incident report, and documented incident in progress notes. Nurse #3 stated that he did check on Resident #70 a little while later and observed the dressings were intact and his pain medication was successful with no complaints of pain. Review of physician progress note written by the NP dated 5/01/26 revealed Resident #70 reported he had spilled hot soup noodles on himself by accident last night and sustained burns to his right abdomen and right upper thigh. Upon exam, Resident #70 was assessed to have stage 2 burns (partial-thickness burn is a burn that affects the outer layer of the skin (epidermis) and part of the underlying dermis) to his right lower abdomen and right upper thigh that had been treated and was currently dressed with dry dressing with no evidence of drainage, infection or swelling. Wound Care NP would assess burns during routine rounds next week to make further recommendations. Resident #70 endorsed mild pain at burn site and advised he had an order for as needed pain medication that could be administered for burn pain. Continue new orders for thermal wound care to right upper thigh and right lower abdomen. Review of physician order written by NP for Resident #70 dated 5/01/26 revealed thermal wound care to right upper thigh and right lower abdomen with betadine paint (fast drying topical treatment used to kill germs and prevent infection in skin wounds), Dermasyn (provides moist environment for maximum healing to skin wounds and burns) ointment and covered with dry dressing. Review of physician progress note written by the NP dated 5/04/26 revealed Resident #70 was seen for follow-up of recent second-degree thermal wound to right upper thigh and right lower side of abdomen to assess healing and assure no evidence of wound infection. Upon exam, abdominal wound was noted to be open with a deep red base and areas of yellow crusting. Given the location of wounds in areas more prone to increased moisture and friction, there was concern for potential secondary infection. Recommended treatment plan revealed the following: discontinue current treatment orders for both burns due to potential for impaired healing, initiate Clindamycin (antibiotic used to treat or prevent serious bacterial infections) 300 MG one (1) tablet by mouth 3 times daily for 7 days for wound infection, apply Silvadene (topical antibiotic cream used to treat serious skin infections associated with second-third degree burns) cream 1% to affected areas once a day (day shift) for wound care, increase as needed pain medication from every 12 hours to every 8 hours as needed, placed consult request for Wound Care NP evaluation on 5/06/26 (routine weekly rounds) for further assessment and recommendations, continue wound hygiene and monitor closely for any signs or symptoms of infection. Review of physician orders written by NP for Resident #70 dated 5/04/26 revealed the following:Hydrocodone Acetaminophen 5-325 MG one (1) tablet by mouth every 8 hours as needed for treatment of pain.Clindamycin 300 MG 1 tablet by mouth 3 times daily for 7 days for wound infectionSilvadene cream 1% applied to affected area (right upper thigh and right lower abdomen) once a day (day shift) for wound care An interview conducted with the NP on 5/06/26 at 10:15 AM revealed he was familiar with Resident #70. He stated on the morning of 5/01/26 he received a telephone call from Nurse #3 stating the previous evening Resident #70 had accidentally spilled a cup of hot soup noodles on himself and had some burns to his lower right abdomen and right upper thigh and they appeared red and as if blister had opened. He revealed he gave orders to clean both burns and treat with betadine, medicated cream, and cover with dry dressing and to administer Resident #70's as needed pain medication if needed and that he would be in to assess burn that morning. The NP stated on 5/01/26 he assessed Resident #70's burns and felt they were stage 2 and continued with the current treatment order to be completed daily during day shift. He revealed Resident #70 stated only some mild pain from the burns and he reminded him that he had an order for pain medication every 12 hours that he could request as needed. The NP stated he followed up with Resident #70's burns on 5/04/26 and they appeared a little worse with a red base and yellow crustiness so he changed the treatment order to an antibiotic cream specifically for burns to be administered daily during day shift, ordered an antibiotic to prevent infection, and changed his as needed pain medication to every 8 hours as needed instead of every 12 hours due to new treatment orders. He revealed Resident #70 was also (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluated today by the Wound Care NP and they agreed to keep the treatment order the same and will continue to see him weekly until the burns have healed. The NP stated as of right now there were no signs of infection present in Resident #70's burns and he has not complained of any severe pain and has only requested his as needed pain medication sporadically with a documented pain level of 5 and medication seemed to be working effectively. He revealed he was not notified and to his knowledge neither was the on-call service notified of Resident #70's incident or his burns on the evening the incident occurred and although in his opinion it would not have changed the degree of the burn he still would have liked to have been notified or at least on-call to have been notified so they could have had an initial assessment of the burn after it occurred and treatment recommended. Review of Wound Care NP progress note dated 5/06/26 revealed Resident #70 being seen for initial evaluation. He received burns from accidental spilling of hot soup noodles onto right thigh and right abdomen, both areas with dermis (middle layer of skin) and scabbed areas, some trace erythema (redness) on edges, and received antibiotic. Resident #70 reported some drainage, but none seen on assessment. Wound to right thigh measured 16 centimeters (cm) by 4.5 cm by 0.1 cm and wound to right abdomen measured 6 cm by 3 cm by 0.1 cm. Continue current treatment course. An interview and observation with Resident #70 on 5/06/26 at 2:15 PM revealed he believed his burns were starting to heal, nursing staff were providing his treatment daily, the NP continued to follow-up with him weekly, and he had also been seen and treated by the Wound Care NP. Resident #70 stated he had some mild to moderate pain from the burns from time to time but once he received his as needed pain medication the pain would stop. Observation of Resident #70 burns on his lower right abdomen and right upper thigh revealed both areas covered with dry dressing, dated, and initialed. An interview conducted with the Director of Nursing (DON) and Regional Nurse Consultant on 5/07/25 at 3:30 PM revealed both were familiar with Resident #70. The DON stated she was not made aware of the incident with Resident #70 and the burns until 5/04/26 due to being out of town and then was only notified that Resident #70 had spilled his cup of hot soup noodles on himself by accident and received burns to his stomach and thigh. The DON revealed she was not aware of staff being told after the incident occurred on 4/30/26 and not assessing or treating the burns until the following morning. The Regional Nurse Consultant stated that she was made aware of the incident on 5/01/26 while at the facility and had spoken with Resident #70 who had told her a similar version of how he had accidentally spilled the cup of hot soup noodles onto him and caused him to get burned but could not recall him telling her the specifics about the staff and not providing care. She stated when she saw Resident #70 on 5/01/26 his wounds had been treated, and he had no complaints of pain. The Regional Nurse Consultant stated she expected that nursing staff should immediately report to their supervisor any incidents involving residents as soon as they are made aware, nursing staff should physically assess any reports of resident injury as soon as they are made aware, nursing staff should notify the physician of any incidents as soon as they are made aware, and nursing staff should always document any incidents involving residents as soon as possible. The DON agreed with the expectations from the Regional Nurse Consultant and stated that Medication Aide #1 should have assured that Nurse #4 was notified of the incident and Nurse #4 should have physically assessed Resident #70's burns, notified the physician for further recommendations, applied any treatments as ordered, and documented the incident. An interview conducted with the Administrator on 5/07/26 at 4:00 PM revealed he was familiar with Resident #70. The Administrator stated he believed he was made aware on 5/01/26 of Resident #70 accidentally spilling his cup of hot soup noodles onto himself causing him to get burned and having to receive treatments for his burns. He revealed he was not aware that Resident #70 had told Medication Aide #1 and Nurse #4 the previous night when the incident happened and that he was not physically assessed or provided care until the following morning. He stated nursing staff were aware to notify their supervisors immediately when notified of any type of incident or injury involving a resident, to immediately physically assess residents once they were notified of an incident or injury, to notify the physician for further recommendations and treatment orders, and to complete incident reports and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document the reported incidents or injury in a timely manner. The Administrator stated Medication Aide #1 should have made sure Nurse #4 was aware of Resident #70's incident and his burns and once notified Nurse #4 should have physically assessed Resident #70 immediately, notified the physician for further treatment recommendations, completed an incident report and documented the incident and injury in a nursing progress note.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with the Responsible Party (RP), staff, Nurse Practitioner (NP), and hospice staff, the facility failed to ensure effective communication and coordination of care occurred with the hospice provider. On 6/29/25, Resident #101, who was under the care of hospice, fell in his room and was assessed by Nurse #1, assisted back to bed and then sent to the Emergency Department (ED) for evaluation. The hospice on call provider was not notified by facility staff before Emergency Medical Services (EMS) was called. This deficient practice affected 1 of 4 sampled residents reviewed for coordination of hospice services (Resident #101).The findings included:The Hospice Facility and Services Agreement contract dated 4/30/19 stated, With respect to the management of the resident's terminal illness, the facility shall notify Hospice immediately of any significant change in the Patient's status (mental, social, emotional, or physical), clinical complication that suggest a need to alter the plan of care; a need to transfer the Patient out of the Facility; or the Patient's death regardless of the time or the day since a Hospice staff member is available (24) twenty four hours a day, every day.Resident #101 was admitted to the facility on [DATE] under hospice services with diagnoses which included protein-calorie malnutrition (when the body does not receive enough protein and calories to maintain proper health and functioning), and ascorbic acid deficiency (a deficiency caused by low vitamin C levels).Resident #101's care plan dated 4/21/25 revealed a focus area for hospice services with expected decline in condition due to terminal progressive disease related to protein calorie malnutrition. Interventions included notifying the Medical Director and hospice of complications as indicated.Resident #101's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired and received hospice care. Resident #101 required substantial and maximal assistance to set up assistance from staff for all Activities of Daily Living (ADL).A review of Resident #101's physician's orders revealed an order dated 4/24/25 for hospice due to protein-calorie malnutrition. The order read to notify Hospice 24 hours a day, seven days a week of any change in condition or question/concern.A review of a document entitled Interact Transfer Form dated 6/29/25 and signed by Nurse #1 revealed Emergency Contact #2 was called and notified of the transfer to the hospital. The reason for transfer to the ED was due to altered mental status. A nursing progress note dated 6/30/25 and written by Nurse #1 revealed after a fall on 6/29/25, Resident #101 appeared lethargic and was observed head to toe with no wounds or bruises noted and Resident #101 was assisted back to his bed. Resident #101 was restless and repeatedly stated he was having difficulty breathing. A pulse oximetry (a non-invasive test that measures the oxygen saturation level in the blood and heart rate) reading was obtained and noted to be in the low 60s (normal range is between 95% and 100%) and oxygen was applied immediately. The nursing progress note continued that due to Resident #101's continued lethargy and low oxygen saturation, EMS was contacted and he was transported to the hospital via ambulance for further evaluation and treatment. The note indicated that the RP and nurse supervisor were notified. There were no physician orders documented to send Resident #101 to the ED for evaluation on 6/29/25.A telephone interview with Nurse #1 occurred on 5/7/26 at 12:37 PM. She stated she couldn't remember exact details from 6/29/25 but did generally recall Resident #101. Nurse #1 stated the Former Nurse Supervisor that night called EMS, and she stayed with Resident #101 in the meantime. She stated Resident #101's oxygen saturation was low and just because he used hospice services didn't mean he didn't need to be treated although she did not specifically recall if Resident #101 utilized hospice services. Nurse #1 stated she did not call hospice or the NP, but the Former Weekend Supervisor did. A telephone interview with the Former Weekend Supervisor on 5/8/26 at 1:23 PM revealed he was not assigned to Resident #101 on the night of 6/29/25 and that Nurse #1 was. He stated he did not assist with calling EMS for Resident #101 but knew he was sent (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of the facility for evaluation at the ED. The Former Weekend Supervisor stated he did not remember many details about what happened on 6/29/25 but knew he did not complete any paperwork or make any calls to hospice, the on-call service for the NP, or the RP regarding Resident #101. A phone interview with Hospice Nurse #1 on 5/6/26 at 3:40 PM revealed the hospice agency was not contacted about Resident #101's fall on 6/29/25. She stated Resident #101 was documented in their EMR as not wanting any aggressive treatment. Hospice Nurse #1 stated she reviewed the coordination notes in their system call log and it revealed no calls or notes regarding Resident #101 that night. Hospice Nurse #1 stated they became aware of his hospitalization the following day on 6/30/25 because Resident #101's RP called stating he was sent to the hospital and did not know which one. She stated generally hospice should be called for any change in condition. Hospice Nurse #1 stated their on-call service would track the call, coordinate with the RP or family to see what their wishes were and typically a nurse from the hospice agency would be sent out to evaluate. She stated a MOST form was signed on 7/2/25 after Resident #101's hospitalization on 6/29/25 indicating no further hospitalizations.In a telephone interview with Resident #101's RP on 5/6/26 at 1:16 PM she revealed Resident #101 did not want to go to the hospital for treatment. She stated Emergency Contact #2 was called instead of her on 6/29/25. The RP stated she had recently become Emergency Contact #1 for Resident #101 due to a change in health status concerning Emergency Contact #2. She stated the facility called Emergency Contact #2 and stated Resident #101 was being sent to the ED for evaluation. The RP stated the facility did not call hospice for any orders or evaluation of Resident #101 and as a result, a MOST (Medical Orders for Scope of Treatment) form was signed indicating Resident #101 did not want to be hospitalized when he returned from the ED. The RP stated she also placed a sign in Resident #101's room indicating his wishes to not be hospitalized again.A review of Resident #101's Electronic Medical Record (EMR) revealed Emergency Contact #2 was labeled as Emergency Contact #2, but listed first on the form and Emergency Contact #1 was labeled as Emergency Contact #1, but listed second on the form.A review of Resident #101's hospital records dated 6/30/25 revealed Resident #101 was sent by EMS for treatment after a fall with a fever and low oxygen saturation. Resident #101 was found to have a fractured rib, pneumonia, and osteomyelitis (a bone infection) in one toe. Broad spectrum antibiotics were initiated but were stopped due to comfort measures wishes as directed by the RP. Resident #101's hospital records also revealed hospice was contacted by hospital staff and confirmed only comfort measures were desired at that time per the RP and Resident #101 would be discharged back to the facility when transport became available. Resident #101 was discharged from the hospital back to the facility 7/01/25.An additional review of Resident #101's EMR revealed a MOST form signed on 7/2/25 indicating Comfort Measures. Keep clean, warm and dry. Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital unless comfort needs cannot be met in current location.A telephone interview with the Former Director of Nursing (DON) on 5/8/26 at 2:20 PM revealed that generally, if the nurse on duty was not familiar with any resident, she would expect them to call the provider and provide care for the resident's safety. She stated she did not recall the exact details of Resident #101's fall and transfer to the ED on the night of 6/29/25 but stated unless his EMR stated to not call 911 due to hospice services, she expected Nurse #1 to call the provider and let hospice know. The Former DON was not sure when hospice was contacted for Resident #101 but stated she recalled doing some education to the nursing staff about hospice coordination. A telephone interview with the former Administrator on 5/11/26 at 1:45 PM revealed he did not recall Resident #101 or the coordination of care the night of 6/29/25 but stated the Former DON expected providers to be called and indicated education for staff was probably completed on hospice coordination by the Former DON.

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	05/11/2026

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

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews with residents, Responsible Party, and staff, the facility failed to ensure the call light system was functioning properly for 3 of 27 residents who required assistance for activities of daily living (Resident #5, Resident #19, and Resident #48). The findings included:a. Resident #5 was admitted on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was assessed as moderately cognitively impaired.An observation of the call light for Resident #5's room and an interview with the resident occurred on 5/4/26 at 11:00 AM. The light in the hallway above the Resident #5's door did not light up when the call light was pressed. Resident #5 stated he was not aware the call light was not working and had been waiting for a staff member to provide ice water and take money to get a soda for him out of the drink machine. He stated he might have to yell if he needed assistance since his call light was not working. There was not a manual hand bell present for Resident #5's use. An interview with Unit Manager #1 occurred on 5/4/26 at 11:10 AM. She stated she was not aware there was an issue with Resident #5's call light. Unit Manager #1 went to Resident #5's room to test call light. She stated she had no idea the call light was not working and provided a hand bell to Resident #5 and immediately notified maintenance to address the issue. b. Resident #19 was admitted to the facility on [DATE]. The significant change MDS assessment dated [DATE] revealed Resident #19 was moderately cognitively impaired. An observation of the call light for Resident #19's room and an interview with Resident #19 occurred on 5/4/26 at 11:50 AM. When Resident #19's call light was pressed it did not light up in the hallway above the door. Resident #19 stated he did not know that the bell was not working. There was no hand bell present in Resident #19's room. c. Resident #48 was admitted to the facility on [DATE]. The admission MDS assessment dated [DATE] revealed Resident #48 was moderately cognitively impaired. An observation of Resident #48's call light and interview with Resident #48's Responsible Party (RP) occurred on 5/4/26 at 11:45 AM. When the bell was pressed, the light in the hallway did not turn on. Resident #48's RP stated she was not aware the call light was not working. There was no hand bell present in Resident #48's room.An interview with Nurse #2 on 5/4/26 at 11:03 AM revealed it was her first day at the facility and she did not know there was any issue with the call lights not lighting up in the hallway. An interview with Nurse Aide (NA) #1 on 5/4/26 at 11:05 AM revealed she did not know there was any issue with the call lights not lighting up in the hallway.An interview with the Maintenance Director occurred on 5/7/26 at 9:24 AM. He stated he was notified by Unit Manager #1 of call lights not lighting up in the hallway on 5/4/26. He was not aware of the call lights not functioning for Resident #5, Resident #19, and Resident #48's rooms before 5/4/26 and no staff had reported any issues. A follow-up interview with the Maintenance Director on 5/7/26 at 1:10 PM was conducted. The Maintenance Director stated any staff member could place a request in the online system for maintenance. He stated staff would frequently stop Maintenance staff members in the hallway with requests. The Maintenance Director stated the Maintenance department did random call light checks often and the nonfunctioning call lights were not identified before 5/4/26. An interview with the Maintenance Assistant on 5/7/26 at 1:35 PM revealed the Maintenance staff did random rounds to check on the call lights in resident rooms, but he was not aware of any of the call lights not working before 5/4/26.An interview with the Director of Nursing (DON) was conducted on 5/8/26 at 4:03 PM. She stated she was not aware of the call lights not working in Resident #5, Resident #19, and Resident #48's rooms before 5/4/26 but stated if there was a concern regarding call lights not working after hours, staff could borrow a call light from an empty room and put a request in the online maintenance request system. The DON stated nursing staff could also give any resident a physical hand bell to use, alert the staff of the use of the physical hand bell, and then put in a request in the online maintenance request system. An interview with the Administrator on 5/7/26 at 2:58 PM revealed he did not know the call lights in Resident #5, Resident #19, and Resident #48's rooms were (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not working before 5/4/26 and he had the expectation that all staff would make a request to fix call lights in the online maintenance request system as soon as the issue was identified.