STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 000	INITIAL COMMENTS The survey team entered the facility on 4/5/2023 to conduct a complaint investigation. The survey team was onsite 4/5/2023 and 4/6/2023. Additional information was obtained offsite on 4/10/2023. Therefore, the exit date was 4/10/2023. Event ID# 32U111. The following intakes were investigated NC00196852, NC00197416, NC00199277, NC00199739, NC00199774, and NC2000046. Three of the 16 complaint allegations resulted in deficiency.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and family interviews the facility failed to ensure a resident was seated in a safe position on the bed after a transfer which resulted in a fall with femur fracture for 1 of 3 residents reviewed for accidents (Resident #19). The findings included: Resident #19 was admitted to the facility on 8/13/16 with diagnoses that included stroke with hemiplegia and hemiparesis affecting the left side, vertigo, presence of left artificial knee joint and muscle weakness.	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 1	F 689		

A quarterly Minimum Data Set dated 2/1/23 for Resident #19 revealed she was cognitively intact with no refusals or rejection of care. Resident #19 required extensive 2 person assist with transfers and bed mobility.

Review of a fall note for Resident #19 authored by Nurse # 3 and dated 3/17/23 read in part: During a transfer using the sit to stand lift, the CNA positioned the patient on her bed and while removing the sit to stand the patient slipped off the side of the bed.

Review of a nurse note for Resident #19 authored by Nurse # 3 and dated 3/18/23 read in part: the patient has a complaint of left knee pain. Nurse received a new order for x-ray of left knee related to pain from fall.

Review of a left knee x-ray report for Resident #19 dated 3/19/23 revealed an acute, transverse, non-displaced fracture of the distal femur metaphysis (a portion of the femur close to the knee).

Review of the hospital Discharge Summary dated 3/24/23 for Resident #19 read in part: the resident presented to the Emergency Department on 3/20/2023 for the evaluation of left knee pain following falling out of bed on 3/17/23. Xray of the left femur revealed possible impacted fracture comminuted displaced fracture involving the distal femoral metaphysis just above the femoral component of the total knee arthroplasty. Subsequent imaging confirmed moderately comminuted and mildly displaced periprosthetic fracture of the distal femur. Diagnoses: Displaced comminuted fracture of shaft of left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

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F 689	Continued From page 2	F 689		

femur. She underwent left femur open reduction internal fixation (a surgery to repair a broken bone) on 3/22/23 and the procedure was uneventful. Continue non-weight bearing on the left lower extremity (which is her baseline). The resident was discharged back to the facility on 3/24/23.

During an interview on 4/5/23 at 1:15 PM Resident #19 revealed a couple of weeks ago at night a Nurse Aide (NA) was helping her get ready for bed. She had been up in her wheelchair. The NA got her up from the wheelchair with the sit to stand lift and positioned her on the edge of the bed. Resident #19 stated as the NA was removing the sit to stand from her room, she felt like she was falling. She tried to hold the side rail but fell to the floor on her side. She explained she called to the NA and said, "come back in here and help me". The NA came and saw her on the floor and went to get more staff to help get her up. Resident #19 revealed three staff members got her up from the floor with the mechanical lift. She stated her leg was hurting, but the nurse gave her something for the pain. She did not request to be sent to the hospital.

An interview was conducted on 4/5/23 at 4:51 PM. Nurse #3 revealed she was assigned to care for Resident #19 on the night of her fall. She explained she had left the room after giving Resident #19 her medications, shortly after NA #1 came out in the hall and said Resident #19 had fallen. Nurse #3 did not witness the fall but was told by NA #1 she was getting the resident ready for bed and transferred her with the sit to stand lift from the wheelchair to the bed. She sat the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 689	Continued From page 3	F 689		

resident on the side of the bed and as she was removing the sit to stand from the room, Resident #19 slid off the bed and fell to the floor. Nurse #3 further explained NA #1 said she thought Resident #19 was seated on the bed better than she was. Nurse #3 revealed when she went to the resident's room she was on the floor, lying on her right side. She completed a full head to toe assessment and took vital signs. Nurse #3 stated there was no bruising, redness, or open areas on the resident. Resident #19 was moved to her bed with the mechanical lift. She complained of pain in her left knee, and it had a small amount of swelling. Nurse #3 explained this resident had a history of left knee pain and the left knee normally had a little swelling related to a past surgery. She had given scheduled pain medication to the resident during medication pass, so at this time she offered an ice pack. She further explained the resident did not show any physical signs of pain, she did not grimace, moan or cry out in pain. Nurse #3 returned the following morning on 3/18/23 and asked Resident #19 "how is your knee", and the resident said it still hurts. Nurse #3 revealed at that time she called the provider and obtained an order for an x ray because the resident was still experiencing pain. Nurse #3 explained the x-ray provider came and completed the x-ray on the evening of Sunday 3/19/23. On Monday morning 3/20/23 the facility received the results of the x-ray, and it revealed Resident #19 had a femur fracture. The family and Physician were notified, and the resident was sent to the hospital.

During an interview on 4/6/23 at 9:07 AM NA #1 revealed on the evening of 3/17/23 she was putting Resident #19 back to bed from her wheelchair with the sit to stand lift. She sat the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 689	Continued From page 4	F 689		

resident on the side of the bed, then began to back the sit to stand lift out of the resident's room. While backing the lift out of the room she saw Resident #19 slip off the bed. She saw the resident falling but could not get to her to prevent the fall because she was moving the sit to stand lift. NA #1 further revealed she went to get the nurse and while the nurse was with the resident, she went to get more staff to help get the resident off the floor. The mechanical lift was used to move the resident from the floor to the bed. NA #1 stated Resident #19 said her leg hurt but she did not notice any obvious injuries.

An interview was conducted with the Director of Nursing (DON) on 4/6/23 at 12:29 PM. The DON revealed Resident #19 had a fall on Friday night 3/17/23, and she was made aware of the fall on Monday 3/20/23 when she returned to work. It was reported to her that NA #1 was transferring Resident #19 from the wheelchair to the bed with the sit to stand lift, and the resident was not seated well on the bed and fell to the floor. The DON stated she personally educated NA #1 on ensuring residents are seated properly and secure on the side of the bed prior to leaving their side. Education was also provided to the rest of the staff. The facility initiated a 4-point plan to prevent this from reoccurring.

During an interview on 4/6/23 at 2:30 PM the Administrator revealed after he was made aware of Resident #19's fall, he spoke to the resident and staff members to identify a root cause. Based on his interview with Resident #19 and NA #1 the facility concluded that the root cause for Resident #19's fall was that she was not placed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

(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 689	Continued From page 5	F 689		

securely on the side of the bed, and this resulted in a fall. The Administrator stated after the facility identified the root cause for Resident #19's fall they put in place a 4-point plan to prevent reoccurrence. NA #1 had received 1:1 education, in addition all other nursing staff had been educated. The facility also implemented monitoring.

The facility provided the following correctivce action plan with a completion date of 3/24/23.

Corrective action plan: Resident #19 is a 77 y/o female who admitted to Huntersville Health and Rehab Center on 08/13/2016 status post stroke and is currently residing on the long-term care unit. Her medical history includes cerebral infarction, dysarthria, hemiplegia, hemiparesis, anemia, anxiety, vertigo, dysphagia, hypomagnesemia, muscle weakness, unsteadiness on feet, HTN, GERD, DM2, major depressive disorder, osteoarthritis, and hyperlipidemia. Overall, Resident #19 is alert and oriented to person, place, time, and situation, has a BIMs of 14, struggles with depression and anxiety, and has some age-related confusion. In terms of her functional status, she requires moderate to extensive assist for ADL's and mobility.

On 3/17/2023, Resident #19 endured a witnessed fall from the edge of the bed, and on 3/18/2023 she reported having knee pain. The resident was assessed by the center's nurse and NP as a result x-rays were ordered. On 3/20/2023 X-ray results were reviewed and showed left acute, transverse, non-displaced fracture at distal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 689	Continued From page 6	F 689		

femoral metaphysis. The family was updated on the x-ray results and the resident was sent to hospital for evaluation. The hospital confirmed the fracture and scheduled resident for an ORIF to left leg.

On 3/20/2023, the Administrator met with Resident #19 and discussed the details of her fall from 3/17/2023. Resident #19 reported that the C.N.A had just finished sitting her on the edge of the bed with the sit to stand machine, however that she did not feel that she was on the bed good. The patient has a BIMs of 14 and was therefore able to recall the details of the event. When asked if she told the C.N.A. that she did not feel secure, she reported no. The resident went on to state the C.N.A. proceeded to leave the room with the machine but left her on the edge of the bed. She reported that she started to slide from the bed, hitting her knee on the floor. She then stated that she is normally able to sit on the edge of the bed, but this time she did not feel that she was on the bed good enough.

The Administrator and DON interviewed the involved C.N.A and she reported that she had just finished transferring Resident #19 to the bed as normal, and that Resident #19 normally is able to sit on the edge of the bed without any issues.

The root cause of this fall is that the patient was not on the bed securely. The root cause is not related to the actual transfer, or the use of the sit to stand equipment. The patient acknowledges through her recall of the event.

How the facility is addressing the non-compliance for the resident affected: The CNA, upon witnessing the fall, immediately when to get the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 689	Continued From page 7	F 689		

nurse. Resident #19 was assessed by nurse on duty and assisted to bed by mechanical lift and staff. The patient continued to be monitored, and offered her an ice pack, which was declined, patient had no complaints throughout the night. The patient continued to receive her normal doses of scheduled pain meds, unrelated to the fall. The patient, upon complaint of new pain the following morning, received intervention via x-ray and ultimately discharge to the hospital on 3/20/2023 around 9:40am for follow-up care.

The CNA received education the following day, on 3/18/23 to ensure that patients are balanced before leaving the patients side after transfer.

How the facility is addressing other current residents at risk All residents are at risk of this deficient practice. On 3/21, staff and residents were interviewed to determine who uses the sit to stand lift, it was determined that Resident #19 was the only current resident who was using the sit to stand. On 3/21, residents were asked to share any concerns related to how they are transferred, no concerns were voiced. Residents were asked 1) Have you had any concerns regarding how staff assist with your transfers? 2) Do you feel secure when staff are transferring you? Resident interviews included residents on the C.N.A track, residents who do not require use of mechanical lift, and residents who require use of mechanical lift.

How the facility will ensure that noncompliance does not reoccur: Education was provided 03/21-03/24/2023. Current nursing staff were educated on ensuring patients are secure and balanced prior to leaving the patient's side, education provided by center leadership, by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 689	Continued From page 8	F 689		

SDC, DON, or designee. New employees will be educated by SDC or designee during the orientation process of this process as well.

How the facility will monitor to ensure the noncompliance does not reoccur: DON or designee will monitor 5 patient transfers for security and balance before walking away weekly x 4; then 3x weekly; then monthly x 4. Any staff member observed to be non-compliant with the education will receive education and/or counseling, up to and including suspension and/or termination. The results will be reported to the monthly QAPI Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then the review will be completed on a random basis.

Date of completion 03/24/2023

The person responsible for implementing this plan is the Administrator.

The facility provided a plan of corrective action for the incident that happened on 3/17/23. Validation was completed through observations, staff interviews, and record review. Observations were made of residents seated or positioned safely in their beds and in wheelchairs. Multiple observations were made of Resident #19 positioned safely in her bed. Interviews with nurses and nurse aides stated they had recently received education on ensuring the residents are seated in safe and secure positions before leaving the resident's side. A review of monitoring tools revealed the facility was conducting ongoing audits to ensure the residents were being seated in safe positions.

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	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 689	Continued From page 9 The facility's action plan was validated to be completed as of 3/24/23.	F 689		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 10	F 842		

activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to document in the medical record the effectiveness of pain medication administered to Resident #18. This occurred for 1 of 1 sampled resident reviewed for pharmaceutical services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 842	Continued From page 11	F 842		

The findings included:

Resident #18 admitted to the facility 2/13/23. Diagnoses included fracture of left pubis, and osteoarthritis of left hip, among others.

A physician order dated 2/13/23 recorded Hydrocodone-Acetaminophen tablet 5-325 milligrams (MG), give one tablet by mouth (po) every (q) 6 hours as needed (prn) for pain for 30 days. The order discontinued on 2/17/23.

A physician order dated 2/13/23 recorded Acetaminophen Extra Strength tablet 500 MG, give two tablets po q eight hours prn for pain.

A physician order dated 2/17/23 recorded pain assessment using 0-10 scale, q day and night shift.

A physician order dated 2/17/23 recorded Hydrocodone-Acetaminophen tablet 5-325 MG, give one tablet po q six hours for pain.

An admission Minimum Data Set dated 2/19/23 assessed Resident #18 with clear speech, intact cognition, experienced frequent pain in the last five days, rated seven out of ten at assessment, and received pain medication scheduled and prn.

Review of the Medication Administration Record (MAR) for February 2023 recorded Resident #18 received the following:
- 2/14/23, 8:25 AM Hydrocodone-Acetaminophen tablet 5-325 MG; pain rated eight out of ten.
- 2/14/23, 3:55 PM Hydrocodone-Acetaminophen tablet 5-325 MG; pain rated nine out of ten.
- 2/21/23, 12 AM Hydrocodone-Acetaminophen tablet 5-325 MG; pain rated six out of ten.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 842	Continued From page 12	F 842		

- 2/21/23, 8 AM Hydrocodone-Acetaminophen tablet 5-325 MG; pain rated eight out of ten.

Review of the February 2023 MAR and nurse progress notes revealed there was no documentation that the pain medication was effective after administration.

During a phone interview with Nurse #1 on 4/5/23 at 5:00 PM Nurse #1 stated that she was the Nurse for Resident #18 on 2/14/23 for the 7 AM - 7 PM shift. Nurse #1 stated when she came on shift, Resident #18 complained of pain, and rated her pain an eight out of ten, so she medicated her. Nurse #1 stated she followed up with Resident #18 and the Resident said the medication was effective. Nurse #1 stated it was quite possible that she did not put a note in her record about that. Nurse #1 stated that later in the shift, she assessed Resident #18's pain and it was a nine out of ten, which could have been after therapy, so she medicated her again. When Nurse #1 followed up, Resident #18 rated her pain six out of ten, and said her pain had improved. Nurse #1 stated she knew to assess and document the effectiveness of pain management but could not explain why there was no documentation for the effectiveness of the pain medication she administered to Resident #18 on 2/14/23.

Nurse #2 stated on 4/10/23 at 12:19 PM during a phone interview that she was the Nurse for Resident #18 on the 7 PM - 7 AM shift on 2/21/23. Nurse #2 stated it was her practice to assess for pain during her rounds and medication pass. After administration of pain medication, Nurse #2 stated it was her practice to return and assess the effectiveness. Nurse #2 stated could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

(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 842	Continued From page 13 not really say why she did not document the effectiveness of pain medication after administration to Resident #18 because she could not remember what happened that night. Nurse #2 stated she knew to assess pain level at the time of administration of pain medication and to reevaluate the effectiveness. The Director of Nursing stated on 4/6/23 at 12:30 PM that she expected nurses to assess the effectiveness of pain medication during the same shift of administration and document the effectiveness in the resident's medical record.	F 842		