STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE 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
E 000	Initial Comments An unannounced recertification and complaint investigation were conducted on 11/13/23 through 11/16/23. The facility was found in compliance with the requirment CFR 483.73, Emergency Preparedness. Event ID #LNUV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/13/23 to 11/16/23. Event ID: LNUV11. The following intakes were investigated NC00209726, NC00209608, and NC00197032. 7 of 7 complaint allegations did not result in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		12/14/23

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

Electronically Signed | 12/10/2023

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interview the facility failed to treat a resident in a dignified manner by not adequately preparing her for an outside medical appointment for 1 of 3 residents reviewed for dignity (Resident #18). This made Resident #18 feel forgotten and unimportant. The findings included: Resident #18 was admitted to the facility on 04/05/21 with diagnoses that included seizure, history of a cerebrovascular accident (stroke), and dysphagia as late effect of a stroke. A review of Resident #18's annual Minimum Data Set assessment dated 09/14/23 revealed her to be cognitively intact with no psychosis, behaviors, or rejection of care. Resident #18 had indicated	F 550	On 11/9/23, Resident #18 was scheduled for a follow-up appointment. Prior to transportation arriving, Resident #18 exercised her right to refuse assistance from staff to get dressed and adequately prepared for the appointment. Resident□s appointment was rescheduled on 11/16/2023 and resident was dressed based on her preferences and ready for transportation for her outside medical appointment. On 12/8/2023, Social Worker and/or designee will assess how long it would take a resident to get ready for 100% of residents, to ensure that appointment schedules reflect the appropriate time for residents to be ready.	

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F 550	Continued From page 2 is was very important to choose what clothes she wore daily. Resident #18 was also coded as requiring extensive assistance with dressing and bathing and required limited assistance with toilet use and personal hygiene. During an interview with Resident #18 on 11/13/23 at 12:18 PM, she reported she had been scheduled for a follow-up appointment on 11/09/23 but she had to cancel it because she was not dressed and adequately prepared to go out when transportation showed up to take her to the appointment. Resident #18 reported when transportation arrived to take her to the appointment she was still in her pajamas and had not yet had time to get herself "put together". Resident #18 reported it was very important to her to be dressed and ready to go to her appointments outside of the facility and that the incident made her feel forgotten and unimportant. A review of Resident #18's electronic progress notes revealed a note dated 11/09/23 that read: "Patient states she was upset about a mix-up today pertaining to the schedule and an appointment that she missed. Patient states she was scheduled to go out, but no one informed her ...Patient states she likes to be aware of her schedule ..." An interview with the Social Worker on 11/16/23 at 11:33 AM revealed she was responsible for scheduling follow-up appointments and transportation. She reported she was aware of the incident where Resident #18 was not gotten up and dressed before her appointment and stated because the appointment was early in the morning, the Nurse Aide (NA) that was assigned to Resident #18 on 3rd shift the night before,	F 550	On 12/8/23, all nursing staff education was initiated by the Educator and/or designee to ensure residents are provided adequate time to prepare the resident for scheduled appointments, process for reviewing appointments at shift change, and appointment schedule update. Any nursing staff members who do not receive the training by 12/13/2023 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be required during new hire orientation. On 12/13/2023 the appointment schedule will be updated to include Time to Be Ready to ensure adequate time for residents to be ready for his/her appointment. Beginning 12/13/2023, the Social Worker or designee will audit 10% of residents who had appointments weekly for 12 weeks, to ensure they feel that they were provided with appropriate preparation for appointments. Any identified issues will be addressed with the assigned Certified Nursing Assistant (CNA) and Nurse by the Director of Nursing. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.¿ Plan of Correction date is 12/14/2023.	

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F 550	Continued From page 3 should have gotten Resident #18 up and assisted her in getting dressed and ready for her appointment. She stated she did not know why the NA did not get Resident #18 up and dressed and indicated that she knew Resident #18 was upset about the situation. An interview by telephone was attempted on 11/16/23 at 1:02 PM with third shift NA #4 who was the NA assigned to Resident #18 the morning of her appointment and would have been responsible for ensuring Resident #18 was up, dressed, and prepared for her appointment by 8:00 AM. Unfortunately, that interview was unsuccessful. During an interview with the Director of Nursing (DON) on 11/16/23 at 2:49 PM, her reported he was aware of the incident regarding Resident #18 not being adequately prepared to go to her appointment. He also stated that he was aware that Resident #18 was very particular and that it took some time to get her up, dressed, and ready to go to outside appointments. He stated he did not know why she was not adequately prepared to go to her appointment and that she should have been given ample and sufficient time to get up, get dressed, and prepare herself to go to her appointment. An interview with the Administrator on 11/16/23 at 2:56 PM revealed she was aware of the incident regarding Resident #18 and she reported Resident #18 should have been gotten up and dressed before her appointments. She further stated she expected all residents to be sufficiently prepared for appointments.	F 550		
F 600 SS=D	Free from Abuse and Neglect	F 600		12/14/23

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F 600	Continued From page 4 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 observations, record review, and staff interviews the facility neglected to feed a dependent resident (Resident #15) her lunch meal for 1 of 2 residents reviewed for neglect. The findings included: Resident #15 was admitted to the facility on 03/29/21 with diagnosis that included vascular dementia with severe anxiety. Review of the significant change Minimum Data Set (MDS) dated 08/10/23 revealed that Resident #15 was severely cognitively impaired and required total assistance with eating. The MDS further revealed no behaviors or rejection of care and indicated that Resident #15 received Hospice services during the look back period. An observation of Resident #15 was made on	F 600	On 11/13/2023, Resident #15 was provided a meal tray and staff provided feeding assistance. On 12/6/23, the Registered Dietician, Minimum Data Set (MDS) Coordinator, Social Worker, Unit Coordinator(s), and Director of Nursing reviewed all current residents receiving assistance and updated the list to include all residents needing cueing/supervision, and feeding assistance. Beginning 12/6/2023, a list of residents requiring cueing/supervision and feeding assistance will be posted in each nursing office by Nursing Administration and monitored by the Interdisciplinary Team weekly and as needed. ¿	

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F 600	Continued From page 5 11/13/23 at 4:19 PM. Resident #15 was resting in bed with head of bed elevated and was resting on her left side. Resident #15's lunch tray sat on her sink counter. The silverware on the tray had not been unrolled or taken out of the sealed plastic bag, the lids of the drink and dessert had not been removed. Once the tray lid was lifted the three scoops of puree food were undisturbed. An interview was conducted with Nurse Aide (NA) #1 on 11/13/23 at 4:20 PM who confirmed that she was one of two NAs that were working on the unit where Resident #15 resided. She stated that she had fed Resident #15 her breakfast tray and she had eaten about 33% of the meal and drank most of her supplement but stated she had not fed Resident #15 her lunch tray. She also was not aware of who had fed Resident #15 her lunch tray. An interview was conducted with NA #2 on 11/13/23 at 4:22 PM who confirmed that she was the second NA that was working on the unit where Resident #15 resided. She stated that she had not fed Resident #15 her lunch and was not sure who had fed Resident #15. NA #2 stated that maybe "someone from the office fed her." Nurse #1 was interviewed on 11/13/23 at 4:24 PM who confirmed that she was the nurse on the unit where Resident #15 resided. She was asked to observe Resident #15 in her room and also her lunch tray that remained untouched on her sink counter. Nurse #1 stated she had not fed Resident #15, and she was not sure who had but she would find out who had fed her. She indicated it would have either been NA #1 or NA #2 as they were the assigned NAs to that unit. Nurse #1 also stated that Unit Manager (UM) #1 may have fed	F 600	On 12/8/23, nursing, dietary, administration, environmental services, and therapy staff education was initiated by the Educator and/or Department Leader regarding the practice to wait until the staff member is ready to provide feeding assistance and leaving the tray with the dependent resident is not permitted under any circumstance. Any nursing staff members who do not receive the training by 12/13/23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be required during new hire orientation. Beginning 12/13/23 the Registered Dietician or designee will conduct 5 observations weekly for 12 weeks to audit residents requiring assistance with meals, was provided the appropriate assistance. Any identified issues will be corrected immediately. Results of the audits will be shared with the Administrator on a weekly basis and with QAPI for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.¿ Plan of correction date is 12/14/2023	

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F 600	Continued From page 6	F 600		

Resident #15 her lunch tray.

UM #1 was interviewed on 11/13/23 at 4:37 PM who stated that she had not fed Resident #15 her lunch tray but observed the lunch tray sitting untouched on her sink counter. She stated she would find out what happened.

A follow up interview was conducted with UM #1 on 11/13/23 at 4:54 PM who stated that she had spoken to the two NAs on the unit where Resident #15 resided as well as the two NAs on the other unit and it "was a breakdown in communication and it got missed" and no one had fed Resident #15 her lunch tray. UM #1 stated that she ordered Resident #15 an early dinner tray and was going to feed her.

An observation of Resident #15 was made on 11/13/23 at 5:12 PM. Resident #15 was in bed with her head of bed elevated. UM #1 was seated next to her bed and was feeding her dinner meal. Resident #15 appeared calm and did not appear to be grabbing at the food tray but was accepting of each bite of food offered to her.

UM #1 was again interviewed on 11/16/23 at 11:06 AM. UM #1 stated that Patient Safety Attendant (PSA)#1 had taken the lunch tray into Resident #15's room on 11/13/23 but she was unable to assist residents with their meals. She explained that the meal tray should not have been delivered to Resident #15's room until the staff were ready to assist her with the meal. UM #1 stated she fed Resident #15 her early dinner tray on 11/13/23 and she had eaten 25% of the meal and drank 300 milliliters (ml) of fluid.

PSA #1 was interviewed on 11/16/23 at 3:27 PM

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F 600	Continued From page 7 who confirmed that she worked on 11/13/23 on the other unit. She stated she did not recall if she delivered Resident #15's lunch tray to her or not. She explained that she generally only delivered the trays of independent residents and just could not recall if she had accidentally delivered Resident #15's tray or not. The Administrator and Director of Nursing (DON) were interviewed on 11/16/23 at 2:41 PM. The DON stated that the staff had told him that there was a miscommunication on who was going to feed Resident #15 on 11/13/23. He further explained that they immediately got Resident #15 a tray and fed her. The Administrator stated that the meal tray should not have been taken into Resident #15's room until someone was ready to assist her with the meal.	F 600		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		12/14/23

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F 761	Continued From page 8 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to remove expired medications from 1 of 2 medications carts reviewed (Pine Bluff medication cart). The findings included: An observation of the Pine Bluff Medication cart was conducted on 11/15/23 at 10:38 AM along with Nurse #2 revealed the following expired medications that were on the cart and available for use: -Open bottle of Multivitamin 220 tablets that expired on 06/22. -Open bottle of Vitamin B complex 60 tablets that expired September 2022 Nurse #2 was interviewed on 11/15/23 at 10:42 AM who stated that she was a resource nurse and floated to wherever she was needed. She stated she had not been to the facility in months and was not familiar with their procedures. Nurse #2 explained the Pine Bluff Medication cart was generally assigned to the supervisor and it would their responsibility to go through the cart and look for any expired medications, but she did not know how often they did that. Nurse #2 confirmed that she had not gone through the medication cart	F 761	The expired medications identified by the surveyor were removed from the medication cart and discarded on 11/15/23 by the Director of Nursing. The medication cart and storage areas were inspected by the Consultant Pharmacist on 11/20/23 to confirm that all expired medications were discarded. ¿ On 12/8/23 all nurse□s education was initiated by the Educator and/or designee regarding medication storage, and proper discarding of expired medications. Any staff members who do not receive the training by 12/13/23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be required during new hire orientation. Beginning 12/13/23, the Director of Nursing or designee will audit 100 % of medication carts twice weekly for 12 weeks to ensure compliance. Any identified issues will be corrected immediately. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI for a period of	

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F 761	Continued From page 9 before her shift started to check for expired medications. The Pharmacist was interviewed on 11/16/23 at 1:50 PM who stated that she did monthly inspections of each medication room and each medication cart and removed any expired medications and to ensure proper storage of each medication. The Pharmacist explained when an expired medication was found it would be pulled off the medication cart and placed in a bin to return to the pharmacy. She stated if there was no bin in the facility the medication would remain on the cart but separate from the active medications until a bin was available for return to the pharmacy. She added that she had completed her monthly review of the Pine Bluff Medication cart on 11/02/23 and again on 11/13/23 and found no expired medications. The Pharmacist explained maybe the medications were placed on the medication cart while waiting on a bin from the pharmacy to return them or they were waiting to be returned to a family member, but she was not sure who or when the medications were placed on the medication cart. The Director of Nursing (DON) was interviewed on 11/16/23 at 2:45 PM who stated the expired medication should not have been on the medication cart. If they needed to be returned to the family or to the pharmacy, it should have been pulled off the medication cart and secured in the medication room.	F 761	90 days at which time frequency of monitoring will be determined by the QAPI Committee.¿ Plan of correction date is 12/14/2023	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining	F 791		12/14/23

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F 791	Continued From page 10	F 791		

routine and 24-hour emergency dental care.

§483.55(b) Nursing Facilities.
The facility-

§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:
(i) Routine dental services (to the extent covered under the State plan); and
(ii) Emergency dental services;

§483.55(b)(2) Must, if necessary or if requested, assist the resident-
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services locations;

§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;

§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred

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F 791	Continued From page 11 medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to ensure routine dental care for 1 of 2 residents reviewed for dental services (Resident #52). The findings included: Resident #52 was admitted to the facility on 10/31/21 with diagnoses that included history of hemorrhagic stroke with residual hemiplegia, A review of Resident #52's significant change Minimum Data Set assessment dated 10/06/23 revealed she was cognitively intact with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #52 was coded as needing limited assistance with personal hygiene and was independent with oral hygiene. Resident #52 was coded with no noted dental issues which included no obvious or likely cavities or broken natural teeth. A review of Resident #52's care plan revealed a care plan for [Resident #52] has her own teeth, requires supervision with oral care and hygiene. Interventions included [Resident #52] will comply with oral care and hygiene and there would be no avoidable complications through the review date. An observation which included an interview with Resident #52 on 11/14/23 at 2:42 PM revealed possible poor oral dentition with presence of plaque on her teeth. Resident #52 was able to eat, was not in pain, and had not lost any unintended weight. Resident #52 reported at that time she had not seen a dentist in a while and	F 791	On 11/15/23, the Recreation Therapy Director reviewed the dental consent with Resident #52 and it was signed by the resident. On 11/16/23, resident received services from the dental clinic. Resident will be scheduled for dental services for the next dental clinic date which is pending and will be arranged by Social Worker. Beginning 11/28/23, Social Worker initiated a 100% audit of residents, to ensure consents were obtained and sent to the dental clinic provider for services. For residents without a consent, services were offered, and consents were obtained and sent to the dental clinic provider. Beginning 12/14/23, the Social Worker will provide the Administrator and Director of Nursing an active dental clinic census list from the dental provider to validate that the necessary paperwork is in place for residents to receive dental services. Beginning 12/13/23, the dental consent form will be reviewed in the nursing admissions packet with the nurse to obtain consents. Following completion, the Health Information Manager will scan the document to the resident's electronic medical record. Consents will be presented by the Health Information Manager during weekday interdisciplinary team meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

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F 791	Continued From page 12 that she was aware that a dentist came into the facility and saw residents but reported she had not been seen. Resident #52 added she had seen the facility dentist before and did not know why she had not been seen for a while. Resident #52 also indicated she would like to be seen by the facility's dentist for routine cleanings. A review of Resident #52's electronic medical record revealed the last time resident was seen by a dentist was on 12/22/21 for tooth extractions. Additional review of Resident #52's medical record revealed a note dated 04/22/22 indicating Resident #52 was discharged per Social Worker #1. During an interview with the Administrator on 11/15/23 at 3:09 PM, she verified Resident #52 had not been seen by a dentist since 2021. She reported she was unsure why Resident #52 had not been seen by a dentist since then and reported she would see if there were any notes from the contracted dental company. An interview with Social Worker #1 on 11/16/23 at 11:17 AM revealed she was the social worker in the facility from October 2019 until October 2022. She verified while she was at the facility, she was responsible for scheduling dental appointments for residents. She also stated she did not remember requesting that Resident #52 be discharged from the dental practice and stated it must have been a misunderstanding. Social Worker #1 reported Resident #52 was in and out of the hospital around that time and she most likely called to let them know Resident #52 had been discharged to the hospital. She also reported she left the facility prior to when Resident #52 would have been scheduled to be	F 791	On 12/8/23 the Social Worker, Recreation Therapy Director, Health Information Manager, and Nurses will be in-serviced by the Educator or designee on the new consent process. Any staff members who do not receive the training by 12/13/2023 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be required during new hire orientation. Beginning 12/13/23, the Health Information Manager or designee will audit 100% of new admissions and readmissions weekly for 12 weeks to ensure compliance. Any identified issues will be corrected immediately. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of correction date is 12/14/2023	

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F 791	Continued From page 13 seen again. During a follow-up interview with the Administrator on 11/16/23 at 2:56 PM, she reported the facility has a dental consult binder that was maintained by the Social Worker. She indicated if Resident #52 was discharged from the dental services provider she would not be in the binder. She also reported any residents who complain about dental issues or if nursing staff report possible dental concerns, the resident's name would be placed in the binder and, to her knowledge, Resident #52 had not voiced any complaints. The Administrator stated she was unsure how Resident #52 had been overlooked for so long and that every resident should be seen by the facility's dentist or dentist of the resident's choice at least annually.	F 791		