	-	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB NC</u>	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	COMF	SURVEY PLETED
		345096	B. WING				C / 05/2017
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	2019 VERHOEFF DRIVE		
HUNTERS				ŀ	HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	483.12(b)(1)-(3) PRO MISTREATMENT/NE §483.12 The resident abuse, neglect, misag property, and exploita subpart. This includes freedom from corpora seclusion and any ph not required to treat th 483.12(b) The facility implement written pol (b)(1) Prohibit and pre exploitation of resider resident property, (b)(2) Establish policie investigate any such a (b)(3) Include training §483.95, This REQUIREMENT by: Based on record revi interviews the facility surgical incision on a	HIBIT GLECT/MISAPPROPRIATN has the right to be free from opropriation of resident tition as defined in this s but is not limited to al punishment, involuntary ysical or chemical restraint he resident's symptoms. must develop and icies and procedures that: event abuse, neglect, and hts and misappropriation of es and procedures to	TAG		DEFICIENCY)	an	DATE 10/24/17
	physician's orders wh the hospital for an inc of the incision due to	o had to be readmitted to ision drainage and revision a wound infection of their			conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely becau	ISE	
	lower back (Resident sampled with a surgic	#2) for 1 of 1 resident cal incision.			it is required by the provisions of Feder and State law.	al	
	Findings included: Resident #2 was adm				The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.	е	
	-	ses which included in part			cited;	οv	
	low back pain, degen	-			" Resident #2 identified during the surv	еу	
ABORATORY	DIRECTOR'S OR PROVIDER/9	SUPPLIER REPRESENTATIVE'S SIGNATUR	F		TITLE		(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

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.

10/24/2017

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
					C
		345096	B. WING		10/05/201
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
HUNTERS	SVILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE COMPL THE APPROPRIATE DAT
F 224		- 4			
1 224			F 22		0/7/47
	(deterioration) of the	spine and spinal surgery.		discharged from the facili " The 3 nurses identified of	-
	A review of the 5 Day	Admission Minimum Data		as not completing the dre	u
		02/17 indicated Resident #2		and assessing the surgica	
	· · ·	aired in cognition for daily		received a one-on-one in-	
	decision making. The			receive one prior to 10/17	
		extensive assistance by		Educator or RN designee	
		transfers, dressing, toileting, asionally incontinent of		surgical dressing changes dating and initialing the d	
	bladder and always c			signing the MAR upon co	
				nurse is no longer employ	-
		lischarge instructions dated		facility. The two remainin	-
		continue with daily dressing		received disciplinary action	
	changes and follow up with surgeon in 2 weeks for suture removal.			assess the surgical incision daily dressing changes.	on and provide
		n care plan dated 08/27/17			
		indicated to check surgical		The procedure for implem	
	site every day.			acceptable plan of correc specific deficiency cited;	tion for the
	A review of nurse's p	rogress notes dated		" All patients and resident	s with surgical
		e dressing on Resident #2's		dressing orders were ider	
	back was changed pe	er order but there was no		was completed by the DC	N or RN
		ding the appearance of the		designee to determine wh	
	incision.			physician order was being	
		an's order dated 08/28/17		change the dressing for the and residents.	lese patients
		dressing on incision for 1		" Surgical dressing chang	es will be
		ery day per discharge		completed per MD orders	
	instructions.			dressings being dated for	
				were changed with the ini	
	A review of a MAR da	ated from 08/29/17 through		completing the dressing c Additionally, the nurse wil	•
	documented for daily			the Electronic Medication	
		ut there were no nurse's		Record (EMAR) that he o	
	progress notes regar	ding an assessment or		the dressing change per I	MD order. Daily
	appearance of the su	irgical incision.		the surgical dressing will	-
		atad 00/02/17 through		the licensed nurse and do	
	A review of a MAR da	ated 09/02/17 through		the EMAR to ensure that	uressing is ary

Facility ID: 923277

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	· · · ·	OMPLETED
						С
		345096	B. WING			10/05/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
HUNTERS	VILLE OAKS			12019 VERHOEFF DRIVE		
				HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page	e 2	F 22	24		
		ere were no nurse's initials		and intact and assessment of	of the surgical	
	documented for daily	dressing change to		wound. RN Nurse Educator	-	
		nd there were no nurse's		designee will in-service all n	urses	
	progress notes regar			regarding these practices.		
	appearance of the inc	CISION.		The monitoring procedure to	onguro that	
	Further review of Res	sident #2's medical record		the plan of correction is effect		
	revealed there were i			specific deficiency cited rem		
		ent #2's back incision on		and/or in compliance with the		
	09/04/17.			requirements; The title of the		
				responsible for implementing		
	-	in condition form titled		acceptable plan of correction		
	· •	d, Assessment/Appearance		when corrective action will b	•	
		ns (SBAR) dated 09/05/17		The corrective action dates r	nust be	
		#3 indicated a wound to		acceptable to the State.		
		ad a foul smell. The section appearance indicated vital		" The facility will convert to a medical record in October 20		
		to documentation of the		change the process for the c		
	-	sment of Resident #2's		of surgical dressing changes		
		ection on the back of the		assessment of the surgical v		
	-	ditional notes was blank.		Auditing and monitoring will		
				place as outlined, adhering t	o the	
		an's progress note dated		timeframe and guidelines.		
		part a surgical incision		" DON or RN designee will a		
	-	ed from Resident #2's back		residents with surgical incision	-	
		and foul odor. A section d to change dressings daily		changes (to include frequent date/initialing of Surgical dre		
	to absorb any serosa			documenting of completion i	-	
		ollow up with surgeon as		once a dressing change is c		
	outpatient.			" An in-service will be compl		
	-			licensed nurses by the RN N		
	•	l history and physical dated		Educator or RN designee to		
		esident #2 returned to the		following MD orders for Surg	-	
	surgeon's office for a	-		changes (to include frequend	• ·	
		ck surgery and her incision		date/initialing of Surgical dre		
		nounts of serosanguineous		signing the EMAR once a dr		
		ik or red drainage). A cal exam revealed Resident		change is completed and da surgical dressing will be che	-	
	#2's back incision ha			licensed nurse and documer	-	

Facility ID: 923277

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		MB NO. 0938-03 3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			(^	COMPLETED
						С
		345096	B. WING			10/05/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CI	ITY, STATE, ZIP CODE	
				12019 VERHOEFF DE	RIVE	
HUNTERS	SVILLE OAKS			HUNTERSVILLE, N	NC 28078	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 224	Continued From pag	e 3	F 22	4		
1 227					ure that dressing is dry and	
	-	and what appeared to be the cence mid incision (rupturing			ure that dressing is dry and essment of the surgical	
		notes further revealed the			pleted. Any nurse who is	
	,	to be healthy with large			nd the mandatory in-service	,
		juineous drainage with			ill receive the in-service	
		I was foul smelling. A		prior to workin		
		ssment and plan revealed			ssings will be checked daily	,
	Resident #2 would be	e admitted to the hospital for		by licensed nu	urse and documented on the	e
	wound irrigation, deb	ridement, wound revision,		EMAR to ensu	ure that dressing remains	
	obtain cultures and c	onsult infectious disease for			hanged per MD orders and	
	antibiotics.				f the surgical wound is	
				completed.		
	-	on 10/03/17 at 2:57 PM, the			ervisor or licensed nurse	
	Director of Nursing (I			report any new surgical		
		ble for interview because she			rning stand up meeting dail	-
	was away for 2 week wound nurse (Nurse	s but they had a part-time			iday) and/or to the weekend	
		wound nurse was not		change the dr	along with the MD orders to)
		er explained the nurse			dentified will be corrected	
		ent was also responsible for			ind will also be taken to dail	v
		ents when a wound nurse			p meeting (Monday	5
	was not working in th				reported to the weekend	
				RN in charge		
	During an interview of	on 10/03/17 at 3:16 PM,			designee will audit daily x 1	
	Nurse #2 stated she	provided wound treatments		month, then w	veekly x 2 months surgical	
	when the wound nurs	se was not working at the		incision dress	ing changes (to include	
		call dressing changes or			ate/initialing of Surgical	
		dent #2's surgical incision on			cumenting in the EMAR	
	-	ined documentation of			ng change is completed and	t
		ed to be done on the MAR			f the surgical wound to	
		wounds were usually written			iance. Any identified issues	
	in the nurse's progre	SS NOTES.			ed at that time. Results of	
	During a follow up int	terview on 10/03/17 at 3:33		-	y will be shared with the and/or Director of Nursing	
	- · ·	ed Resident #2 was ordered			asis and with QAPI monthly	,
		ve a dry dressing daily to her			f 90 days at which time	·
		or 1 week. She stated it was			nonitoring will be	
		ursing staff to assess			/ the QAPI Committee.	
	-	d should document their			ittee will only consider	

Facility ID: 923277

If continuation sheet Page 4 of 25

						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
		345096	B WING			С
	ROVIDER OR SUPPLIER	343096		STREET ADDRESS, CITY, STATE, ZIP CO		0/05/2017
NAME OF P	ROVIDER OR SUPPLIER			12019 VERHOEFF DRIVE	DE	
HUNTERS	SVILLE OAKS			HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page	e 4	F 22			
1 227	assessments.	5 4	F 22		ibeoquont	
	assessments.			discontinuing monitoring if su surveys through the annual r		
	During an interview o	on 10/03/17 at 3:53 PM,		survey results in no repeat c		
		s also the facility Medical		" (Completion 10/24/17)		
		e did not examine Resident				
		cian #2 had examined her ainage. He stated it was his				
		ng staff to follow physician's				
		ons were for dressings to be				
	changed daily they sl	-				
		with drainage were a culture				
	medium for bacterial growth. He further stated if an incision was foul smelling or had more drainage than what the resident came to the facility with nursing staff should call the surgeon to see what they wanted them to do.					
		nterview on 10/04/17 at 9:19				
		ad signed the SBAR on				
		recalled Resident #2 but did pout the surgical incision,				
		e explained she did not				
	-	BAR and explained if she				
		ment of the incision she				
		nted it on the SBAR or in the				
	nurse's progress note	es.				
	During an interview o	on 10/04/17 at 10:25 AM,				
		ed she had examined				
	Resident #2 on 09/06	6/17 because a nurse had				
		which indicated Resident #2				
		oul smell. She explained				
		ent #2 who had recently had e bandage on her incision				
		anguineous drainage. She				
		wound nurse to the room				
		clean it. She further stated				
		the dressing dated and				
	signed but it was not	signed or dated so she was				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/30/2017 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345096	B. WING				C 1 05/2017
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTERS	SVILLE OAKS				12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	not sure how long it h had been changed. S understanding Reside appointment on 09/07 sent to the hospital ar facility. During an interview of DON verified there wa documentation after 0 assessments or appe- incision. She confirm initials on the MAR for 09/02/17 or 09/03/17 had not been changed During an interview of the Administrator and verified after review of there was documenta signs but there was no assessment of Reside there was no assess documented in the nu 09/05/17. The DON s expected to see nurse assessments to descri- incision, any redness, like and a description explained the nurse w dressing changes on longer worked at the f On 10/05/17 at 3:05 F received from Reside He stated Resident #2 09/07/17 for what was week follow up visit for	ad been since the dressing She explained it was her ent #2 went for a follow up 7/17 and from there was nd had not returned to the n 10/04/17 at 12:00 PM the as no nursing 08/28/17 regarding arance of the surgical ed there were no staff r dressing changes on and she felt the dressing d on those days. n 10/04/17 at 12:30 PM with DON, the Administrator f the SBAR dated 09/05/17 tion of Resident #2's vital o documentation of an ent #2's surgical incision arse's progress notes on stated she would have e's progress notes and ribe the length of the , what the drainage looked of the odor. The DON vho should have done the 09/02/17 and 09/03/17 no	F	224			

Facility ID: 923277

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 10/30/2017 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345096	B. WING				C 05/2017
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
HUNTERS	SVILLE OAKS			2019 VERHOEFF DRIVE UNTERSVILLE, NC 2807	'8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 224 F 225 SS=D	there was wound deh healed as he had exp take Resident #2 to su and clean it out and h was infected with bac explained Resident #2 deconditioned and ha which put her at great contamination. He fur #2's family had told hi at the facility and he f saturated or soiled wi contaminated the wou expectation for attenti the wound and it shou and dressed accordin infection. 483.12(a)(3)(4)(c)(1)- ALLEGATIONS/INDIV 483.12(a) The facility (3) Not employ or othe who- (i) Have been found g exploitation, misappro- mistreatment by a cou (ii) Have had a finding nurse aide registry co exploitation, mistreatr misappropriation of th (iii) Have a disciplinar or her professional lic	back had a foul odor and iscence and it was not well ected. He stated he had to urgery that night to wash e cultured the wound and it teria from urine. He 2 was elderly and d not mobilized quickly ter risk for wound ther explained Resident m Resident #2 wore a brief elt the dressing had been th urine which then und. He stated it was his on to have been given to uld have been kept clean g to his orders to prevent (4) INVESTIGATE/REPORT //IDUALS must- erwise engage individuals uilty of abuse, neglect, opriation of property, or urt of law; g entered into the State ncerning abuse, neglect, nent of residents or	F 224				10/17/17

Facility ID: 923277

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	MENT OF HEALTH AN				FO	ED: 10/30/2017 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345096	B. WING		1	C 0/05/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODI		
HUNTER	SVILLE OAKS			2019 VERHOEFF DRIVE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	 exploitation, mistreatr misappropriation of re (4) Report to the State licensing authorities a actions by a court of I which would indicate nurse aide or other fa (c) In response to alle exploitation, or mistre (1) Ensure that all alle abuse, neglect, explo including injuries of un misappropriation of re reported immediately, after the allegation is cause the allegation is cause the allegation is serious bodily injury, of the events that cause abuse and do not ress the administrator of th officials (including to the adult protective service for jurisdiction in long- accordance with State procedures. (2) Have evidence that thoroughly investigates (3) Prevent further po- exploitation, or mistre investigation is in pro- 	nent of residents or esident property. e nurse aide registry or iny knowledge it has of aw against an employee, unfitness for service as a cility staff. gations of abuse, neglect, atment, the facility must: eged violations involving itation or mistreatment, nknown source and esident property, are but not later than 2 hours made, if the events that nvolve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other he State Survey Agency and es where state law provides term care facilities) in a law through established at all alleged violations are ed. tential abuse, neglect, atment while the gress. of all investigations to the	F 225			

If continuation sheet Page 8 of 25

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II 7		CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	i í			1 Y /	PLETED
							С
		345096	B. WING			10	/05/2017
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
	VILLE OAKS			12	019 VERHOEFF DRIVE		
HUNIERS	WILLE UARS			н	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 225	Continued From pag	e 8		225			
		o other officials in accordance		225			
		ling to the State Survey					
		king days of the incident, and					
	if the alleged violation	n is verified appropriate					
	corrective action mus						
		T is not met as evidenced					
	by: Based on staff inten	views and record review the			Preparation and/or execution of this	Dlan	
		the State Survey Agency			of Correction does not constitute	rian	
		4 hour initial report timeframe			admission or agreement by the provid	ler of	
	-	buse for 1 of 7 residents			the truth of the facts alleged or		
		iled to notify the State Survey			conclusions set forth in this statement		
	Agency within the rec			deficiencies. The Plan of Correction			
	timeframe of allegation 2 of 7 residents with			prepared and/or executed solely beca it is required by the provisions of Feder			
	(Resident #5 and #2)				and State law.		
	Findings included:			The plan of correcting the specific	l		
	1 Pesident #5 was a	admitted to the facility on			deficiency. The plan should address t processes that lead to the deficiency	ne	
		longer a resident in the			cited;		
	facility.				" Facility failed to complete 24-hour ir	itial	
					report after the required 24 hours for		
		sion Minimum Data Set			resident #5.		
		ated Resident #5 was			" The facility failed to complete the 5		
	cognitively intact for	daily decision making.			working day report within 5 working d of incident for Residents #2 and #5.	ays	
	A review of the facilit	ies abuse investigations			" The 2 nurses identified during the si	INVEV	
		at 3:00 PM Resident #5			as not completing the investigation	ai v C y	
		n of abuse. The 24 Hour			24-hour initial report and the 5 workin	g	
	Initial Report with a fa	acsimile (fax) confirmation			day report within days of the incident		
		2:46 PM which was after the			received a one-on-one in-service or w		
		vealed "during care by 2			receive one prior to working a shift by		
	by 2 lesbians."	ed she was being molested			Nursing Home Administrator on ensur that all alleged violations involving ab	-	
	by 2 100010110.				neglect, exploitation or mistreatment,	us c ,	
	A review of a 5 Work	ing Day Report with a fax			including injuries of unknown source	and	
	confirmation date of				misappropriation of resident property,		
	revealed the facility f			- 1	reported immediately, but not later that		1

Facility ID: 923277

If continuation sheet Page 9 of 25

			()(0) 10 17			0.0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY
					(0
		345096	B. WING	······	10/	05/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	P CODE	
HUNTERS	VILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE A		(X5) COMPLETIC
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	DATE
F 225	Continued From page	e 9	F 22	25		
	investigation to the H	ealth Care Personnel		hours after the allegation	n is made, if the	
	-	ing days after the allegation		events that cause the all	-	
	was made.			abuse or result in seriou		
	During an interview o	on 10/03/17 at 3:35 PM the		not later than 24 hours it cause the allegation do		
	-	DON) explained she was		and do not result in serio		
		tigating an allegation of		to the administrator of th		
	abuse. She stated sl			other officials (including	-	
	timeframe for submit	ting the 24 hour initial report		Survey Agency and adu		
	-	Resident #5's report had		services where state law	-	
	been sent in late. Sh	-		jurisdiction in long-term		
	-	the 5-day investigation after		accordance with State la	•	
	notifying the Health C	24 hours of the allegation.		established procedures. that all alleged violations		
	The DON stated she	thought the 5 days to		investigated. Prevent fur	ther potential	
		ation started after the first		abuse, neglect, exploitat		
	24 hours.			mistreatment while the in progress. Report the res	•	
	During an interview o	on 10/03/17 at 5:25 PM the		investigations to the adn		
		he expected the DON to		or her designated repres		
		ulations. The Administrator		other officials in accorda		
	stated he understood	I that an abuse investigation		law, including to the Stat		
		rking days from the time of		within 5 working days of		
	the allegation was re-	ceived.		if the alleged violation is		
	 Resident #2 was admitted to the facility on 01/13/17. 			appropriate corrective ad taken.	cuon must de	
	-	s abuse allegations revealed PM Resident #2 reported an		The procedure for imple acceptable plan of corre		
		The 24-hour report dated		specific deficiency cited;		
		esident #2 alleged she had		" An in-service will be co		
		a nurse that was rude and		staff by the RN Nurse Ed		
	had "shoved" pills in pain.	her mouth while she was in		designee to ensuring that violations involving abus	-	
	Provi 1			exploitation or mistreatm		
	A document titled "5	day Working Report" dated		injuries of unknown sour	-	
	07/06/17 revealed the	e facility faxed the completed		misappropriation of resid	lent property, are	
	investigation to the H	ealth Care Personnel		reported immediately, bu	it not later than 2	1

Facility ID: 923277

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	CS FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · ·	OMPLETED
						С
		345096	B. WING			10/05/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
HUNTERS	SVILLE OAKS					
				HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIOI DATE
F 225	Continued From page	e 10	F 22	25		
	was made. On 10/03/17 at 3:27 I Resident #2 was mad she was in too much On 10/03/17 at 3:35 I (DON) was interview was responsible for in abuse. She reported start the 5-day invest Health Care Personn hours of the allegatio thought the 5 days to started after the first 2 On 10/03/17 at 5:25 I interviewed and repo DON to follow the fee Administrator stated	PM the Administrator was rted that he expected the deral regulations. The he understood that an abuse insidered 5 working days from		hours after the allegation events that cause the allegation abuse or result in serious not later than 24 hours if cause the allegation do n and do not result in serio to the administrator of the other officials (including t Survey Agency and adult services where state law jurisdiction in long-term of accordance with State lar established procedures. that all alleged violations investigated. Prevent furt abuse, neglect, exploitati mistreatment while the im progress. Report the resu investigations to the adm or her designated repress other officials in accordar law, including to the State within 5 working days of ti if the alleged violation is appropriate corrective ac taken. Any staff who is un the mandatory in-service receive the in-service prior shift. " Any issues identified wi	egation involve s bodily injury, or the events that not involve abuse us bodily injury, e facility and to to the State t protective provides for care facilities) in w through Have evidence are thoroughly ther potential on, or vestigation is in ults of all inistrator or his entative and to nce with State e Survey Agency, the incident, and verified tion must be nable to attend by 10/17/17 will or to working a	
				immediately and will also clinical start-up meeting (Friday) and/or reported to RN in charge and QAPI. The monitoring procedure the plan of correction is e specific deficiency cited r	Monday □ the weekend e to ensure that effective and that	

Facility ID: 923277

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/30/20 RM APPROVE NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		TE SURVEY MPLETED
		345096	B. WING			1	C 0/05/2017
NAME OF PF	OVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		0.00.2011
	VILLE OAKS			12	2019 VERHOEFF DRIVE		
HUNTERS	VILLE OARS			Н	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 225 F 309 SS=G	FOR HIGHEST WEL 483.24 Quality of life Quality of life is a fun applies to all care and residents. Each resid	PROVIDE CARE/SERVICES		225	and/or in compliance with the regulate requirements; The title of the person responsible for implementing the acceptable plan of correction. Dates when corrective action will be comple The corrective action dates must be acceptable to the State. " Nursing home administrator or desig will audit 100% of abuse investigation ensure reporting results of all investigations of abuse to the administrator or his or her designated representative and to other officials in accordance with state law, including t state survey agency, within 24 hours initial notification and 5 working days of i notification of the incident, and if the alleged violation is verified appropriat corrective action must be taken x 3 months to ensure compliance. Any identified issues will be corrected at th time and disciplinary action provided the staff member. Results of the monitoring will be shared with QAPI monthly for a period of 90 days at wh time frequency of monitoring will be determined by the QAPI Committee.	ted. Inee s to o the of eport nitial e nat	10/24/17
	services to attain or n practicable physical,	mental, and psychosocial			sility ID: 923277 If conti		

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If continuation sheet Page 12 of 25

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 10/30/2017 APPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345096	B. WING			(10/	C 05/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTERS	VILLE OAKS				2019 VERHOEFF DRIVE UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	483.25 Quality of care Quality of care is a fur applies to all treatmer facility residents. Base assessment of a resident that residents receive accordance with profe- practice, the compreh care plan, and the residents but not limited to the f (k) Pain Management The facility must ensu- provided to residents consistent with profess the comprehensive pe and the residents' goa (I) Dialysis. The facilit residents who require services, consistent w of practice, the compre- care plan, and the residents who requires preferences. This REQUIREMENT by: Based on record revi- interviews the facility incision on a resident daily dressing change orders who had to be for an incision and dra incision due to a wour	with the resident's sement and plan of care. Indamental principle that and care provided to ed on the comprehensive lent, the facility must ensure treatment and care in essional standards of ensive person-centered sidents' choices, including following:	F	309	Preparation and/or execution of this Pl of Correction does not constitute admission or agreement by the provide the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely becau it is required by the provisions of Feder and State law.	er of of Ise	

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				OMPLETED
						С
		345096	B. WING			10/05/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		
				12019 VERHOEFF DRIVE		
HUNTERS	VILLE OAKS			HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 309	Continued From page	e 13	F 30	a		
	Findings included:		1 50	The plan of correcting the sp	ecific	
	. mango molaca.			deficiency. The plan should a		
	Resident #2 was adm	nitted to the facility on		processes that lead to the de		
	08/26/17 with diagnos	ses which included in part		cited;	-	
	low back pain, degen	•		"Resident #2 identified durin		
	(deterioration) of the	spine and spinal surgery.		discharged from the facility o		
	A review of the 5 Day	y Admission Minimum Data		" The 3 nurses identified duri as not completing the dressir	• •	
		02/17 indicated Resident #2		and assessing the surgical w	• •	
		aired in cognition for daily		received a one-on-one in-ser		
	decision making. The	e MDS also revealed		receive one prior to 10/17/17	by RN Nurse	
		extensive assistance by		Educator or RN designee on		
		transfers, dressing, toileting		surgical dressing changes pe		
		occasionally incontinent of		dating and initialing the dress	-	
	bladder and always o	continent of bower.		signing the MAR upon compl nurse is no longer employed		
	A review of hospital d	discharge instructions dated		facility. The two remaining n		
		continue with daily dressing		received disciplinary action for		
		ip with surgeon in 2 weeks		assess the surgical incision a		
	for suture removal.			daily dressing changes.		
	A review of a monthly	y Medication Administration				
		08/26/17 through 08/31/17		The procedure for implement		
		n notes for dry dressing (low		acceptable plan of correction	for the	
	-	I change every day until the		specific deficiency cited; " All patients and residents w	ith ourginal	
	last day 09/01/17.			dressing orders were identified		
	A review of nurse's p	rogress notes dated		was completed by the DON of		
	-	esident #2 was admitted to		designee to determine wheth		
	the facility and had a	dressing to her back with no		physician order was being fo		
	drainage noted.			change the dressing for thes	e patients	
				and residents.		
		n care plan dated 08/27/17		" Surgical dressing changes		
	check surgical site ev	labeled skin integrity and		completed per MD orders to dressings being dated for the		
	CHECK SULVICAL SILE EV	very day.		were changed with the initial	-	
	A review of nurse's p	rogress notes dated		completing the dressing char		
	-	e dressing on Resident #2's		Additionally, the nurse will do		
		er order but there was no		the Electronic Medication Ad		

Facility ID: 923277

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345096 B. WING 10/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE OAKS HUNTERSVILLE, NC 28078 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 14 F 309 documentation regarding the appearance of the Record (EMAR) that he or she completed incision. the dressing change per MD order. Daily the surgical dressing will be checked by A review of a physician's order dated 08/28/17 the licensed nurse and documented on indicated to keep dry dressing on incision for 1 the EMAR to ensure that dressing is dry week and change every day per discharge and intact and assessment of the surgical instructions. wound. RN Nurse Educator or RN designee will in-service all nurses A review of nurse's progress notes dated regarding these practices. 08/28/17 indicated the dressing was changed on Resident #2's back per order and there were no The monitoring procedure to ensure that signs or symptoms of infection. the plan of correction is effective and that specific deficiency cited remains corrected A review of a MAR dated from 08/29/17 through and/or in compliance with the regulatory 08/31/17 revealed nurse's initials were requirements; The title of the person documented for daily dressing changes to responsible for implementing the Resident #2's back but there were no nurse's acceptable plan of correction. Dates progress notes regarding an assessment or when corrective action will be completed. appearance of the surgical incision. The corrective action dates must be acceptable to the State. A review of a MAR dated 09/01/17 revealed " The facility will convert to an electronic nurse's initials were documented for a daily medical record in October 2017, which will dressing change to Resident #2's back but there change the process for the documentation were no nurse's progress notes regarding of surgical dressing changes and assessment or appearance of the incision. assessment of the surgical wounds. Auditing and monitoring will remain in Further review of a MAR dated 09/01/17 indicated place as outlined, adhering to the dry dressing to surgical incision on Resident #2's timeframe and guidelines. back until 09/03/17. " DON or RN designee will audit 100% of residents with surgical incision dressing A review of a MAR dated 09/02/17 revealed there changes (to include frequency), were no nurse's initials documented for daily date/initialing of Surgical dressings, dressing change to Resident #2's back and there documenting of completion in the EMAR were no nurse's progress notes regarding once a dressing change is completed. assessment or appearance of the incision. " An in-service will be completed for licensed nurses by the RN Nurse A review of a MAR dated 09/03/17 revealed there Educator or RN designee to include were no nurse's initials documented for daily following MD orders for Surgical dressing dressing change to Resident #2's back and there changes (to include frequency),

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923277

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ND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE \$	
NAME OF PR		IDENTIFICATION NUMBER:				COMPL	
NAME OF PR						C)
NAME OF PR		345096	B. WING			10/0)5/2017
	OVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				12	019 VERHOEFF DRIVE		
IUNIERS	VILLE OAKS			нι	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 309	Continued From page	e 15	F 30	09			
	were no nurse's progr				date/initialing of Surgical dressings,		
	assessment or appea				signing the EMAR once a dressing		
					change is completed and daily the		
	Further review of nurs	se's progress notes revealed			surgical dressing will be checked by the		
		ss notes or assessment of			licensed nurse and documented on the		
	Resident #2's back in	cision on 09/04/17.			EMAR to ensure that dressing is dry an	d	
					intact and assessment of the surgical		
		in condition form titled			wound is completed. Any nurse who is		
		d, Assessment/Appearance ns (SBAR) dated 09/05/17			unable to attend the mandatory in-service by 10/17/17 will receive the in-service	ce	
		#3 indicated a wound to			prior to working a shift.		
	• •	ad a foul smell. The section			" Surgical dressings will be checked dai	lv	
	labeled assessment/a	appearance indicated vital			by licensed nurse and documented on t		
		ssure 102/71, pulse 83,			EMAR to ensure that dressing remains		
	respirations 16, tempe	erature 98 degrees			intact and is changed per MD orders an	d	
		oximetry was 96 percent			assessment of the surgical wound is		
	but there was no docu				completed.		
		sment of Resident #2's			" Clinical supervisor or licensed nurse		
	•	ection on the back of the ditional notes was blank.			designee will report any new surgical wounds in morning stand up meeting da	aily	
					(Monday Friday) and/or to the weeke	-	
	A review of a physicia	in's progress note dated			RN in charge along with the MD orders		
		part a surgical incision			change the dressing.		
		d from Resident #2's back			" Any issues identified will be corrected		
	-	nd foul odor. A section			immediately and will also be taken to da	aily	
	•	to change dressings daily			clinical start-up meeting (Monday		
	to absorb any serosar				Friday) and/or reported to the weekend		
	•	bllow up with surgeon as			RN in charge and QAPI. " DON or RN designee will audit daily x	1	
	outpatient.				month, then weekly x 2 months surgical		
	A review of a hospital	history and physical dated			incision dressing changes (to include		
		esident #2 returned to the			frequency), date/initialing of Surgical		
	surgeon's office for a	2 week follow up			dressings, documenting in the EMAR		
		ck surgery and her incision			once a dressing change is completed a	nd	
		nounts of serosanguineous			assessment of the surgical wound to		
	fluid (thin, watery, pin				ensure compliance. Any identified issue		
		cal exam revealed Resident			will be corrected at that time. Results of		
		d visible eschar (dry, dark and what appeared to be the			the monitoring will be shared with the Administrator and/or Director of Nursing		

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		MEDICAID SERVICES	(X2) MULT	IPI F (CONSTRUCTION		<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			1 Y	MPLETED
							С
		345096	B. WING			1	0/05/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	SVILLE OAKS			12	019 VERHOEFF DRIVE		
				н	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIC DATE
F 309	Continued From page	e 16	F 3	809			
		ence mid incision (rupturing			on a weekly basis and with QAPI mon	thlv	
		notes further revealed the			for a period of 90 days at which time	,	
	-	to be healthy with large			frequency of monitoring will be		
	-	ineous drainage with applied			determined by the QAPI Committee.		
	pressure and was fou	-			" QAPI committee will only consider		
		and plan revealed Resident			discontinuing monitoring if subsequen		
		I to the hospital for wound ment and wound revision			surveys through the annual recertificat survey results in no repeat citations.	lion	
	-	nd consult infectious disease			" (Completion 10/24/17)		
	for antibiotics.				(
		l discharge summary dated esident #2 went for a 2 week					
		t on 09/07/17 and her					
		and was grossly infected.					
		ed Resident #2 was admitted					
		pation and debridement and					
		ame day and a wound					
		over the incision to assist					
		y catheter was kept in place ntamination due to wound					
		ne bacteria was present in					
		ed the wound infection and					
	antibiotics were giver	n through a peripherally					
		eter (PICC line) to continue					
	for at least 6 weeks u	intil the infection resolved.					
	During an interview o	n 10/03/17 at 2:57 PM, the					
	Director of Nursing (E	DON) confirmed the facility					
		I nurse who worked during					
		M-3:30 PM. She explained					
		not available for interview ay for 2 weeks but they had					
		rse #2) who was trained by					
		did wound treatments when					
		not available. She further					
		assigned to the resident was					
		loing wound treatments					
	when a wound nurse	was not working in the					1

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/30/2017 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345096	B. WING					C 05/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE	, ZIP CODE		
HUNTERS	VILLE OAKS				12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page facility.	: 17	F	30	9			
	Nurse #2 stated she p when the wound nurs facility. She explained wound, the treatment and if a wound did no and let the physician of stated she did not rec assessments of Resid her back. During a follow up inte PM the DON confirme by her surgeon to hav lower back incision fo her expectation for nu surgical incisions and assessments. During an interview of Physician #1 who was Director explained he #2 but recalled Physic because of wound dra expectation for nursin orders and if instruction changed daily they she dressings saturated w medium for bacterial of a wound or incision w more drainage than w facility with nursing stato buring a telephone in	should document their n 10/03/17 at 3:53 PM, s also the facility Medical did not examine Resident cian #2 had examined her ainage. He stated it was his g staff to follow physician's ons were for dressings to be rould do so because with drainage were a culture growth. He further stated if as foul smelling or had that the resident came to the aff should call the surgeon ted them to do.						
	AM, Nurse #3 who ha	d signed the SBAR on ecalled Resident #2 but did						

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	MENT OF HEALTH AN	ID HUMAN SERVICES			FOR	D: 10/30/2017 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345096	B. WING			C / 05/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTERS	SVILLE OAKS			2019 VERHOEFF DRIVE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	odor or drainage. Shi recall filling out the St had done an assessm would have documen nurse's progress note usually wrote a note in if she did an assessm incision. During an interview of Physician #2 confirme Resident #2 on 09/06 completed an SBAR H wound with a foul sm examined Resident # spinal surgery and the was soiled with seros stated she called the and instructed her to she could not identify been changed becaus so she was not sure h the dressing had been she wrote orders for of continue for 5 more d to prevent soiling of R stated it was her unde for a follow up appoin there was sent to the returned to the facility During an interview of DON verified Resider plan which indicated t day but there was no 08/28/17 regarding as	out the surgical incision, e explained she did not BAR and explained if she nent of the incision she ted it on the SBAR or in the is. She further stated she in the nurse's progress notes tent of a wound or a surgical in 10/04/17 at 10:25 AM, ed she had examined /17 because a nurse had because Resident #2 had a ell. She explained she 2 who had recently had be bandage on her incision anguineous drainage. She wound nurse to the room clean it. She further stated when the dressing had last se it was not signed or dated how long it had been since in changed. She explained dressing changes to ays because she was trying Resident #2's clothing. She erstanding Resident #2 went timent on 09/07/17 and from hospital and had not c. in 10/04/17 at 12:00 PM the tif #2 had an interim care to check surgical site every documentation after sessments or appearance in She confirmed there was	F 309			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/30/2017 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345096	B. WING					C 05/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				1	2019 VERHOEFF DRIVE			
HUNIERS				H	HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B HE APPROPRIA		(X5) COMPLETION DATE
F 309	initials on the MAR ar initials she felt the dre changed. During an interview of the Administrator and stated an assessmen completed as part of the SBAR dated 09/00 only documentation of He confirmed there w documentation of the assessment of the su progress notes on 09, she would have expen notes and assessmen the incision, any redn looked like and a desiverified the back of the the nurse to use for a should have been use appearance of the su explained the nurse w dressing changes on longer worked at the f On 10/05/17 at 3:05 F received from Reside He stated Resident #2 09/07/17 for what was week follow up visit for surgery. He explaine incision on her lower there was wound deh	because there were no ad because there were no essing had not been In 10/04/17 at 12:30 PM with DON, the Administrator t was supposed to be the SBAR but after review of 5/17 he verified there was f Resident #2's vital signs. as no additional surgical incision and no rgical incision in the nurse's /05/17. The DON stated cted to see nurse's progress ints to describe the length of ess, what the drainage cription of the odor. She e S-Bar was available for dditional nurse's notes and ed to describe the rgical incision. The DON /ho should have done the 09/02/17 and 09/03/17 no facility. PM a telephone call was nt #2's Orthopedic Surgeon. 2 came to his office on a supposed to be a routine 2 or suture removal after spinal d Resident #2's surgical back had a foul odor and iscence and it was not well	F	309		Y)		
	take Resident #2 to s	ected. He stated he had to urgery that night to wash e cultured the wound and it teria from urine. He						

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345096	B. WING				C 05/2017
NAME OF P	ROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTERS	SVILLE OAKS				12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309 F 520 SS=G	explained Resident #2 deconditioned and ha which put her at great contamination. He fur #2's family had told hi at the facility and he f saturated or soiled wi contaminated the wou expectation for attenti the wound and it shou and dressed accordin infection. 483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMBI QUARTERLY/PLANS (g) Quality assessme (1) A facility must mai and assurance comm minimum of: (ii) The director of nurs (ii) The Medical Direc (iii) At least three othe staff, at least one of w administrator, owner, individual in a leaders (g)(2) The quality ass committee must : (i) Meet at least quart coordinate and evalua	2 was elderly and d not mobilized quickly ter risk for wound ther explained Resident im Resident #2 wore a brief elt the dressing had been th urine which then and. He stated it was his ion to have been given to ald have been kept clean g to his orders to prevent (i)(ii)(h)(i) QAA ERS/MEET int and assurance. Intain a quality assessment ittee consisting at a sing services; tor or his/her designee; er members of the facility's <i>v</i> ho must be the a board member or other ship role; and essment and assurance erly and as needed to ate activities such as a respect to which quality		520			10/24/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345096	B. WING				C 05/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	2019 VERHOEFF DRIVE		
HUNIERS	VILLE OAKS			F	IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page necessary; and (ii) Develop and imple action to correct ident (h) Disclosure of infor Secretary may not rec records of such comm such disclosure is rela such committee with the section. (i) Sanctions. Good fa committee to identify deficiencies will not be sanctions. This REQUIREMENT by: Based on record revi facilities Quality Asset Committee failed to m procedures and monit the committee put into recertification survey one recited deficiency in October 2016 and of the current follow up a 10/05/17. The repeat to provide care to mai continued failure of the surveys of record show	e 21 ement appropriate plans of ified quality deficiencies; mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this with attempts by the and correct quality e used as a basis for is not met as evidenced ews and staff interviews the ssment and Assurance naintain implemented tor these interventions that		520	DEFICIENCY)	lan er of of al e ey vey	
	This tag is cross refer F 309: Provide Care t	red to: o Maintain Well Being:			and assessing the surgical wound received a one-on-one in-service or wil receive one prior to 10/17/17 by RN Nu	I	

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C	
		345096	B. WING		10/05/20 [/]	17
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTERS	VILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMP	(X5) PLETIOI DATE
F 520	interviews the facility incision on a resident daily dressing change orders who had to be for an incision and dra incision due to a woul back (Resident #2) fo surgical incision. During the recertificat 2016 the facility was of follow a physician ord inserted central cathe weekly for 1 of 1 sam During an interview of Administrator explain monthly Quality Asses meetings and the Adr Nursing, Medical Dire various department m meetings. He confirm ongoing topics at the past deficiencies they auditing either on a m	ews and physician and staff failed to assess a surgical 's lower back or provide es according to physician's readmitted to the hospital ainage and revision of the nd infection of their lower or 1 of 1 resident with a tion survey of October 6, cited at F 309 for failure to ler to change a peripherally eter (PICC) line dressing pled resident. n 10/04/17 at 1:21 PM, the ed the facility conducted ssment and Assurance ministrator, Director of	F 52		MD orders, ng, and tion. 1 y the rses failure to nd provide ng the or the h surgical d. An audit RN r the bwed to patients ill be clude the date they of the nurse ge. nument on inistration completed rder. Daily necked by ented on sing is dry the surgical	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/30/2017 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345096	B. WING			10	C / 05/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	VILLE OAKS			12	2019 VERHOEFF DRIVE		
HUNTERS	WILLE OARS			H	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	e 23	F	520	the plan of correction is effective and specific deficiency cited remains corr and/or in compliance with the regulat requirements; The title of the person responsible for implementing the acceptable plan of correction. Dates when corrective action will be comple The corrective action dates must be acceptable to the State. " The facility will convert to an electron medical record in October 2017, whic change the process for the document of surgical dressing changes and assessment of the surgical wounds. Auditing and monitoring will remain in place as outlined, adhering to the timeframe and guidelines. " DON or RN designee will audit 1000 residents with surgical incision dressi changes (to include frequency), date/initialing of Surgical dressings, documenting of completion in the EM once a dressing change is completed incensed nurses by the RN Nurse Educator or RN designee to include following MD orders for Surgical dress changes (to include frequency), date/initialing of Surgical dressings, signing the EMAR once a dressing change is completed and daily the surgical dressing will be checked by the licensed nurse and documented on the EMAR to ensure that dressing is dry intact and assessment of the surgical wound is completed. Any nurse who unable to attend the mandatory in-se by 10/17/17 will receive the in-service prior to working a shift.	ected ory ted. nic the will tation % of ng AR l. sing he he and is rvice	

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STATEMENT	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED			
		345096	B. WING		C 10/05/2017			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/03/2017			
HUNTER	SVILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC			
F 520	Continued From page	je 24	F 52	 " Surgical dressings will be check by licensed nurse and document EMAR to ensure that dressing re- intact and is changed per MD ord assessment of the surgical woun completed. " Clinical supervisor or licensed r designee will report any new sur- wounds in morning stand up mee (Monday	ed on the emains ders and dis hurse gical eting daily weekend orders to rrected en to daily y eekend daily x 1 surgical dude gical MAR leted and do to d issues sults of h the Nursing I monthly time tee. der equent rtification			

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