PRINTED: 01/22/2018 FORM APPROVED OMB NO. 0938-0391

PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
STREET ADDRESS, CITY, STATE, ZIP CODE 912 SHEPARD STREET MOREHAD CITY, NC 28557 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGION AND THE PROPRIET AND THE PR			345244	B. WING				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			NTER	•	81	12 SHEPARD STREET		
No deficiencies were cited as a result of complaint investigation conducted on 10/26/2017. Event ID #WQXQ11. F 279 SS=D CFR(s): 483.20(d):483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
complaint investigation conducted on 10/26/2017. Event ID #WQXQ11. F 279 SS=D DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d):483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive	F 000	INITIAL COMMENTS	3	F	000			
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive		complaint investigation Event ID #WQXQ11 DEVELOP COMPRE	on conducted on 10/26/2017. :HENSIVE CARE PLANS	F	279			11/22/17
(b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive		(d) Use. A facility mu assessments comple months in the resider results of the assess and revise the reside	eted within the previous 15 nt's active record and use the ments to develop, review					
care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse		(b) Comprehensive C (1) The facility must of comprehensive personal comprehensive personal comprehensive asset forth at §483.10(of includes measurable to meet a resident's rand psychosocial necomprehensive assecare plan must describe (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, includer §483.10, inc	develop and implement a con-centered care plan for stent with the resident rights c)(2) and §483.10(c)(3), that objectives and timeframes medical, nursing, and mental eds that are identified in the ssment. The comprehensive ibe the following - are to be furnished to attain ent's highest practicable I psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse					(X6) DATE

Electronically Signed 11/22/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345244	B. WING _		C 10/26/2017	
NAME OF PROVIDER OR SUPPLIER HARBORVIEW HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 812 SHEPARD STREET MOREHEAD CITY, NC 28557	•	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 279	rehabilitative services provide as a result of recommendations. If findings of the PASA rationale in the reside (iv)In consultation wit resident's representation (A) The resident's profuture discharge. Fact whether the resident's community was assellocal contact agencies entities, for this purpose. (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on the medicinterviews, and resident failed to develop a coof 1 sampled resident.	B.10(c)(6). Rervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. The the resident and the tive (s)- als for admission and Reference and potential for cilities must document a desire to return to the seed and any referrals to be and/or other appropriate one. In the comprehensive care in accordance with the h in paragraph (c) of this I is not met as evidenced all record reviews, staff ent observation, the facility comprehensive care plan of 1	F 2	• F279 483.21(b) 1) On 10/26/17 a contracture assessment was completed for #63 by a facility Registered Nurs addition, a referral was made for occupational therapy and evalual completed 10/31/2017. Physicial were obtained for a use of hand	se. In r ation was an Orders	
	01/05/2017 with diag	nosis of Alzheimer's, oressive disorder, muscle		Resident #63 on 10/31/2017 by facility's medical director. The facility's care plan coordinates	the	

			E SURVEY MPLETED			
		345244	B. WING		1	C 0/ 26/2017
NAME OF PE	ROVIDER OR SUPPLIER	1 2 3 2 2 3		STREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2017
TO UNIC OF TH	TO VIDER OR GOTT EIER			812 SHEPARD STREET		
HARBOR\	IEW HEALTH CARE CE	NTER				
				MOREHEAD CITY, NC 28557		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From page	e 2	F 27	9		
	(MDS) dated 07/07/2 one side for both upp A review of care plan	erly Minimum Data Set 017 coded impairment on oer and lower extremity. stated onset problem dated		updated the care plan on 10/31 reflect the intervention of the hat to evaluate the effectiveness of intervention. Facility RNs, LPNs, NAs, and Administrative nursing staff have	androll and f the ve been	
		ed weakness, left hand/wrist		in-serviced on contracture man	J	
		erately impaired cognition.		for resident #63 and the use of		
		to feed self after tray set up		handroll to assist in the prevent	tion of	
		include if decline in function		contracture development.	***	
	noted, refer to therap	y for evaluation.		Staff failing to ensure complian		
	A review of googge	ent of contracture risk form		facility contracture managemen	•	
	and instructions date			will be subject to further training subject to the facility's progress		
		er 80. No use of lower		disciplinary policies up to and in		
		e of 7. Instructions state the		termination of employment.	icidaling	
		greater the potential to		termination of employment.		
	_	. Residents with scores		2) All facility residents have h	ad a new	
		uld be considered at risk and		contracture assessment comple		
		ar positioning schedule for		identify residents who may requ		
	both bed and chair a	· ·		potential interventions for the p		
	protocol should be im			of contractures. Residents idea		
	proteon orreard so			requiring interventions will be d		
	Review of provider note dated 04/28/2017 stated by the facility inter-disciplinary care plan resident has flexion contracture of his left hand team (IDCPT), interventions will be					
				1 7	•	
	and wrist.			implemented per individualized		
				assessment, and care plans up		
	Review of physician of	orders revealed diagnosis of		necessary.		
		Residents that are newly a	dmitted will			
				be assessed by facility's admitt	ing nurse	
	Review of Occupational Therapy (OT) plan of			and interventions, if necessary,	, will be	
	care dated 01/06/201	7 stated skilled OT to		implemented by the IDCPT for	or these	
	provide management	t of hand contracture. OT to		residents.		
	assess need for splin	iting and/or positioning. Will		Facility RNs, LPNs, NAs, thera	py, and	
	instruct nursing staff	in on-going needs and		Administrative nursing staff have	/e been	
	positing to maximize	hand function.		in-serviced on contracture man	agement	
				for residents, identifying contra	ctures,	
	Review of OT discha	rge summary dated		referral's to therapy, and use of	f assistive	
	01/19/2017 stated se	vere tone in left hand with		devices to prevent contractures	3.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION		E SURVEY IPLETED
			A. BUILDIN			С
		345244	B. WING		1	0/26/2017
NAME OF P	ROVIDER OR SUPPLIER	0.02	 	STREET ADDRESS, CITY, STATE, ZIP CODE	•	0/20/2017
NAME OF T	TO VIDER OR OUT LIER			812 SHEPARD STREET	-	
HARBOR\	IEW HEALTH CARE	CENTER				
				MOREHEAD CITY, NC 28557		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From p	page 3	F 2	79		
	resultant contracti	ures prohibits functional use for				
		iving. Summary of note stated		3) It has been determined th	at this cited	
	Passive Range of	Motion (PROM) to left hand,		deficiency occurred in relation	to a recent	
	training in use of h	nand roll to prevent further		transition from paper documer	ntation and	
	contraction and to	maintain gains realized in		assessment monitoring to an e		
		om treatment. Nursing staff		medical record system and the		
	education provide	d in use of hand roll.		systemic change is not necess	-	
		0/05/00/45		believed that processes were		
		0/25/2017 revealed no orders		unintentionally, during this tran		
	for hand roll to left	r nand.		that the correction will require		
	Observation of na	med resident 10/24/2017 at		modification of paper docume assessment in conjunction wit		
		/wrist contracture noted with no		documentation.	II LIVIIX	
	hand roll in place.			The facility has a system	of checks	
				and balances to ensure orders		
	Observation of na	med resident 10/25/2017 at		followed through. The facility		
	2:15 PM, no hand	roll in place.		completed contracture assess		
				residents and quality assurance	ce efforts of	
		A #3 10/25/2017 at 1:45 PM		current system should be suffi	cient to	
		assists resident with getting		sustain compliance.		
		to do range of motion with left				
		ated that resident does not use		4) The facility's Director of N	-	
	hand roll to left ha	ina.		conduct direct observation qua	•	
	Intonuious with CN	A #4 10/25/2017 at 3:20 PM		assurance rounds to identify c	-	
		aware of resident getting any		with contracture management preventative measures identifi		
		xercises or using a hand roll.		facility IDCPT. The direct obs		
		Acroided of doing a fland foli.		will be completed weekly for for		
	Interview with owr	ner of facility and Director of		and monthly thereafter to ensu		
		0/25/2017 at 3:30 PM stated that		compliance. Data will be eval		
	named resident di	id not have a hand roll and that		facility's Quality Assurance Pe	rformance	
		d be evaluated, policy reviewed,		Improvement Committee (QAI		
		rapy services to review plan of		corrected actions taken if iden		
		nat expectation would be for any		These actions may include fur		
		racture to be evaluated and		education or re-evaluation of s		
	referred to therapy	y as needed.		the scope to be determined by		
				provided through observations		
		med resident's left hand		Quarterly contracture aud		
	1U/∠0/∠U1/ WITH TI	reatment nurse noted hand roll		completed by the IDCPT to re-	view	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345244	B. WING		C 10/26/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 812 SHEPARD STREET MOREHEAD CITY, NC 28557	10/20/2017
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 279	in place, nails trimme skin of palm. Interview with Nurse regarding how she we recommendations state orders for plan and not linterview with Minimu 10/26/2017 at 10:15 / copies of all new order of any changes that in plan. Stated that han as there had not been linterview with DON 1 stated her expectation recommendations afticend been discontinued we the order for nursing morning meetings are inform staff of plans. Interview with owner/ 10/26/2017 at 10:35 / expectation of therap recommendations for services have been dispolicy and procedure on follow up care and necessary with instrunurse of new order for INCREASE/PREVEN.	d, and no noted breaks in #1 10/26/2017 at 10:10 AM build be aware of any therapy ted that therapy writes ursing carries out. Im Data Nurse (MDS) AM stated that she gets ers every morning for review eed to made to the care d roll was not on care plan in an order written. 10/26/2017 at 10:25 AM in for follow up er therapy services have build be for therapy to write it carry out. Stated that e attended by therapy also to 15 stand in Administrator at AM regarding her by to make nursing aware of follow up care after their discontinued stated that dis for therapy to train staff to obtain order as ections and inform the charge or nurse to follow up with. T DECREASE IN RANGE	F 279	contracture management protocols an ensure effectiveness. Interventions w reviewed and care plans update as necessary to ensure compliance. Res of audits will be discussed in facility Q and corrective actions taken to ensure compliance. 5) Date of Compliance: Decembe 2017	ill be ults API
	(c) Mobility.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345244	B. WING		C 10/26/2017
	ROVIDER OR SUPPLIER	ENTER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 112 SHEPARD STREET MOREHEAD CITY, NC 28557	10/20/2011
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 318	receives appropriate increase range of modecrease in range of modecrease independent of modelity is demonstrated independent of modelity is demonstrated. This REQUIREMENT by: Based on the medicinterviews, and reside failed to prevent decrease of 1 sampled resided Resident #63) Findings include: Resident #63 was accontinuous modecrease and contrated in the quart (MDS) dated 07/07/2 one side for both upper modecrease in range of mo	mited range of motion treatment and services to botion and/or to prevent further imotion. mited mobility receives , equipment, and assistance we mobility with the maximum lence unless a reduction in ably unavoidable. T is not met as evidenced all record reviews, staff ent observation, the facility rease in range of motion of ent with contracture.(dmitted to the facility on gnosis of Alzheimer's, pressive disorder, muscle reacture to left hand. derly Minimum Data Set 2017 coded impairment on over and lower extremity.	F 318	F318 483.25(C)(2)(3) 1) On 10/26/17 a contracture assessment was completed for reside #63 by a facility Registered Nurse. In addition, a referral was made for occupational therapy and evaluation occupational therapy and evaluation occupated 10/31/2017. Physician On were obtained for a use of handroll for Resident #63 on 10/31/2017 by the facility's medical director. The facility's care plan coordinator updated the care plan on 10/31/2017 reflect the intervention of the handroll to evaluate the effectiveness of the intervention. Facility RNs, LPNs, NAs, and	was ders r to and
	07/07/2107 of left side contracture and mode Goal was to continue by staff. Approaches noted, refer to therapy A review of assessment and instructions date	ent of contracture risk form		Administrative nursing staff have been in-serviced on contracture management for resident #63 and the use of the handroll to assist in the prevention of contracture development. Staff failing to ensure compliance with facility contracture management protokill be subject to further training and/of subject to the facility's progressive disciplinary policies up to and including the subject with the subject with the facility of the subject with the facility of the subject with the	n ocols or

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		345244	B. WING			C			
NAME OF PE	ROVIDER OR SUPPLIER	0.02.4	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/26/2017			
TVAINE OF T	COVIDER OR OUT FILE								
HARBORV	HARBORVIEW HEALTH CARE CENTER			812 SHEPARD STREET					
				MOREHEAD CITY, NC 28557					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
F 318	Continued From page	e 6	F 31	8					
		e of 7. Instructions state the		termination of employment.					
		greater the potential to		terrimaners of employments					
	~	. Residents with scores		2) All facility residents have h	ad a new				
	•	uld be considered at risk and		contracture assessment comple					
	` '	ar positioning schedule for		identify residents who may requ					
	both bed and chair a			potential interventions for the pr					
	protocol should be in	•		of contractures. Residents iden					
	•	•		requiring interventions will be di		ıssed			
	Review of provider no	ote dated 04/28/2017 stated		by the facility inter-disciplinary of					
	•	contracture of his left hand		team (IDCPT), interventions wil	•				
	and wrist.			implemented per individualized					
				assessment, and care plans up	dated as				
	Review of physician	orders revealed diagnosis of		necessary.					
	contracture, left hand	I.		Residents that are newly admitt	ed will be				
				assessed by facility's admitting	nurse and				
	Review of Occupatio	nal Therapy (OT) plan of		interventions, if necessary, will	be				
	care dated 01/06/201	17 stated skilled OT to		implemented by the IDCPT for t	hese				
		t of hand contracture. OT to		residents.					
		nting and/or positioning. Will		Facility RNs, LPNs, NAs, therap					
		in on-going needs and		Administrative nursing staff hav					
	positing to maximize	hand function.		in-serviced on contracture mana					
				for residents, identifying contract					
	Review of OT discha			referral's to therapy, and use of					
	01/19/2017 stated severe tone in left hand			devices to prevent contractures					
		s prohibits functional use for							
		g. Summary of note stated		3) It has been determined tha		 			
	_	otion (PROM) to left hand,		deficiency occurred in relation to					
		d roll to prevent further		transition from paper document					
		aintain gains realized in		assessment monitoring to an el					
range of motion from t		•		medical record system and ther					
	education provided in	n use of hand roll.		systemic change is not necessa		 			
	Davious of short 40/0	E/2017 revealed to a state		believed that processes were of		 			
		5/2017 revealed no orders		unintentionally, during this trans		 			
	for hand roll to left ha	inu.		that the correction will require a		 			
	Observation of name	d resident 10/24/2017 at		modification of paper document		 			
				assessment in conjunction with documentation.	⊏IVI™	 			
		ist contracture noted with no			aka and	 			
	hand roll in place.			The facility has a system of che balances to ensure orders are f		 			
				שמומווטבט נט בווטעוב טועבוט מופ ו	OIIOW C U	1 1			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′				OATE SURVEY OMPLETED
							С
		345244	B. WING _				10/26/2017
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				81	2 SHEPARD STREET		
HARBOR	VIEW HEALTH CARE	CENTER		M	OREHEAD CITY, NC 28557		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION DATE
F 318	Continued From pa	age 7	F3	318			
	Observation of nar	ned resident 10/25/2017 at			through. The facility has completed		
	2:15 PM, no hand	roll in place.			contracture assessments on all reside	ents	
		•			and quality assurance efforts of curre	nt	
	Interview with nurs	ing assistant (NA) #3			system should be sufficient to sustain		
	10/25/2017 at 1:45	PM stated that when assists			compliance.		
	resident with gettin	g dressed, attempts to do					
	range of motion wi	th left arm and hand. Stated			4) The facility's Director of Nursing	will	
	that resident does	not use hand roll to left hand.			conduct direct observation quality		
					assurance rounds to identify compliar	ıce	
		#4 10/25/2017 at 3:20 PM			with contracture management		
		ware of resident getting any			preventative measures identified by the	*	
	range of motion ex	ercises or using a hand roll.			facility IDCPT. The direct observation		
	1-4				will be completed weekly for four wee	KS	
		er of facility and Director of			and monthly thereafter to ensure	v tho	
		25/2017 at 3:30 PM stated that do not have a hand roll and that			compliance. Data will be evaluated b facility's Quality Assurance Performar	-	
		be evaluated, policy reviewed,			Improvement Committee (QAPI) and	ice	
		apy services to review plan of			corrected actions taken if identified.		
		at expectation would be for any			These actions may include further		
		acture to be evaluated and			education or re-evaluation of systems	with	
	referred to therapy	as needed.			the scope to be determined by the da		
	, ,				provided through observations.		
	Observation of nar	ned resident's left hand			Quarterly contracture audits will be		
	10/26/2017 with tre	eatment nurse noted hand roll			completed by the IDCPT to review		
	in place, nails trimr	med, and no noted breaks in			contracture management protocols ar	nd to	
	skin of palm.				ensure effectiveness. Interventions a	nd	
					care plans update as necessary to en	sure	
		se #1 10/26/2017 at 10:10 AM			compliance. Results of audits will be		
		would be aware of any therapy			discussed in facility QAPI and correct	ive	
		stated that therapy writes			actions taken to ensure compliance.		
	orders for plan and	I nursing carries out.			5) Data of Compliance December		
	Intonious with Mini	mum Data Nurso (MDC)			5) Date of Compliance: December 01, 2017	51	
		mum Data Nurse (MDS) 5 AM stated that she gets			01, 2017		
		rders every morning for review					
		at need to made to the care					
	plan.	at need to made to the care					
	F.2						
	Interview with DON	N 10/26/2017 at 10:25 AM					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345244	B. WING _			C 10/26/2017	
NAME OF PROVIDER OR SUPPLIER HARBORVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 812 SHEPARD STREET MOREHEAD CITY, NC 28557			10/20/2017	
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 318	stated her expectation recommendations aftitude been discontinued with the order for nursing morning meetings are inform staff of plans. Interview with owner/ 10/26/2017 at 10:35 // therapy to make nurs recommendations for services have been dipolicy and procedure on follow up care and necessary with instru	n for follow up er therapy services have ould be for therapy to write to carry out. Stated that e attended by therapy also to estand in Administrator at AM regarding expectation of ing aware of follow up care after their iscontinued stated that is for therapy to train staff	F3	318			