| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | ATE SURVEY OMPLETED | |
|--------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------|--|
| | | 345570 | B. WING | | | 06/07/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | | | |
| | | | | 13835 BOREN STREET | | | |
| HUNTERS | VILLE HEALTH & REH | ABCENTER | | HUNTERSVILLE, NC 28078 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE | (X5) COMPLETION DATE | |
| F 554 SS=D | Resident Self-Admi CFR(s): 483.10(c)(7 | n Meds-Clinically Approp 7) | F | 554 | | 7/5/18 | |
| | medications if the ir defined by §483.21 this practice is clinic | ight to self-administer iterdisciplinary team, as (b)(2)(ii), has determined that cally appropriate. IT is not met as evidenced | | | | | |
| | Based on observat and resident intervia assess the ability of oral medications (R at the bedside for 1 | ions, record review and staff ews, the facility failed to a resident to self-administer olaids and Tums) that he kept of 2 residents (Resident self-administration of | | The statements included admission and do not corr agreement with the allege herein. The plan of corre completed in the complian federal regulations as out in compliance with all feder regulations the center has | astitute ed deficiencies ection is nce of state and lined. To remain eral and state | | |
| | Findings Included: | admitted to the facility on | | take the actions set forth plan of correction. The for correction constitutes the allegation of compliance. deficiencies cited have be | llowing plan of centers All alleged | | |
| | 5/21/18. Diagnoses | s included fractured neck of nal disease, pressure ulcer | | completed by the dates in | | | |
| | | ea, muscle weakness and | | F554 The plan of correcting the deficiency. The plan shou processes that led to the | ld address the | | |
| | Screening form date Resident #239 was #239 had adequate #239 was not asses | ssion Nursing Assessment/ ed 5/21/2018 revealed that cognitively intact. Resident vision and hearing. Resident sed to self-administer o medications at the bedside. | | The facility staff nurses fa that the patient had over-i medications at beside and policy on Self Administrat Medications at bedside. | iled to identify the-counter d did not follow | | |
| | Review of the care | plans dated 5/25/2018 ent #239 was not care | | The procedure for implem acceptable plan of correct specific deficiency cited. were checked for medical (prescription or over-the-or- ensure that no other med | tion for the All patient rooms tions counter), to | | |

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.

06/25/2018

| STATEMENT | OF DEFICIENCIES | MEDICAID SERVICES | (X2) MUI TIPI | LE CONSTRUCTION | | <u>NO. 0938-03</u> TE SURVEY | |
|------------------------------------|---------------------------------------------|---------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------|--------------------------------|---------------------------------|--|
| | CORRECTION | IDENTIFICATION NUMBER: | . , | | · · · · | MPLETED | |
| | | 345570 | B. WING | | C | 6/07/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | | |
| HUNTERSVILLE HEALTH & REHAB CENTER | | | | 13835 BOREN STREET 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 ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETIC DATE | |
| F 554 | Continued From page | e 1 | F 554 | 4 | | | |
| | | | | found at bedside. When a r | | | |
| | | sion Minimum Data Set | | during the initial audit, were | | | |
| | (MDS) dated 5/28/20 assessment was still | | | they were removed from the room until determination by | • | | |
| | 235535115111 Was Still | in progress. | | Interdepartmental Team and | | | |
| | | | | evaluate the abilities of the | | | |
| | An observation on 6/- | 4/2018 at 3:23pm revealed | | safely administer medication | n. A patient | | |
| | - | Tums on the bedside table | | with a BIMS score of 12 or l | | | |
| | of Resident #239. | | | considered for self-administ | | | |
| | | | | patients inconsistent cogn | | | |
| | An observation and i | nterview with Resident #239 | | Nurses, CNA s and Therap educated on Nursing Policy | | | |
| | | m revealed a bottle of | | Self-Administration of Medic | | | |
| | | the bedside table. Resident | | bedside and making sure th | | | |
| | #239 stated that he u | used the medications for | | payed to items in resident ro | oms when | | |
| | | omach or gas as symptoms | | providing care. Location of | | | |
| | occurred. | | | availability will continue to b | | | |
| | | | | during orientation for staff. Therapy staff were educated | | | |
| | Review of the physic | ian orders on 6/05/18 4:25 | | charge nurse of any medica | | | |
| | | r for Resident #239 to | | bedside. Immediately, and | | | |
| | | cations or keep medications | | remove and report to the | | | |
| | at the bedside. | | | DON/Administrator, so that | | | |
| | | | | steps could be taken to prop | • | | |
| | Δn interview with the | Unit Manager (UM) on | | determine the patients abilit administer medications and | | | |
| | | evealed that she was not | | secured the medications in a | | | |
| | | ations were at the bedside. | | determination is made by th | | | |
| l F | An observation with t | he UM revealed that | | patient can safely administe | | | |
| | Resident #239 did no | | | medications. A, letter was c | | | |
| | | cation in the electronic | | families and patients outlining | | | |
| | had not been assess | palized that Resident #239 | | necessity for patients and fa the facility of medications th | • | | |
| | | explained that residents that | | into the facility. Patients and | - | | |
| | | cations have to be assessed, | | during the admission proces | | | |
| | | nstration, a physician order | | given, a letter explaining the | | | |
| | | or self-administration & to | | self-administration process. | | | |
| | - | ne bedside, and a lock box | | provide families with educat | | | |
| | provided for storage. | | 1 | process, effective July 5, 20 | 18 forward | 1 | |

Facility ID: 110346

If continuation sheet Page 2 of 19

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 08/24/2018 M APPROVED D. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | (X3) DATE | |
| | | 345570 | B. WING | | | 06/ | /07/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HUNTERS | VILLE HEALTH & REHA | B CENTER | | | 3835 BOREN STREET | | |
| | | | | н | UNTERSVILLE, NC 28078 PROVIDER'S PLAN OF CORRECTION | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 554 | Continued From page | e 2 | F | 554 | | | |
| | 6/6/2018 at 3:27pm rethe resident to be associated and the care the resident has been medications. An interview with the 3:54pm revealed that self-administration of once the medication of the | Director of Nursing on evealed that he expected for sessed, a physician order e plan to be developed after n assessed to self-administer Administrator on 6/6/2018 at ther expectation regarding medication would be that was discovered, the resident a physician order obtained loped. | | | The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements. The charge nurse is responsible for the medication cart and the assigned rooms for that cart will be responsible to check each patient □s ro- daily to ensure no medications are at bedside for a period of 3 months. The DON, SDC or Unit Coordinator/Manag- will do visualization of each patient □s room weekly for a period of 3 months, observing for medications at bedside. These audits will be completed and provided to the QAPI committee for review quarterly and reviewed during weekly risk to ensure continued compliance. The title of the person responsible for implementing the acceptable plan of | nat cted Ty I | |
| F 565 SS=D | Resident/Family Grou CFR(s): 483.10(f)(5)(| | F | 565 | correction. The Director of Nursing wil responsible to ensure compliance with Plan of Correction. | | 7/5/18 |
| | and participate in res (i) The facility must pr group, if one exists, v reasonable steps, wit to make residents an upcoming meetings in (ii) Staff, visitors, or o | ident has a right to organize ident groups in the facility. rovide a resident or family vith private space; and take th the approval of the group, d family members aware of n a timely manner. ther guests may attend hily group meetings only at | | | | | |

Facility ID: 110346

If continuation sheet Page 3 of 19

| | - | ND HUMAN SERVICES MEDICAID SERVICES | | | | FO | ED: 08/24/201 RM APPROVE IO. 0938-039 |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | IPLE CONSTRUCTIO | | (X3) DATE SURVEY COMPLETED | |
| | | 345570 | B. WING | | | 0 | 6/07/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | S, CITY, STATE, ZIP CODE | | |
| HUNTERS | VILLE HEALTH & REHA | B CENTER | | 13835 BOREN S | | | |
| (X4) ID PREFIX TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI TAG | K (EAC | ROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 565 | the respective group' (iii) The facility must person who is approviding assistance requests that result fr (iv) The facility must for resident or family groups concerning is in the facility. (A) The facility must for response and rationa (B) This should not b facility must impleme request of the resident §483.10(f)(6) The resident §483.10(f)(7) The resident family member(s) or representative(s) meri- families or resident re- residents in the facility This REQUIREMENT by: Based on resident and record review, the fac- concerns of the resident April 24, 2018 and M The findings included Review of resident co- 04/24/18 revealed the | s invitation. provide a designated staff yed by the resident or family and who is responsible for and responding to written rom group meetings. consider the views of a up and act promptly upon ecommendations of such sues of resident care and life be able to demonstrate their ale for such response. e construed to mean that the nt as recommended every nt or family group. sident has a right to proups. sident has a right to have other resident et in the facility with the epresentative(s) of other ty. T is not met as evidenced and staff interviews, and cility failed to respond to ent council for 2 of 2 council meetings held on ay 30, 2018. d: puncil minutes dated e resident council asked for g meal times to assist with | F | deficiency. processes The Direct the resider resolution Resident C The procee | of correcting the specific The plan should addre that led to the deficient or of Nursing failed to re to a concern brought up council. dure for implementing the plan of correction for the ficiency cited. Activitie | ss the cy cited. eturn to port o during ne he | |

Event ID: FJ4S11

Facility ID: 110346

If continuation sheet Page 4 of 19

| | | | | OMB NO. 0938-03 |
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| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | (X3) DATE SURVEY COMPLETED |
| | 345570 | B. WING | | 06/07/2018 |
| ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DDE |
| HUNTERSVILLE HEALTH & REHAB CENTER | | | 13835 BOREN STREET HUNTERSVILLE, NC 28078 | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE COMPLETIC TE APPROPRIATE DATE |
| Continued From page | e 4 | F 56 | 5 | |
| Review of resident co 05/30/18 revealed no response to the reque The minutes docume resolutions and chang the concerns. During a group interv Residents #12, #15, a service continued to 1 beverage service, iter with departure from the Interview with Reside president, on 06/05/1 resident council did no dining service concer the group voiced the ago." Interview with the act 06/06/18 at 8:53 AM council's concern with documented and forw Nursing (DON). The council did not receiv Interview with the DC revealed he was awa concern with dining s he did not respond to concerns formally but concern was resolved | buncil minutes dated o documentation of a est regarding dining service. Inted "update on going ges" without specification of iew on 06/05/18 at 2:11 PM, #33, and #35 reported dining be a problem with delay in m requests and assistance he dining room. ent #15, resident council 8 at 2:35 PM revealed the tot receive a response to the ms. Resident #15 explained concern "several months ivity director (AD) on revealed the resident h dining service was varded to the Director of AD reported the resident e a response. ON on 06/06/18 at 8:58 AM are of the resident council's ervice. The DON reported the resident council thought the dining service d. The DON could not | | Director will document Cour concerns/problems in Resid Minutes. Individual concerns addressed on the Service C form and turned into the Ada upon completion of the Res The Administrator will be, in informed of any urgent issue concerns, or problems. Dur subsequent Activities Direct Meeting with the Administra Activities Director will valida of both the Resident Counci and the corresponding Adm Response to Resident Counci administrator □s signature. Director or designated perso present back to the Resider resolutions to the previous r Administrator and DON may invited by the resident counci the facility responses. The Assistant Administrator and Director were educated by N Consultant, on the, Activities Resident Council on June 7 The monitoring procedure to the plan of correction is effer specific deficiency cited rem and/or in compliance with th requirements. A copy of th Resident Council Meeting M any concerns. The results of | lent Council s, will be concern Report ministrator ident Council. mediately es, council ing the or □ s Weekly tor, the te completion il Minutes form inistrative neil form with The Activities on will then at Council the meeting. The y attend if cil to address Administrator, Activities Nurse s Policy #601, , 2018. o ensure that ctive and that nains corrected ne regulatory e completed linutes and of the |
| | Continued From page Review of resident co 05/30/18 revealed no response to the reque The minutes docume resolutions and chan the concerns. During a group interv Residents #12, #15, s service continued to beverage service, ite with departure from th Interview with Reside president, on 06/05/1 resident council did n dining service concer the group voiced the ago." Interview with the act 06/06/18 at 8:53 AM council's concern with documented and forv Nursing (DON). The council did not receiv Interview with the DC revealed he was awa concern with dining s he did not respond to concerns formally bu concern was resolved | DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: SCILLE HEALTH & REHAB CENTER SVILLE HEALTH & REHAB CENTER SVILLE HEALTH & REHAB CENTER SVILLE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Review of resident council minutes dated 05/30/18 revealed no documentation of a response to the request regarding dining service. The minutes documented "update on going resolutions and changes" without specification of the concerns. During a group interview on 06/05/18 at 2:11 PM, Residents #12, #15, #33, and #35 reported dining service continued to be a problem with delay in beverage service, item requests and assistance with departure from the dining room. Interview with Resident #15, resident council president, on 06/05/18 at 2:35 PM revealed the resident council did not receive a response to the dining service concerns. Resident #15 explained the group voiced the concern "several months | CORRECTION IDENTIFICATION NUMBER: A. BUILDING A. BUILDING 345570 B. WING | DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 345570 B. WING STREET ADDRESS, CITY, STATE, ZIP CC 13335 BOREN STREET HUNTERSVILLE, NC 28078 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 F 565 Director will document Cour Continued From page 4 F 565 Director will document Cour Continued From page 4 F 565 Director will document Cour Concerms. Director will document Cour Concerms. The Administrator will be, in informed of any urgent issue concerms, or problems. Du subsequent Activities Director will be, in informed of any urgent issue concerms, or problems. Du subsequent Activities Director will valida of both the Resident Council president council did not receive a response to the dining service concerm. Resident the signature. Interview with the activity director (AD) on 06/06/18 at 8.53 AM revealed the resident council did not receive a response. Director were educated by 1 Consultant, on the, Activities Present back to the Resider resolutions to the previous r Administrator and DON may invited by the resident council numered and forwarded to the Director of Consultant, on the, Activities Resident Council did not receive a response. Interview with the DON on 06/06/18 at 8:58 AM revealed he was aware |

Facility ID: 110346

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 08/24/2018 M APPROVED D. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345570 | B. WING | B. WING | | | /07/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE 3835 BOREN STREET | 1 00. | |
| HUNTERS | VILLE HEALTH & REHA | B CENTER | | | UNTERSVILLE, NC 28078 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 565 | CFR(s): 483.10(g)(10 §483.10(g)(10) The re (i) Examine the result of the facility conduct surveyors and any pla respect to the facility; (ii) Receive information client advocates, and to contact these ager §483.10(g)(11) The fa (i) Post in a place real and family members residents, the results the facility. (ii) Have reports with certifications, and cor respecting the facility years, and any plan of respect to the facility, to review upon reque | b concerns. Its/Advocate Agency Info D)(11) esident has the right to- ts of the most recent survey ed by Federal or State an of correction in effect with and on from agencies acting as I be afforded the opportunity ncies. acility must idily accessible to residents, and legal representatives of of the most recent survey of respect to any surveys, mplaint investigations made during the 3 preceding of correction in effect with available for any individual st; and availability of such reports in nat are prominent and | | 565 | have not been addressed and resolution presented back to the Resident Counce a written format to prove that it was accomplished, the designated person responsible to have delivered the information will receive disciplinary act The title of the person responsible for implementing the acceptable plan of correction. The Activities Director will responsible to ensure compliance with Plan of Correction. | tion. | 7/5/18 |

Facility ID: 110346

If continuation sheet Page 6 of 19

| | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | | LE CONSTRUCTION | | 10. 0938-039 TE SURVEY | |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------|--|
| | CORRECTION | IDENTIFICATION NUMBER: | · / | | · · · · | MPLETED | |
| | | 345570 | B. WING | | 0 | 06/07/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | STREET ADDRESS, CITY, STATE, ZIP CO | | | |
| HUNTERS | SVILLE HEALTH & REHA | B CENTER | | 13835 BOREN STREET 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 577 | Continued From page | 26 | F 57 | 7 | | | |
| | (iv) The facility shall r information about cor This REQUIREMENT by: | not make available identifying nplainants or residents. is not met as evidenced n, staff interview, and record | | F577 | | | |
| | review, the facility fail surveys conducted af | ed to have the results of the ter the prior recertification esidents and visitors to | | The plan of correcting the sp deficiency. The plan should processes that led to the def The Administrator failed to h results easily accessible to a | address the iciency cited. ave survey | | |
| | The findings included | : | | wanted to review the results | • | | |
| | at 1:51 PM and on 06 a framed sign placed facility. The messag "Survey Results Loca of our most recent su | 4/18 at 9:00 AM, 06/05/18 6/06/18 at 9:09 AM revealed on a table upon entry to the e on the sign included: tition. Please find the results rvey in the Survey Results were no available survey n or on the table. | | The procedure for implement acceptable plan of correction specific deficiency cited. At the time of the deficiency identified, the Administrator in placed the missing survey re- book. The Nurse Consultant signage and placed a sign of receptionist desk denoting loc | n for the when being immediately esults in the t made new n the | | |
| | survey results binder | 6/18 at 9:11 AM revealed the was located at the end of ter against the wall behind a | | survey book and another sig developed, and placed below top underneath the book. Th handicap accessibility for wh bound visitors/patients, to be | n was w the counter nis allows neelchair | | |
| | revealed the most red | results binder contents cent survey result available and complaint investigation 08/24/17. | | identifiable of the location of Results Book. Education w given to the Administrator as Administrator was clearly aw requirement and knew it was | the Survey ill not, be the vare of the | | |
| | the state agency cond 10/12/17, complaint in | gency database revealed ducted a revisit survey on nvestigation surveys on 8. and a follow up complaint | | responsibility and took owne oversight. | rship of the | | |
| | | 8, and a follow up complaint int investigation survey on | | The monitoring procedure to the plan of correction is effect specific deficiency cited rem and/or in compliance with the | ctive and that ains corrected | | |
| | Interview with the Adr | ministrator on 06/06/18 at | | requirements. Upon return | | | |

Facility ID: 110346

If continuation sheet Page 7 of 19

| | | | | LE CONSTRUCTION | | NO. 0938-03 TE SURVEY | |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------|--|
| | CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | · · · | MPLETED | |
| | | 345570 | B. WING | | | 06/07/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COL | | E | | |
| HUNTERS | VILLE HEALTH & REHA | B CENTER | | 13835 BOREN STREET 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 | (X5) COMPLETIC DATE | |
| F 577 | the binder current. Th | e 7 e was responsible to keep ne Administrator reported the should contain the most | F 57 | 7 results, the administrator will p sign an audit tool verifying the and place with the Plan of Cor indicate compliance. | placement | | |
| | | | | The title of the person response implementing the acceptable p correction. The Activities Dire responsible to ensure complia Plan of Correction. The Admi Assistant Administrator will be to ensure compliance with the Correction. | blan of ctor will be nce with the nistrator or responsible | | |
| F 636 SS=D | Comprehensive Asse CFR(s): 483.20(b)(1) | - | F 63 | 6 | | 7/5/18 | |
| | a comprehensive, ac | duct initially and periodically | | | | | |
| | A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess | ent Assessment Instrument. | | | | | |
| | the following: (i) Identification and c (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavi | S. | | | | | |
| | (vii) Psychological we | | | | | | |

Facility ID: 110346

If continuation sheet Page 8 of 19

| | | ID HUMAN SERVICES | | | | FOR | D: 08/24/2018 M APPROVED |
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| STATEMENT | S FOR MEDICARE & DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | (X3) DATE | D. 0938-0391 SURVEY PLETED |
| | | 345570 | B. WING | | | 06/07/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | HUNTERSVILLE HEALTH & REHAB CENTER | | | 13 | 835 BOREN STREET | | |
| HUNTERS | | | | н | JNTERSVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 636 | (ix) Continence. (x) Disease diagnosis (xi) Dental and nutritic (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatment (xvi) Discharge plann (xvi) Discharge plann (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Set (xviii) Documentation assessment. The assistic discovery with the resident, as which the resident, as which the resident, as which the resident, as which the resident and nonlicer members on all shifts §483.20(b)(2) When the timeframes prescribed chapter, a facility must assessment of a resident through (iii) of this set prescribed in §413.34 apply to CAHs. (i) Within 14 calendare excluding readmission significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: | a and health conditions. onal status. Ats and procedures. ing. of summary information hal assessment performed igered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with hased direct care staff a. required. Subject to the d in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 43(b) of this chapter do not a days after admission, ns in which there is no the resident's physical or r purposes of this section, a return to the facility v absence for hospitalization a every 12 months. T is not met as evidenced iews and record review, the | F | 636 | F636 The plan of correcting the specific | | |

Facility ID: 110346

If continuation sheet Page 9 of 19

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | FORM APPROV OMB NO. 0938-03 |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
| | | 345570 | B. WING | | 06/07/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | · 1 | STREET ADDRESS, CITY, STATE, ZI | P CODE |
| HUNTERSVILLE HEALTH & REHAB CENTER | | | | 13835 BOREN STREET 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 T DEFICIE | ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE |
| F 636 | Continued From page | e 9 | F 63 | 36 | |
| F 030 | assessment to identifi affected function and for 1 of 10 sampled re assessments of fall ri The findings included Resident #67 was ad 04/16/18 with diagnor fracture of the right ne falls, glaucoma, and of Review of Resident # summary dated 04/16 fell prior to hospitaliza fracture. Review of Resident # Data Set (MDS) date assessment of severo physical behavior dire past 1 to 3 days. The #67 required the exter persons with transfer fall history prior to ad the Fall Care Area As Review of Resident 6 05/17/18 revealed no | fy and analyze how condition quality of life related to falls esidents who required isk (Resident #67). d: Imitted to the facility on ses which included recent eck of the femur, repeated dementia. f67's hospital discharge 6/18 revealed Resident #67 ation which resulted in a f67's admission Minimum d 04/23/18 revealed an ely impaired cognition with ected toward others in the e MDS indicated Resident ensive assistance of two rs and inability to determine mission. The MDS triggered assessment (CAA). | F 63 | deficiency. The plan sho processes that led to the The Minimum Data Set 0 to give a thorough invest cause of a fall while at h admission and failed to o and/or representative to analysis and determine f proceed to care plan. The procedure for implet acceptable plan of corre specific deficiency cited. 2018, the MDSC Consul education to the MDSC I Rules for completion of f analyze the findings with the problem, contributing factors related to falls. MDS Coordinator and/or Consultant will conduct a current residents □ recer MDS to ensure the trigge included an analyze of th documentation the findin description of the proble factors, and risk factors I The audit by te MDS Co MDSC Consultant will be | e deficiency cited. Coordinator failed tigation to the ome prior to contact family perform an the need to menting the ction for the On June 7, Itant provided regarding the RAI Fall CAA to n a description of g factors, and risk r MDSC an audit of all nt comprehensive ered fall CAA he findings with ngs with a m, contributing related to falls. ordinator and/or |
| | did not describe or ar prior to admission. T of input from Resider representative. There an analysis of finding | ors related to falls. The CAA nalyze Resident #67's fall The was no documentation nt #67's family and/or was no documentation of s supporting the decision to ceed to the care plan. | | July 5, 2018. The monitoring procedur the plan of correction is specific deficiency cited and/or in compliance wit requirements. The MDS | effective and that remains corrected h the regulatory |
| | | Coordinator #1 on 06/06/18 at | | designee will audit five re completed Comprehensi | esidents□ |

Facility ID: 110346

If continuation sheet Page 10 of 19

| | | | | | OMB NO. 0938-03 | |
|--------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | (X3) DATE SURVEY COMPLETED | |
| | | 345570 | B. WING | | 06/07/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | : | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| UNTERS | VILLE HEALTH & REHA | B CENTER | | 13835 BOREN STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | DATE | |
| F 636 | Continued From page | e 10 | F 636 | | | |
| | #67's fall CAA did not | e did not realize Resident t contain documented ting factors, risk factors and | | ensure the triggered fall CAA included a analysis of the findings with documentation of a description of the problem, contributing factors, and risk factors related to falls. The audits will b | | |
| | 10:39 AM revealed sl Coordinator to follow Instrument process. CAAs should contain | ministrator on 06/06/18 at the expected the MDS the Resident Assessment The Administrator reported documentation of ting factors, risk factors and | | completed, one time a week for 1 month twice a month for 1 month and monthly ten months. Any coding issue identified during the audits, will be, immediately corrected, with coaching/discipline as needed to the MDS. The Audits are to the presented, at the Quality Assurance Performance Improvement Committee | ı, for | |
| | | | | (QAPI) meeting for a period of two months. The title of the person responsible for implementing the acceptable plan of correction. MDSC Consultant will be responsible for ensuring the Plan of Correction is implemented and audits completed and presented to QA/Risk as listed. | 5 | |
| F 641 SS=D | Accuracy of Assessm CFR(s): 483.20(g) | ients | F 641 | | 7/5/18 | |
| | resident's status. This REQUIREMENT | of Assessments. at accurately reflect the is not met as evidenced | | | | |
| | facility failed to accur Set (MDS) related to | iews and record review, the ate code the Minimum Data falls for 1 of 1 sampled or to admission (Resident | | F641 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cite Facility failed to, accurately code the MI assessment related to fall prior to | d. | |

Event ID: FJ4S11

Facility ID: 110346

If continuation sheet Page 11 of 19

| | S FOR MEDICARE & | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPI | E CONSTRUCTION | OMB NO. 0938-039 (X3) DATE SURVEY |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | , , | | COMPLETED |
| | | 345570 | B. WING | | 06/07/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | ODE |
| HUNTERSVILLE HEALTH & REHAB CENTER | | | | 13835 BOREN STREET 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 OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE COMPLETIO THE APPROPRIATE DATE |
| F 641 | Continued From page | e 11 | F 64 | 1 | |
| | 04/16/18 with diagno | lmitted to the facility on ses which included recent eck of the femur, repeated | | MDSC modified Resident # Admission MDS, to accurat prior to Admission. | |
| | fracture of the right neck of the femur, repeated falls, glaucoma, and dementia. Review of Resident #67's hospital discharge summary dated 04/16/18 revealed Resident #67 fell prior to hospitalization which resulted in a fracture. Review of Resident #67's admission Minimum | | | The procedure for impleme acceptable plan of correction specific deficiency cited. C 2018, the MDSC Consultant education to the MDSC reg Rules for coding Question of History on Admission/Entry | on for the On June 7, ht provided garding the RAI J1700 Fall |
| | Data Set (MDS) date assessment of sever physical behavior dire past 1 to 3 days. The #67 required the exter persons with transfer fall history prior to ad | d 04/23/18 revealed an ely impaired cognition with ected toward others in the e MDS indicated Resident ensive assistance of two rs and inability to determine | | The MDS Coordinator and/ Consultant will conduct an current residents□, Admiss first MDS, completed since entry to ensure, Question J History on Admission/Entry coded correctly. The audit i completed, by July 5, 2018 | audit of all sion MDS or most recent 11700, Fall or Reentry is is to be, |
| | 1:55 PM revealed the fall history was an ov #1 reported the MDS to admission. | e omission of Resident #67's rersight. MDS Coordinator should be coded as fall prior ministrator on 06/06/18 at e expected the MDS to be | | The monitoring procedure to the plan of correction is effect specific deficiency cited ren and/or in compliance with to requirements. The MDS Co designee will audit five resi Admission MDS or first MD since most recent entry to a Question J1700, Fall Histor Admission/Entry or Reentry MDS is correctly coded. The accomplished, one time a w month, twice a month for 1 monthly for one month. Any identified, on the audits, will immediately corrected with | ective and that mains corrected he regulatory Consultant or dents□, DS completed ensure ry on y, ensuring the his will be week for 1 month and y coding issue II be |

Facility ID: 110346

If continuation sheet Page 12 of 19

| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIF | LE CONSTRUCTION | (X3) DATE | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| | | A. BUILDING | 3 | COMP | LETED | |
| | 345570 | | B. WING | | 06/ | 07/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HUNTERS | SVILLE HEALTH & REHA | B CENTER | | 13835 BOREN STREET 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 641 | 641 Continued From page 12 | | F 64 | the Quality Assurance meeting month. The title of the person responsi implementing the acceptable pl correction. MDSC Consultant v responsible for ensuring the Pla Correction is implemented and | ble for an of will be an of audits | |
| F 867 SS=D | CFR(s): 483.75(g)(2) §483.75(g) Quality as §483.75(g)(2) The qu assurance committee | (ii) ssessment and assurance. ality assessment and must: | F 86 | completed and presented to Q/ listed. | | 7/5/18 |
| | action to correct iden This REQUIREMENT by: Based on staff interv facility's Quality Asse Committee failed to m procedures and moni committee put into pl were for deficiencies recertification and cor conducted on 08/24/7 the areas of compreh infection control. The facility to sustain corr surveys of record sho | ement appropriate plans of tified quality deficiencies; T is not met as evidenced riews, and record review, the ssment and Assurance naintain implemented itor interventions that the ace in August, 2017. These cited during the facility ' s mplaint investigation survey 17. The deficiencies were in nensive assessments and e continued failure of the npliance, during two federal lows a pattern of the facility ' s effective Quality Assurance | | F867 The plan of correcting the spect deficiency. The plan should add processes that led to the deficie Facility failed to identify areas of incompleteness on Comprehen Assessments and Infection Con the monitoring of previous defic F636- The Minimum Data Set Of failed to give a thorough investi the cause of a fall while at hom admission and failed to contact and/or representative to perform analysis and determine the need proceed to care plan. F880 - N failed to follow injection administ | dress the ency cited. of sive ntrol during ciencies. Coordinator gation to e prior to family n an ed to lurse #1 | |

Event ID: FJ4S11

Facility ID: 110346

If continuation sheet Page 13 of 19

| | | MEDICAID SERVICES | | | OM | IB NO. 0938-03 |
|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------|------------------------------|----------------------------------------|------------------------------------------------------------------------|----------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345570 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | |) DATE SURVEY COMPLETED | |
| | | | | | 06/07/2018 | |
| NAME OF PR | ROVIDER OR SUPPLIER | • | STREET ADDRESS, CITY, STATE, | | , STATE, ZIP CODE | |
| HUNTERSVILLE HEALTH & REHAB CENTER | | | | 13835 BOREN STREET HUNTERSVILLE, NC | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDE | ER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH COR | RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETIO |
| F 867 | Continued From page | e 13 | F 86 | 7 | | |
| | This tag is cross refer | | | policy, and don | aloves. when | |
| | | - | | | n insulin injection. | |
| | F 636: Comprehensiv | e Assessments. Based on | | | - | |
| | | ecord review, the facility | | | for implementing the | |
| | | mprehensive assessment to | | | of correction for the | |
| | | now condition affected | | | cy cited. F-636On June | |
| | | f life related to falls for 1 of | | | SC Consultant provided | |
| | | who required assessments | | | MDSC regarding the RAI etion of Fall CAA to | |
| | of fall risk (Resident # | 407). | | | ings with a description of | |
| | The facility was recite | ed for F 636 for failure to | | - | ntributing factors, and risk | |
| | | nsive assessment related to | | factors related to | u | |
| | falls. The facility was originally cited during a | | | | | |
| | | mplaint investigation survey | | MDS Coordinate | or and/or MDSC | |
| | on 08/24/17 for failure | | | Consultant will o | conduct an audit of all | |
| | comprehensive asses | ssment related to nutrition. | | current resident | s recent comprehensive | |
| | | | | | the triggered fall CAA | |
| | | ol. Based on observations, | | | lyze of the findings with | |
| | | policy review, the facility | | | the findings with a | |
| | - | during the administration of | | | e problem, contributing | |
| | | lents (Resident #7) resulting | | | factors related to falls. | |
| | in a possible staff member exposure to a | | | - | DS will be completed by | |
| | bloodborne pathogen | | | - | d F880 - All staff nurses ed on Infection control | |
| | The facility was recite | ed for F 880 for failure to use | | | on administration and | |
| | | lin injection. The facility was | | - | ted by July 5, 2018, any | |
| | originally cited during | | | | ving the education will be | |
| | | on survey on 08/24/17 for | | | ne staffing schedule until | |
| | | lood glucose meter and | | | completed. During | |
| | adherence to isolation | n procedures. | | | Nurses will be provided | |
| | | | | | a copy of documents for | |
| | | ministrator on 06/07/18 at | | · · · | dminister medications, | |
| | | e facility's quality assurance | | | are 1) Subcutaneous | |
| | committee monitored | - | | | tramuscular Injections, 3) | |
| | | ection control procedures. | | | ps, 4) Orally Inhaled | |
| | | ported the facility conducted | | | Topical Medications, 6) | |
| | which included insulir | ervations on a regular basis | | | lications, 7) Otic Drops, 8) lingual Medications, 9) | |
| | | ssments received oversight | | | ons, 10) Rectal | |

Facility ID: 110346

If continuation sheet Page 14 of 19

| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345570 | | (X2) MULTIPLE | E CONSTRUCTION | (X3) DATE SURVEY | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| | | IDENTIFICATION NUMBER: | A. BUILDING | COMPLETED | | | |
| | | B. WING | | 06/07/2018 | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| HUNTERS | WILLE HEALTH & REHA | B CENTER | | 13835 BOREN STREET 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 OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE COMPLETIO | | |
| F 867 | | imum Data Set consultant. ported the facility did not | F 867 | Suppositories, 11) Vaginal Medicat 12) Enteral Medications. | ions, | | |
| | | | | The monitoring procedure to ensure the plan of correction is effective are specific deficiency cited remains co- and/or in compliance with the regul requirements. F-636 - The MDS Consultant or designee will audit 5 residents □ completed Comprehens MDS to ensure the triggered fall C/ included an analyze of the findings documentation of a description of t problem, contributing factors, and r factors related to falls. These audi be, accomplished, one time a week month, twice a month for 1 month a monthly for one month. Any coding identified on the audits will be, immediately corrected, with coaching/discipline as needed to th MDS. The results of the audits will presented, to the Quality Assuranc Performance Improvement Commi for 10 months. F880 □ The DON of Development Coordinator, will perf one med pass observation on each medication cart every week for 4 w perform one med pass observation every cart every other week x4, th med pass observation on each car monthly x9, utilizing Medication Pa Observation Forms. There will be repeat observations of any nurse u nurses have been observed once, then will a repeat observation be | nd that prrected latory sive AA with he risk ts will k for 1 and j issue ne l be e ttee, pr Staff form n reeks, n on en one t ss no until all | | |

Event ID: FJ4S11

Facility ID: 110346

If continuation sheet Page 15 of 19

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 08/24/2018 MAPPROVED D. 0938-0391 |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY PLETED |
| | | 345570 | B. WING | | | 06 | 07/2018 |
| NAME OF P | NAME OF PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HUNTERS | VILLE HEALTH & REHA | B CENTER | | 1 | 3835 BOREN STREET | | |
| | | 2 02.07.2.0 | | F | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 867 | infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection p program. The facility must esta and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u | & Control (2)(4)(e)(f) htrol blish and maintain an and control program a safe, sanitary and hent and to help prevent the hemission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, ig, and controlling infections iseases for all residents, ors, and other individuals | | 867 | Medication Pass Observation. The Medication Pass Observations result w be discussed, during the weekly Risk Meeting. The title of the person responsible for implementing the acceptable plan of correction. F-636 - MDSC Consultant be responsible for ensuring the Plan of Correction is implemented and audits completed and presented to QA/Risk a listed and F880 - The Director of Nursi will be responsible to ensure compliant with the Plan of Correction. | t will f as ing | 7/5/18 |

If continuation sheet Page 16 of 19

| | MENT OF HEALTH AN S FOR MEDICARE & I | D HUMAN SERVICES | | | | FORM |): 08/24/2018 APPROVED 0. 0938-0391 |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|----------------------------------------------------------------------------------------|-----------|-------------------------------------------|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING _ | CONSTRUCTION | | (X3) DATE | |
| | | 345570 | B. WING | | _ | 06/ | 07/2018 |
| NAME OF PR | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, S | TATE, ZIP CODE | | |
| HUNTERS | VILLE HEALTH & REHAI | 3 CENTER | | 3835 BOREN STREET | 8078 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 880 | procedures for the probut are not limited to: (i) A system of surveil possible communicabin fections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and trant to be followed to prev (iv)When and how iso resident; including but (A) The type and durat depending upon the ir involved, and (B) A requirement that least restrictive possible circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A systemidentified under the far corrective actions take §483.80(e) Linens. Personnel must hand | ndards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a r not limited to: tion of the isolation, ifectious agent or organism at the isolation should be the ble for the resident under the s under which the facility we with a communicable in lesions from direct or their food, if direct ne disease; and procedures to be followed ect resident contact. m for recording incidents cility's IPCP and the | F 880 | | | | |

Facility ID: 110346

If continuation sheet Page 17 of 19

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | FC | TED: 08/24/2018 DRM APPROVED NO. 0938-0391 |
|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------|
| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | PLE CONSTRUCTION G | | ATE SURVEY DMPLETED |
| | 345570 | | | | | 06/07/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | | |
| | | | | 13835 BOREN STREET | | |
| HUNTERS | VILLE HEALTH & REHA | BCENTER | | HUNTERSVILLE, NC 28078 | | |
| (X4) ID PREFIX TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 880 | Continued From page | e 17 | F 88 | 80 | | |
| | §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced | | | | | |
| | by: Based on observatio | ons, staff interviews, and | | F880 | | |
| | | ility failed to wear gloves | | 1000 | | |
| | during the administra | tion of insulin for 1 of 1 7) resulting in a possible | | The plan of correcting the deficiency. The plan shou processes that led to the Nurse #1 failed to follow i | Id address the deficiency cited. | |
| | The findings included | l: | | administration policy and administering an insulin ir | don gloves when | |
| | Injections" undated, r | policy titled, "Subcutaneous read in part, Step 2. Identify pocedure. Step 3. Wash | | The procedure for implem acceptable plan of correct specific deficiency cited. will be in-serviced on Infe during medication administ | tion for the All staff nurses ection control | |
| | (MDS) assessment d | recent Minimum Data Set ated 5/3/18 for Resident #7 noses including diabetes and | | training will be completed any nurse not receiving th be removed from the staff until the education is com orientation Staff Nurses w | by July 5, 2018, ne education will fing schedule pleted. During | |
| | during an insulin (a m | m, Nurse #1 was observed nedication used to manage ion not wearing gloves while aneous injection. | | education and a copy of c procedures to administer areas covered are 1) Sub Injections, 2) Intramuscula Opthalamic Drops, 4) Ora | documents for medications, ocutaneous ar Injections, 3) | |
| | #1 confirmed she had insulin administration indicated she usually | n 6/05/18 at 11:52am, Nurse d not worn gloves during the for Resident #7 and wears gloves but was oservation with the surveyor. | | Medications, 5) Topical M Transderm Medications, 7 Buccal and Sublingual Me Nasal Medications, 10) R Suppositories, 11) Vagina 12) Enteral Medications. | ledications, 6) 7) Otic Drops, 8) edications, 9) ectal | |
| | with the Administrato | 8 at 1:53pm was conducted r. During this interview the nurses should wear gloves | | The monitoring procedure the plan of correction is e | | |

Facility ID: 110346

| STATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED |
|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | 345570 | | B. WING | 00/07/0040 | |
| VAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZI | P CODE 06/07/2018 |
| HUNTERSVILLE HEALTH & REHAB CENTER | | | | | |
| (X4) ID PREFIX TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A | | CTION SHOULD BE COMPLET O THE APPROPRIATE DATE |
| F 880 | of exposure and trans pathogens. An interview on 6/06/ Director of Nursing (E Control Preventionist Coordinator(SDC) wa was covering this role expectation was for n were provided which | tion of insulin for prevention smission of bloodborne 18 at 1:56pm with the DON) revealed the Infection (ICP)/Staff Development as on vacation and the DON e. The DON stated his nurses to follow training they included, washing hands virior to the administration of | F 84 | 80 specific deficiency cited and/or in compliance wit requirements. The DON Development Coordinate med pass observation or cart every week for 4 we med pass observation on every other week x4, the observation on each car utilizing Medication Pass Forms. There will be no observations of any nurs have been observed one repeat observation be per needed to fulfill the audit through its end date for I Observations will be disc weekly Risk Meeting. The title of the person reimplementing the accept correction. The Directo be responsible to ensure the Plan of Correction. | h the regulatory or Staff or will perform one n each medication eks, perform one n every cart on one med pass t monthly x9, s Observation repeat se until all nurses se, only then will a erformed if requirements Medication Pass ation Pass cussed, during the sponsible for able plan of r of Nursing will |

If continuation sheet Page 19 of 19