PRINTED: 09/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345096	B. WING			08/17/2017	
	ROVIDER OR SUPPLIER		ı	12	TREET ADDRESS, CITY, STATE, ZIP CODE 2019 VERHOEFF DRIVE UNTERSVILLE, NC 28078	1 00/	17/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	483.10(j)(2)-(4) RIGH TO RESOLVE GRIEV (j)(2) The resident has must make prompt eff grievances the reside with this paragraph. (j)(3) The facility must to file a grievance or cresident. (j)(4) The facility must to ensure the prompt regarding the residen paragraph. Upon requa copy of the grievance grievance policy must (i) Notifying resident in postings in prominent facility of the right to f (meaning spoken) or grievances anonymou of the grievance officican be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the coindependent entities we be filed, that is, the period of the grievance of the coindependent entities we be filed, that is, the period of the grievance of the coindependent entities we be filed, that is, the period of the grievance of the coindependent entities we be filed, that is, the period of the grievance of the coindependent entities we be filed, that is, the period of the grievance of the gr	T TO PROMPT EFFORTS ANCES Is the right to and the facility forts by the facility to resolve in may have, in accordance It make information on how complaint available to the It establish a grievance policy resolution of all grievances its' rights contained in this uest, the provider must give be policy to the resident. The include: Individually or through locations throughout the ille grievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone is expected time frame for or of the grievance; the right cision regarding his or her intact information of with whom grievances may		166			8/30/17
	program or protection (ii) Identifying a Griev responsible for overse	ng-Term Care Ombudsman and advocacy system; ance Official who is being the grievance process, grievances through to their					
APORATORY	DIDECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

09/05/2017

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.

Electronically Signed

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345096	B. WING		C 08/17/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	00/11/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 166	by the facility; maintainformation associate example, the identity grievances submitted written grievance de coordinating with stanecessary in light of (iii) As necessary, taprevent further poter right while the allege investigated; (iv) Consistent with § reporting all alleged abuse, including injurand/or misappropriation anyone furnishing seprovider, to the admit as required by State (v) Ensuring that all include the date the summary statement the steps taken to in summary of the pertiregarding the resident as to whether the griconfirmed, any correct taken by the facility and the date the writh (vi) Taking appropriation accordance with Staneth of the residents' righ or if an outside entity	any necessary investigations aining the confidentiality of all ed with grievances, for of the resident for those d anonymously, issuing cisions to the resident; and the and federal agencies as specific allegations; king immediate action to notial violations of any resident did violation is being 3483.12(c)(1), immediately violations involving neglect, ries of unknown source, tion of resident property, by ervices on behalf of the inistrator of the provider; and	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		345096	B. WING _		0.	C 3/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	3/1//2017	
HUNTERS	VILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 166	Continued From page	e 2	F 1	66			
	confirms a violation for rights within its area of	I law enforcement agency or any of these residents' of responsibility; and ence demonstrating the					
	result of all grievance 3 years from the issu decision.	es for a period of no less than ance of the grievance					
	Based on record review and family, resident and staff interviews the facility failed provide the grievance investigation and resolution in writing to 2 of 3 sampled resident (Resident #1 and #2).			Preparation and/or execution of Correction does not constitute admission or agreement by the the truth of the facts alleged or conclusions set forth in this sta	ite e provider of		
	08/04/18 and dischar	admitted to the facility on ged on 08/09/17. Resident		deficiencies. The Plan of Correprepared and/or executed sole it is required by the provisions and State law.	ly because		
	anemia, tremors, hyp kidney disease. No m	's diagnoses included: diabetes mellitus, emia, tremors, hypertension, and chronic lney disease. No minimum data set (MDS) was ailable for Resident #1.		Based on observations, record family, resident and staff interv facility failed to provide the grid investigation and resolution in	riews the evance		
	indicated the grievand The summary of the	ce Form dated 08/07/17 ce was filed by Resident #1. grievance read in part, the e has not received his		of 3 sampled residents.			
	told several nurses si facility. The Steps Ta part, social worker sp nurse about which me tremors. The Nurse s check to see if Reside			" The plan of correcting the deficiency. The plan should ad processes that lead to the deficited; o Resident #1 issued a writt grievance resolution for grieval 8/7/17 on 8/28/17.	dress the ciency en nce dated		
	pertinent findings/cor Resident #1's tremore	mors. The summary of nclusion read in part, s address to the physician ng obtained for Primidone		o Resident #2 issued a writt grievance resolution for grieval 8/2/17 on 8/28/17. o The grievance official iden	nce dated		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER	_ L	1	STREET ADDRESS.	, CITY, STATE, ZIP CODE	1 00/11/2017	
				12019 VERHOEFF			
HUNTERS	VILLE OAKS			HUNTERSVILLE			
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F 166	Continued From pag	e 3	F 1	66			
F 166	(medication used to investigation was conthe Director of Nursinform indicated that the resolution to Resident A telephone interview. Resident #1's family family member state right hand tremor that home. The family mesure why but the Printhe facility and Resident #1 had filed a grieva DON had called and no resolution to the inot received the medhave had. The family or Resident #1 had response to the grieval An interview was conformed that she will grievance process in that anytime a grieval by the staff member then given to Resident #1 or response to the for	treat tremors). The mpleted and signed off on by ing (DON). The grievance ine DON had provide int #1's family on 08/09/17. If was conducted with on 08/17/17 at 8:31 AM. The did that Resident #1 had a at he took Primidone for at ember stated she was not midone was never given in item #1 had trouble feeding inedication due to the member stated that Resident ince at the facility and the spoke to her but there was ssue that Resident #1 had dication he was supposed to member confirmed that she not received any written	F 1	the survey a grievance do in-service by on providing to the reside o Comple "The procession of Patients grievances of Ry28/17 will grievance of steps taken summary of conclusions concerns(s) the grievance of confirmed, a to be taken grievance of department supervisors (8/30/17)	as not providing the written lecision received a one-on-ory the Assistant Administrate grievance decision ents on 8/28/17. Setion (8/28/17) Decedure for implementing the plan of correction for the liciency cited; and residents who voiced with facility resolutions as of the pervioled a written lecision to include the date was received, a summary of the resident's grievance, to investigate the grievance of the pertinent findings or a regarding the resident's grievance of the pertinent findings or a regarding the resident's grievance of the pertinent findings or a regarding the resident's grievance of the pertinent findings or a result of the date the written grievance of the date the written grievance of the facility as a result of the date the written grievance of the date o	one or or ons ne d of the the the, a r or othe	
	grievance. She adde new grievances in m would give them to the investigate and then The SW stated that in requested written foll responsible for comp	and that they discussed any corning meeting and then she the appropriate staff to return to her when finished. If the resident or family slow up then she would be obleting that and getting it to y. The SW confirmed that she		" The mo that the plar that specific corrected ar regulatory re person resp	onitoring procedure to ensure of correction is effective a codeficiency cited remains and/or in compliance with the equirements; The title of the consible for implementing the plan of correction. Dates	e e	

STATEMENT OF AND PLAN OF (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345096	B. WING _			08/	17/2017
NAME OF PRO	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	2019 VERHOEFF DRIVE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page		F	166			
	had not provided any #1 or his family becausit. The SW explained attended the recent trace the changes in the griadvised to only provide requested. An interview was cone Administrator on 08/1 Administrator confirm the recent training busined and the process of integral grievances into the losystem included a terrand was computerized track the grievances at 2. Resident #2 admitt with diagnoses that in hypertension, diabeted depression, and other Review of the most redata set (MDS) dated Resident #2 was cognitive and was computerized track the grievance and was computerized track the grievances at 2. Resident #2 admitt with diagnoses that in hypertension, diabeted depression, and other depression, and other data set (MDS) dated Resident #2 was cognitive and a Grievance and Grievance. The Summing at Grievance and Griev	written follow up to Resident use they had not requested that her Administrator had aining and informed her of sevance process, she was de written follow up if ducted with the 7/17 at 3:00 PM. The ed that she had attended t was "under a different w grievances should be that the facility was a part of not recently they had started uting the hospital system for ng term care facility. The implate for written response d so the staff can easily and the written follow up. ded to the facility on 02/28/17 included: anemia, is mellitus, anxiety, is. decent quarterly minimum 08/02/17 revealed that initively intact. de Form dated 08/02/17 in #2 had filed the mary of the grievance read in its each and her scheduled esday and Friday. The steps ead in part, reviewed the			when corrective action will be completed. The corrective action dates must be acceptable to the State. o Grievance official or Social Worker designee will complete and provide to resident a written grievance decision within 5 business days upon facility resolution of grievance decision. o Administrator or Assistant Administrator will co-sign with Grievance official or Social Worker designee writted grievance decisions provided to resident or Copies of written grievance decision provided to the resident will be maintain for a period of no less than 3 years from the issuance of the grievance decision. o Facility grievance log to be update include date of written grievance decision. o Administrator, Assistant Administrator designee will audit facility grievances for written grievance decisions provided resident, 35% of grievances x 1 month, then 20% of grievances x 1 month, then 10% of grievances x 1 month and with QAPI monthly for a period of 90 days a which time frequency of monitoring will determined by the QAPI Committee. o Any issues identified will be correctimmediately and will also be taken to morning stand up meeting held daily Monday - Friday and QAPI. o Completion (8/30/17)	ce en nt. ons ned on ator s d to n t be	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONS	STRUCTION	COMF	SURVEY
		345096	B. WING			1	C
	ROVIDER OR SUPPLIER	345096	B. WING	12019 \	T ADDRESS, CITY, STATE, ZIP CODE VERHOEFF DRIVE ERSVILLE, NC 28078	<u> 08/</u>	17/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 166	shower on 07/28/17. assistant. Summary opart, shower was not had fallen and had lea bed bath. Explained not receive her show understanding and a signed off on the Direct An interview was cor 08/17/17 at 10:11 AN she had filed the gries showers. She indicate forgotten that she refithat her shower days and that for the most scheduled. Resident not received any writt about the grievance. An interview was cor Worker (SW) on 08/1 confirmed that she we grievance process in that anytime a grievate by the staff member of the individual that we grievance. She adden new grievances in mould give them to the individual that it requested written foll responsible for compute resident or family had not provided any #2 or her family became with the second to the resident or family became with the second to the resident or family had not provided any #2 or her family became with the second to the resident or family became with the second to the resident or family became with the second to the resident or family became with the second to the resident or family became with the second to the resident or family became with the second to the resident or family became with the second to the seco	Spoke to the nursing of pertinent findings read in a given because Resident #2 ag pain and she was offered to Resident #2 why she did are and she was very appreciative. The form was actor of Nursing (DON). Inducted with Resident #2 on M. Resident #2 confirmed that are avance on 08/02/17 about her are that she "must have fused." Resident #2 stated as were Tuesday and Friday apart she received them as #2 confirmed that she had ten follow up from the staff	F	66			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345096	B. WING		C
NAME OF PR	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE	08/17/2017
HUNTERS	VILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION
F 166	attended the recent treather changes in the griadvised to only provide requested. An interview was con Administrator on 08/1 Administrator confirm the recent training but understanding of how handled. She added to large hospital chain at the process of integral grievances into the losystem included a terrand was computerized track the grievances at 483.21(b)(3)(i) SERV PROFESSIONAL STATE (b)(3) Comprehensive as outlined by the commustance of the professional state of the professio	ducted with the 7/17 at 3:00 PM. The ed that she had attended the was "under a different was "under a different was "under a different was "under a different was a part of not recently they had started thing the hospital system for nng term care facility. The nnplate for written response dison the written follow up. ICES PROVIDED MEET ANDARDS at Care Plans and or arranged by the facility, mprehensive care plan, standards of quality. The is not met as evidenced the was staff, family, and the facility failed to clarify a na discharge summary that not receiving the stay at the facility for 1 of 3 esident #1).		Preparation and/or execution of this F of Correction does not constitute admission or agreement by the provide the truth of the facts alleged or conclusions set forth in this statement deficiencies. The Plan of Correction is prepared and/or executed solely becaut it is required by the provisions of Fede and State law.	er of of s use
	medication during his sampled residents (R	stay at the facility for 1 of 3 esident #1).		conclusions set forth in this statement deficiencies. The Plan of Correction is prepared and/or executed solely becan it is required by the provisions of Fede	use

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345096	B. WING			C 08/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	1 0.0000	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	I	06/1//2017	
TO WILL OF T	NOVIDER OR COLL FIER			12019 VERHOEFF DRIVE			
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	ı			HUNTERSVILLE, NC 28078			
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F 281	Continued From pag	ge 7	F 2	81			
F 281	Resident #1 admitted and discharged from Resident #1's diagn tremors. No minimu was available for Resident #1's discharge medic (mediation used to at bedtime, dose was summary had been Resident #1's physical Review of the medic (MAR) dated 08/04/the following, Primic strength 08/04/17). The medication indication indication indication indication order Properties at the facility. Review of a physical clarification order Properties at the facility. Review of a physical clarification order Properties at the facility and Resident #1's family family member stated right hand tremor the home. The family more why but the Properties and the side of the s	d to the facility on 08/04/17 in the facility on 08/09/17. oses included essential im data set (MDS) information esident #1. ge summary from a local id/17 read in part that Resident ications included Primidone decrease tremors), daily dose is unknown. The discharge reviewed and initialed by cian at the facility on 08/04/17. cation administration record 17 through 08/31/17 revealed lone 1 tab at bedtime (clarify There were no initials beside ating that the medication had ed to Resident #1 during his an order dated 08/07/17 read, rimidone 50 milligrams (mg)	F 2	Based on record reviews, staphysician interviews the facil clarify a medication order fro discharge summary that resuresident not receiving the meduring his stay at the facility sampled residents (Resident Test). The plan of correcting the deficiency. The plan should a processes that lead to the decited; on the time of survey, Redischarged from the facility to not 8/9/17 and has not return. The procedure for imple acceptable plan of correction specific deficiency cited; on 100% audit will be cond medication administration redication administration redicated to form the facility to 100% audit will be cond medication administration redication administration redication for hursing/Designed residents identified will have orders corrected immediately (Completion 9/1/17) on Licensed Nursing staff we deducation related to proper redication related to proper redication/transcribing medication licensed nurses when transcribing medication licensed nurses signatures	lity failed to om a ulted in the edication for 1 of 3 t #1). The specific address the efficiency esident #1 had to the hospital ed. The menting the efficiency in last ng/Assistant es. Those medication y. Will receive medication will signatures in orders, two		
	Nursing Supervisor	w was conducted with (NS) #1 on 08/17/17 at 1:05 hat she was the nurse that		transcribing medication orde 24-hour chart check to verify of new orders to be complete	r on MAR. A completion		

Facility ID: 923277

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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		345096	B. WING _			17/2017	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COL		1772017	
				12019 VERHOEFF DRIVE			
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F 281	Continued From p	age 8	F 2	81			
	1	ent #1's medications from the		shift nurse with nurse□s sign	ature.		
		ry after the physician had		Duplicate yellow new orders			
	_	ations on the facility's MAR.		brought to the clinical startup			
		ticed that there was not a		Monday through Friday. RN I			
		e Primidone medication so she		review duplicate yellow new			
	had asked Nurse	#1 to ask Resident #1's family		Saturday and Sunday. Discr	epancies		
	what dose he was	taking so the order could be		noted will be brought to the a	ttention of		
	obtained from the	physician. NS #1 stated when		the Director of Nursing/Assist			
		ork on Monday 08/07/17 she		of Nursing/ Administrator/Ass			
	realized that no one clarified the dose with Administrator for proper disciplinary		•				
		ily so she asked Nurse #2 to		action. For any nurse who do			
	·	sident #1's family to verify what		complete the required in-serv	_		
		g at home. NS #1 stated that		he/she will not be allowed to			
		ed the family and gotten no		until the education is complet			
		message and when Resident		Education related to proper n	nedication		
	1	ed the call to the facility NS #1 oken to the family and obtained		administration record verification/transcribing media	cation from		
		lone that Resident #1 was on at		Discharge Summary will be in			
		ed that after she spoke to his		new hire orientation for newly			
		the on-call provider and		nurses. (Completion 8/28/17			
	obtained the order			11a1000: (00111p10a011 0/20/11	,		
				" The monitoring procedur	e to ensure		
	An interview was	conducted with the Physician on		that the plan of correction is			
		PM. The Physician confirmed		that specific deficiency cited			
	that he had review	ved and verified Resident #1's		corrected and/or in compliand			
	medications from	the discharge summary. The		regulatory requirements; The	title of the		
	Physician stated t	hat the Primidone dose needed		person responsible for impler	menting the		
	to be verified with	Resident #1 or his family when		acceptable plan of correction	. Dates when		
		d at the facility. The physician		corrective action will be comp			
		he nurse saw that there was no		corrective action dates must	be		
		done she should have		acceptable to the State.			
	_	acted the on-call provider. The		o Director of Nursing or RI	-		
	' '	hat he would not have stopped		will audit 35% of residents we	, ·		
		r Resident #1 and there were no		x one month to ensure new o			
		to Resident #1 except "the		complete with clarification the			
	annoying tremors.			residents weekly per unit x or			
	A telephone inten	riew was conducted with Nurse		then 10% of residents weekly one month. Results of audits	•		
		2:16 PM. Nurse #1 verified that		reviewed in clinical startup M			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		' '	(X3) DATE SURVEY COMPLETED		
		345096	B. WING _			C 08/17/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	DE	3671772317
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 281	08/04/17 and confirm administered the Printer because there was norder needed to be of #1 had not asked her family and stated that the order then it show being put on the MA had not contacted the she added that NS # clarification when shorders. A telephone interview #2 on 08/17/17 at 2: she was working on asked her to contact clarify the dosage the home. Nurse #2 state and got no answer becall to the facility NS got what she needed on-call physician and #2 confirmed that she Primidone to Reside facility. An interview was con Nursing (DON) on 00 stated that anytime a processed in the facorder that includes the complete then she e immediately contact clarification.	nicion nurse for Resident #1 on med that she had not midone to Resident #1 no dose on the MAR and the clarified. Nurse #1 stated NS or to clarify the order with the at "if there was no dosage on all have been clarified before R." Nurse #1 stated that she ee physician for clarification, it should have gotten the ee was transcribing the W was conducted with Nurse 35 PM. Nurse #2 stated that 08/07/17 when NS #1 had Resident #1's family and at Resident #1's family and at Resident #1 was taking at ed that she called the family ut when they returned the #1 spoke to the family and d and then contacted the d obtained the order. Nurse ee had not administered any int #1 during stay at the Inducted with the Director of 8/17/17 at 3:25 PM. The DON an order was received and ality it must be a complete ne dosage. If any order is not expected the staff to the medical provider for	F 2	through Friday and RN Design complete and review audits of and Sunday. o Director of Nursing will in Director/Nurse Practitioner will discrepancies. o Results of the monitoring shared with the Administrator of Nursing on a weekly basis QAPI monthly for a period of which time frequency of mondetermined by the QAPI Contempletion 9/1/17) o Facility will convert to an medical record in October 20 stops built in requiring the padate, name of the drug, dose frequency of administration, a instructions to be input prior to completing.	on Saturday notify Medical with any g will be r and Director and with 90 days at hitoring will be nmittee. n electronic 017 with hard attent's name, e, route, any special	
F 333 SS=D	483.45(f)(2) RESIDE SIGNIFICANT MED		F 3	33		9/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		345096	B. WING		0.5	C 3/17/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00	5/11/2017		
				12019 VERHOEFF DRIVE				
HUNTERS	VILLE OAKS			HUNTERSVILLE, NC 28078				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 333	Continued From page	e 10	F 30	33				
	483.45(f) Medication	Errors.						
	The facility must ensu	ure that its-						
	by: Based on record rev physician interview th a medication ordered	ree of any significant is not met as evidenced iew, family, staff, and ne facility failed to administer to treat tremors on 5 of 5 r 1 of 3 sampled residents		Preparation and/or execution or of Correction does not constitute admission or agreement by the the truth of the facts alleged or	е			
	(Resident #1.) This altered the resident's ability to feed himself. The findings included:			conclusions set forth in this state deficiencies. The Plan of Corre- prepared and/or executed solely it is required by the provisions o	ction is y because			
	Resident #1 admitted and discharged from Resident #1's diagno	I to the facility on 08/04/17 the facility on 08/09/17. ses included essential n data set (MDS) information		and State law. Based on record reviews, staff, physician interviews the facility tadminister a medication ordered tremors on 5 of 5 days of admis of 3 sampled residents (Resider	family and failed to d to treat sion for 1			
	hospital dated 08/04/ #1's discharge medic (medication used to dose at bedtime, dos summary had been re	e summary from a local 17 read in part that Resident cations included Primidone decrease tremors), daily e unknown. The discharge eviewed and initialed by can at the facility on 08/04/17.		This altered the resident's ability himself. F333 The plan of correcting the s deficiency. The plan should add processes that lead to the deficicited;	specific Iress the			
	(MAR) dated 08/04/1 the following: Primid strength 08/04/17). T on the MAR to indica	ation administration record 7 through 08/31/17 revealed one 1 tab at bedtime (clarify here were no initials in place te the medication had been dent #1 during his stay at the		o At the time of survey, Residuscharged from the facility to thon 8/9/17 and has not returned. "The procedure for impleme acceptable plan of correction for specific deficiency cited;	ne hospital			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							c
		345096	B. WING_			08/	17/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIINTEDS	VILLE OAKS			12	2019 VERHOEFF DRIVE		
HONTERS	VILLE OAKS			Н	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From page	e 11	F	333	o Licensed Nursing staff will receive		
		n order dated 08/07/17 read, midone 50 milligrams (mg) e.			education related to proper documentation of medication administration and the process of addressing omission of medication		
	family member stated	on 08/17/17 at 8:31 AM. The I that Resident #1 had a			administration related to incomplete orders/orders not clarified/medication navailable/documentation of	ot	
	home. The family men sure why but the Prim	t he took Primidone for at mber stated she was not nidone was never given in			refusals/accessing Pyxis and back up pharmacy to obtain medication and MD/NP notification. Education will inclu	de	
	the facility and Resident #1 had trouble feeding himself without the medication due to the tremors. The family member stated that she had visited the resident on 08/05/17 at the facility at				properly filling out the Pharmacy Medication Request Form and faxing the Pharmacy Medication Form Sheet alon with Face Sheet to Pharmacy. Licensee	g	
	approximately 10:30 a from breakfast all over	AM and he had food items or him. She added that or to feed himself even with			nurse will call pharmacy after hours to verify appropriate forms are received. Licensed Nurse to verify by signing		
		ng as he had the Primidone			Medication Request Form with another Licensed Nurse. Licensed Nurse will p faxed copy of Medication Request Forr	ut	
	An interview with Nur	sing Assistant (NA) #2 was			and Face Sheet along with transmissio form verifying time faxed copies sent in	n	
	that she worked on the	ne unit Resident #1 was on ssist him. NA #2 stated that			Clinical Supervisor box. Discrepancies noted will be brought to the attention of the Director of Nursing/Assistant Direct		
		some assistance with nakes." NA #2 stated that t did pick up his tray and at			of Nursing/Administrator/Assistant Administrator for proper disciplinary action. For any nurse who does not		
	times he "was messy	with his food."			complete the required in-service trainin he/she will not be allowed to work a shi	-	
	on 08/17/17 at 12:34 had cared for Resider	was conducted with NA #1 PM. NA #1 stated that she ht #1 on 08/05/17 and had			until the education is completed. Education related to proper documentation of medication		
	#1 was able to feed h	ast. She added that Resident imself but when she e tray she noticed "he did			administration and the process of addressing omission of medication administration related to incomplete		
		ood." NA #1 stated that she t1 hand tremors but she did			orders/orders not clarified/medication n available/documentation of	ot	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345096	B. WING		C 08/17/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/11/2011	
				12019 VERHOEFF DRIVE		
HUNTERS	VILLE OAKS			HUNTERSVILLE, NC 28078		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		ID	PROVIDER'S PLAN OF CORRECTIO		
PREFIX TAG			(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			
F 333	Continued From page 12		F 33	3		
	had not noticed them.			refusals/accessing Pyxis and back up pharmacy to obtain medication and)	
	A telephone interview was conducted with			MD/NP notification will be included in	new	
	Nursing Supervisor (NS) #1 on 08/17/17 at 1:05		hire orientation for newly hired nurse	3 .	
		at she was the nurse that		(Completion 9/3/17)		
	transcribed Resident #1's medications from the					
	discharge summary after the physician had			" The monitoring procedure to ens		
		ons on the facility's MAR.		that the plan of correction is effective		
	She stated she noticed that there was not a			that specific deficiency cited remains		
	strength next to the Primidone medication so she had asked Nurse #1 to ask Resident #1's family			corrected and/or in compliance with t regulatory requirements; The title of t		
	what dose he was taking so the order could be			person responsible for implementing		
	obtained from the physician. NS #1 stated when			acceptable plan of correction. Dates		
		on Monday 08/07/17 she		corrective action will be completed. T		
		clarified the dose with		corrective action dates must be		
	Resident #1's family	so she asked Nurse #2 to		acceptable to the State.		
	please contact Resid	ent #1's family to verify what		o Facility will convert to an electron	nic	
	dose he was taking a	t home. NS #1 stated that		medication administration record in		
		the family and gotten no		October 2017, which will change the		
		ssage and when Resident		process for the plan of correction		
	_	the call to the facility NS #1		described below. Auditing and monito	•	
	-	en to the family and obtained		will remain in place as outlined, adhe	ring	
		e that Resident #1 was on at		to the timeframe and guidelines. o Director of Nursing or RN Design		
		that after she spoke to his		will audit 35% of residents weekly pe		
	family she called the on-call provider and obtained the order for Primidone but for some			x one month to ensure proper	unit	
		the dose on the MAR.		documentation of medication		
	Todoon aid not place			administration and the process of		
	An interview was cor	nducted with the Physical		addressing omission of medication		
		TA) on 08/17/17 at 1:24 PM.		administration related to incomplete		
	The PTA stated that she had worked with			orders/orders not clarified/medication not		
	Resident #1 on 08/05	5/17 and had noticed his		available/documentation of		
	hand tremor. She sta			refusals/accessing Pyxis and back սլ)	
	consistent tremor, it	was "almost stress induced."		pharmacy to obtain medication and MD/NP notification then, 20% of residuals.	dents	
	An interview was cor	nducted with the Physician on		weekly per unit x one month then, 10		
	08/17/17 at 1:48 PM. The Physician confirmed			residents weekly per unit x one mont		
	that he had reviewed and verified Resident #1's			Results of audits will be reviewed in		
	medications from the discharge summary. The			clinical startup Monday through Friday and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345096	B. WING _			C 08/17/2017	
NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE OAKS				STREET ADDRESS, CITY, STATE, ZIP C 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 333	Physician stated that to be verified with F the resident arrived stated that when the dose for the Primide immediately contact further instructions. Would not have stop Resident #1 and the to Resident #1 and the to Resident #1 exce #1 on 08/17/17 at 2 she was the medica 08/04/17 and confir administered the Pribecause there was order needed to be "if there was no dos should have been of the MAR." Nurse #1 contacted the physical A telephone intervie #2 on 08/17/17 at 2 she was working or Supervisor (NS) #1 Resident #1's family Resident #1 was ta that she called the family then contacted the when they returned spoke to the family then contacted the the order. Nurse #2 administered any P during stay at the family there was a contacted the family then contacted the the order. Nurse #2 administered any P during stay at the family there was a contacted the family there was a contacted the family the family the family the family the family the family	at the Primidone dose needed Resident #1 or his family when at the facility. The physician enurse saw that there was no one she should have ted the on-call provider for. The physician added that he oped this medication for ere were no adverse reactions ept "the annoying tremors." Ew was conducted with Nurse #16 PM. Nurse #1 verified that ation nurse for Resident #1 on med that she had not rimidone to Resident #1 no dose on the MAR and the clarified. Nurse #1 stated that sage on the order then it clarified before being put on a stated that she had not cian for clarification. Ew was conducted with Nurse #35 PM. Nurse #2 stated that had asked her to contact by and clarify the dosage that king at home. Nurse #2 stated family and got no answer but the call to the facility NS #1 and got what she needed and on-call physician and obtained confirmed that she had not rimidone to Resident #1	F3	RN Designee will complete audits on Saturday and Su o Director of Nursing will Director/Nurse Practitioner medication omissions. o Pharmacy Consultant medication pass observation nurses per month x 90 day medications are administer and/or documented refusal o Results of the monitor shared with the Administration of Nursing on a weekly bas QAPI monthly for a period which time frequency of modetermined by the QAPI Completion 9/3/17)	Inday. Il notify Medical with to conduct on of 2 licensed is to ensure red as ordered ls. ing will be tor and Director sis and with of 90 days at onitoring will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345096	B. WING			C 08/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	V.0000		STREET ADDRESS, CITY, STATE, ZIP CODE	00	117/2017	
LIINTEDS	VILLE OAKS			12019 VERHOEFF DRIVE			
HUNTERS	VILLE OAKS		HUNTERSVILLE, NC 28078				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 333	acknowledged that th clarified or administer present in the facility. order was received at must be a complete of dosage. If any order wexpected the staff to imedical provider for or	e medication had not been red while Resident #1 was She stated that anytime an one of the processed in the facility it order that included the was not complete then she mmediately contact the	F	333			