PRINTED: 11/29/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |   | (X3) DATE SURVEY COMPLETED C                      |                            |
|---|---|--|--|---|---|---|----------------------------|
|   |   | 345096   | B. WING _                              |   | <del></del>   |   | )<br>02/2017               |
|   | ROVIDER OR SUPPLIER   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078 |   |   | -                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | (   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |   | (X5)<br>COMPLETION<br>DATE |
| F 282<br>SS=D   | CARE PLAN CFR(s): 483.21(b)(3  (b)(3) Comprehension The services provide as outlined by the comust-  (ii) Be provided by quaccordance with eact care. This REQUIREMENT by: Based on observation private duty sitter, Heractitioner interview implement care plant a palm guard as ord sampled (Resident #2 was ad 08/24/16 with diagnoratery disease, demigracture, depression hyperlipidemia.  Review of a Medical 09/02/16 read "paties guard to bilateral ha and can be removed.  Review of a care planted in the complex of the complex of the complex of the complex of the care planted in the care | ve Care Plans ed or arranged by the facility, comprehensive care plan,  ualified persons in the resident's written plan of  T is not met as evidenced  ons, record review, staff, ospice Nurse and Nurse evs, the facility failed to interventions by not applying ered for 1 of 3 residents \$\frac{1}{2}\$2).  d:  mitted to the facility on oses that included coronary entia, history of right hip of anemia, hypertension, and  Doctor (MD) order dated ent to wear bilateral palmar ends for skin protection daily | F2                                     | 882   | F282 The plan correcting the specific deficiency. The plan should address th processes that led to the deficiency cite During a complaint survey ending 11/2 it was identified that Resident #2's plar care was not being followed. The plan care for Resident #2 indicated that he should have a palm guard applied as ordered. The CNAs and nurses failed that apply the palm guard as ordered due to not checking the Resident Profile. When this was brought to the facility's attention the DON immediately reviewed the orders, educated the staff members whorked with Resident #2, made sure the Resident Profile was reviewed, and the palm guard applied as ordered. The DO audited the palm guard application on Resident #2 for 5 consecutive days to ensure compliance.  The procedure for implementing the acceptable POC for the specific deficiencited All residents with palm guards will be | ed /17, n of of o o o o o o o o o o o o o o o o o | 11/30/17                   |

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

11/27/2017

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** 

|               | DF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                    |
|---------------|-------------------------------|--|--|-----|--|-------------------------------|--------------------|
|               |                               |  |  | _   |  | (                             | c                  |
|               |                               | 345096   | B. WING                                |     |  | 11/                           | 02/2017            |
| NAME OF P     | ROVIDER OR SUPPLIER           |  | •                                      | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | ·                             |                    |
|               |                               |  |  | 12  | 2019 VERHOEFF DRIVE  |                               |                    |
| HUNTERS       | VILLE OAKS                    |  |  | Н   | IUNTERSVILLE, NC 28078   |                               |                    |
| (X4) ID       | SUMMARY ST                    | ATEMENT OF DEFICIENCIES                                    | ID                                     |     | PROVIDER'S PLAN OF CORRECTION  |                               | (X5)               |
| PREFIX<br>TAG | (EACH DEFICIENC               | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI<br>TAG                           | X   | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | COMPLETION<br>DATE |
| F 282         | Continued From page           | e 1  | F                                      | 282 |  |                               |                    |
|               |                               | nd have no complications.                                  |  | _0_ | identified and a visual inspection will be   | ,                             |                    |
|               | -                             | luded palm guards as                                       |  |     | performed to ensure order compliance.  |                               |                    |
|               |                               | ne daily and check skin for                                |  |     | Resident refusal or non-compliance wil   |                               |                    |
|               | signs of irritation/brea      |  |  |     | be documented. Date Certain: 11/30/1   |                               |                    |
|               |                               |  |  |     | Responsible Party: DON and MDS   |                               |                    |
|               | Review of the most re         | ecent quarterly minimum                                    |  |     | Coordinator  |                               |                    |
|               |                               | d 09/27/17 revealed that                                   |  |     | All nurses and nursing assistants will   |                               |                    |
|               |                               | erely cognitively impaired for                             |  |     | receive in-service education related to  | the                           |                    |
|               | daily decision making         | g and required total                                       |  |     | process for updating and reviewing the   |                               |                    |
|               |                               | staff members for ADL. No                                  |  |     | resident profile and care plan. Date   |                               |                    |
|               |                               | splinting assistance was                                   |  |     | Certain: 11/30/17. Responsible Party: F  | КN                            |                    |
|               | noted during the asse         | essment period.  |  |     | service line educator and RN facility educator.                                      |                               |                    |
|               | Observations of Resi          | dent #2 made on 11/01/17 at                                |  |     | The facility will establish a weekly   |                               |                    |
|               | 10:00 AM, 11/01/17 a          | at 11:00 AM and 11/01/17 at                                |  |     | interdisciplinary team risk meeting which  | :h                            |                    |
|               |                               | esident #2 was resting in bed                              |  |     | will include discussion of all residents v   | vith                          |                    |
|               | ·                             | Geri sleeves (protective                                   |  |     | palm guards. Date Certain: 11/21/17.   |                               |                    |
|               |                               | e to his bilateral hands/arms                              |  |     | Responsible Party: DON   |                               |                    |
|               |                               | were in place or were visible                              |  |     | The Informatics and Analytics Services   |                               |                    |
|               | in his room.                  |  |  |     | (IAS) team has formatted a report that   |                               |                    |
|               | An intension was son          | dusted with the private duty                               |  |     | can be run for the previous 24 hours to  |                               |                    |
|               |                               | iducted with the private duty                              |  |     | capture new orders. This report will be available and reviewed Monday – Frida        | 201                           |                    |
|               |                               | 4:30 PM. The private duty hired by Resident #2's           |  |     | during the scheduled interdisciplinary   | ıy,                           |                    |
|               |                               | provided care to him for the                               |  |     | team stand-up meeting, The care plan   | will                          |                    |
|               |                               | itter stated that Resident #2                              |  |     | then be updated with appropriate   |                               |                    |
|               |                               | s to both of his arms/hands                                |  |     | interventions to reflect the current resid   | lent                          |                    |
|               | _                             | s never seen him wear any                                  |  |     | status. Date Certain: 11/24/17.  |                               |                    |
|               |                               | lays that she worked with                                  |  |     | Responsible Party: DON   |                               |                    |
|               |                               | een them in his room. The                                  |  |     | The monitoring procedure to ensure the   | at                            |                    |
|               | sitter was observed to        | o begin to look for the palm                               |  |     | the POC is effective and that specific   |                               |                    |
|               | _                             | y opened a drawer under the                                |  |     | deficiency cited remains corrected and   | /or                           |                    |
|               |                               | ed out 2 palm guards and                                   |  |     | in compliance with the regulatory  |                               |                    |
|               |                               | ever seen Resident #2 with                                 |  |     | requirements   | _                             |                    |
|               | them in place.                |  |  |     | DON will conduct weekly 100% audit o   |                               |                    |
|               |                               |  |  |     | residents with palm guards for appropri  | ate                           |                    |
|               |                               | sident #2 was made on                                      |  |     | orders, care plan, up-to-date resident   |                               |                    |
|               |                               | 1. Resident #2 was resting in                              |  |     | profile, and use. Any identified issues  |                               |                    |
|               | bed with eyes closed          | . Geri sleeves were in place                               |  |     | will be corrected at that time. Results o  | T                             |                    |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ' '                 | PLE CONSTRUCTION  G  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---------------------|--|--|-------------------------------|--|
|                          |  | 345096   | B. WING             |  | C<br>11/02/2017  |                               |  |
|                          | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>12019 VERHOEFF DRIVE<br>HUNTERSVILLE, NC 28078  |  | 102/2017                      |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY   | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 282                    | to his bilateral hands were in place or were An interview was cor Assistant (NA) #1 on indicated she routine #2. She stated that R sleeves all during the any other devices incroom or been instruct to Resident #2. NA # to review information refer to the electronic information was loca.  An interview was cor 11/02/17 at 9:58 AM. routinely cared for Re Resident #2 wore ge each day and if he w boots but to her know devices. She stated sapplied palm guards been instructed to ap she needed to know she would generally if needed refer to the the electronic medica.  An interview was cor Practitioner (NP) on NP stated she was a assess a wound to Ra little contracted and his hand up for visual including family knew present which was de She stated she collail. | /arms and no palm guards e visible in the room.  Inducted with the Nursing 11/02/17 at 9:29 AM. NA #1 Ily provided care to Resident Resident #2 wore his geri e day but she had never seen cluding palm guards in his ted to apply any other device 1 added that if she needed on her residents she could medical record and that ted in the resident's profile.  Inducted with NA #2 on NA #2 stated that she resident #2. NA #2 stated that ri sleeves to his arms/hands as in bed he wore puffy wedge he had no other she had not ever seen or to Resident #2 and had not reply them. She added that if information on her residents ask the other NAs and could residents profile located in | F 28                | the monitoring will be shared Administrator and Director of weekly basis and with QAPI period of 90 days at which to of monitoring will be determ QAPI Committee. The DON responsibility for monitoring guards are applied per the oprovider orders. | of Nursing on a monthly for a me frequency ined by the has overall that all palm |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | I ' '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|---|---|-----|--|-------------------------------|----------------------------|--|
|  |  | 345096  | B. WING _                               |     |  |                               | 02/2017                    |  |
|  | ROVIDER OR SUPPLIER  |   |   | 120 | REET ADDRESS, CITY, STATE, ZIP CODE  19 VERHOEFF DRIVE  NTERSVILLE, NC 28078   | ,                             | <u> </u>                   |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                      | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |  |
| F 282  | the treatment choice looked like a laceratic could not make any presumptions. She sany orders for palm would be a good iderivation.  An interview was concern was evaluate the resident intervention.  An interview was concern was evaluated that she visite week. She stated that geri sleeves on both wear mediplex boots to elevate his heels. were no other device never seen him when including palm guard his room.  An interview was concern was every seen him when including palm guard his room.  An interview was concern was a brief synthesis of the electron there was a brief synthesis of the electron there was a brief synthesis was a brie | She stated the wound on but as to the cause she assumptions or stated she was not aware of guards but thought they a, stating Therapy could a for appropriateness of this adducted with the Hospice /17 at 10:31 AM. The HN d Resident #2 two times a at Resident #2 routinely wore of his arms/hands, would on his feet and had a wedge The HN stated that there as that were ordered and had a e any other devices, as, were on Resident #2 or in anducted with Nurse #2 on M. Nurse #2 stated that she esident #2 and the NAs had nic medical record where opsis of the care that each urse #2 stated that the NAs palm guards and gerinurses must check and applied correctly and to the skin. Nurse #2 stated in to assess Resident #2 this eyes were in place and the are but the palm guards were she would make sure they | F                                       | 282 |  |                               |                            |  |

| AND DLAN OF CORRECTION IDENTIFICATION NUMBER |  |   |                    |     | CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY                     |
|--|--|---|--------------------|-----|---|-------------------|----------------------------|
|  |  | 345096  | B. WING            |     |   | 1                 | C<br><b>02/2017</b>        |
|  | ROVIDER OR SUPPLIER  |   |                    | 12  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>2019 VERHOEFF DRIVE<br>IUNTERSVILLE, NC 28078                         |                   | OZ/ZOTI                    |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 282 F 309 SS=D                             | guards were in place There was a wedge by to his feet.  An interview was con Nursing (DON) on 11, stated that she had of few days and that the "Adult System Review staff to apply the order document those on the that could be accessed. She added that she ea and implement the ca as ordered by MD. PROVIDE CARE/SEF WELL BEING CFR(s): 483.24, 483.3  483.24 Quality of life guality of life is a fund applies to all care and residents. Each reside facility must provide the services to attain or in practicable physical, if well-being, consistent comprehensive assess  483.25 Quality of care Quality of care is a fund applies to all treatment facility residents. Bas assessment of a reside that residents receive accordance with profes | ri sleeves in place. No palm or were visible in his room. Netween his knees and boots ducted with the Director of 1/02/17 at 3:13 PM. The DON only been at the facility for a facility utilized a weekly of and she would expect the ered devices and then he "Adult System Review" and at any time by the nurses. Expected the staff to follow are plan for each residents and the he necessary care and haintain the highest mental, and psychosocial at with the resident's esment and plan of care. |                    | 309 |   |                   | 11/30/17                   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |  | COMPLETED   |                            |
|--|--|--|---------------------|--|---|----------------------------|
|  |  | 345096   | B. WING _           |  |   | C<br>11/02/2017            |
|  | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP COD 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078   | E   | 11/02/2017                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  | SHOULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 309  | (k) Pain Management The facility must ensprovided to resident consistent with profet the comprehensive and the residents' go (I) Dialysis. The fact residents who requires services, consistent of practice, the compared plan, and the repreferences. This REQUIREMENT by:  Based on observation private duty sitter, H. Practitioner interview the cause of a wound identified failed to apprehensive the services (Resident #2 was ad 08/24/16 with diagnoratery disease, demigracture, depression hyperlipidemia.  Review of the most data set (MDS) date Resident #2 was set daily decision making the sident making the services of the most data set (MDS) date Resident #2 was set daily decision making the sident making the sid | esidents' choices, including following:  Int. Bure that pain management is so who require such services, essional standards of practice, person-centered care plan, poals and preferences.  Illity must ensure that the dialysis receive such with professional standards prehensive person-centered esidents' goals and  This not met as evidenced ons, record review, staff, ospice Nurse, and Nurse with facility failed to identify did to the left hand and once poply the correct treatment to residents sampled for the test of the facility on oses that included coronary entia, history of right hip the profession, and recent quarterly minimum did 09/27/17 revealed that werely cognitively impaired for | F3                  | F309 Preparation and/or execution of Correction does not constit admission or agreement by the the truth of the facts alleged of conclusions set forth in this standificiencies. The Plan of Corprepared and/or executed solit is required by the provisions and State law.  The plan correcting the specific deficiency. The plan should approcesses that led to the defic During the survey ending 11/2 surveyor and wound treatment conducting treatment observations. When they arrive patient soom, the nurse resulted that already complication is sident #2 sident #2 sidens complications. | ute e provider of atement of rection is ely because of Federal fic ddress the ciency cited 2/17, a at nurse were tions for ed at the sponsible for eted |                            |

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|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                | ` ′                | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |          | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|-------------------------------|---|--------------------|--|--|----------|-------------------------------|--|
|                          |                               |   | 7 501251           | _                                      |  | ، ا      | c                             |  |
|                          |                               | 345096  | B. WING            |  |  |          | 02/2017                       |  |
| NAME OF P                | ROVIDER OR SUPPLIER           | 0.000   |                    | S                                      | TREET ADDRESS, CITY, STATE, ZIP CODE   | 11/      | 02/2017                       |  |
| TO AVIL OF TH            | to vibert of tool i eleft     |   |                    |  | 2019 VERHOEFF DRIVE  |          |                               |  |
| HUNTERS                  | VILLE OAKS                    |   |                    |  | IUNTERSVILLE, NC 28078   |          |                               |  |
|                          |                               |   |                    |  |  |          |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG | X                                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |          | (X5)<br>COMPLETION<br>DATE    |  |
| F 309                    | Continued From page           | e 6   | F;                 | 309                                    |  |          |                               |  |
|                          | · -                           | also indicated that Resident  |                    |  | nurse failed to verify the treatment orde  | are      |                               |  |
|                          | #2 had no speech an           |   |                    |  | for Resident #2 before applying wound  |          |                               |  |
|                          | bilateral upper and lo        |   |                    |  | treatments. Correct treatments were  |          |                               |  |
|                          |                               |   |                    |  | immediately applied by the wound   |          |                               |  |
|                          | Review of a Nurse Pr          | ractitioner (NP) visit note   |                    |  | treatment nurse. The Registered Nurse  | <b>;</b> |                               |  |
|                          | dated 10/27/17 read           | in part that Resident #2 was  |                    |  | who applied the wrong treatment during   | g        |                               |  |
|                          | seen at the request o         | f nursing staff who noted a   |                    |  | the survey was immediately provided v  | /ith     |                               |  |
|                          |                               | hand of unknown duration  |                    |  | re-education from the DON and receive  |          |                               |  |
|                          |                               | ed on the day of this visit.  |                    |  | written counseling. Re-education include   | led      |                               |  |
|                          |                               | d in the crease of his thumb  |                    |  | wound evaluation, reporting and  |          |                               |  |
|                          |                               | sing staff reported no obvious  |                    |  | documentation expectations, and  |          |                               |  |
|                          |                               | hand. Family at his bedside ed they were unsure of its                            |                    |  | importance of following provider orders related to wound treatments. Educatio                                |          |                               |  |
|                          |                               | s well. The impression and  |                    |  | provided to all nurses on verifying  | 11       |                               |  |
|                          |                               | Resident #2 was noted with  |                    |  | treatment orders prior to applying wour  | nd       |                               |  |
|                          |                               | n of skin at his left thumb   |                    |  | treatments.  |          |                               |  |
|                          | _                             | quite significant. The note   |                    |  |  |          |                               |  |
|                          |                               | as no indication or obvious   |                    |  | The procedure for implementing the   |          |                               |  |
|                          | local or systemic infe        | ction, the majority of the  |                    |  | acceptable POC for the specific deficie  | ncy      |                               |  |
|                          | tissue involved appea         | ared to be granulated, there  |                    |  | cited  |          |                               |  |
|                          |                               | age and it appeared as  |                    |  | All nurses will receive wound in-service   | ;        |                               |  |
|                          | •                             | t. The note documented a  |                    |  | education that includes: Prevention,   |          |                               |  |
|                          |                               | ledical Doctor (MD) and care  |                    |  | identification, reporting, documentation   | ,        |                               |  |
|                          | -                             | secondary healing of the  |                    |  | and treatments options. CNAs will receive in-service education related to                                    | 4l       |                               |  |
|                          | _ <del>-</del>                | n surgical/suturing at that   |                    |  |  | lile     |                               |  |
|                          | •                             | mented the cause of the to the cause and the note                                 |                    |  | identification of wounds found during routine care. Date Certain: 11/27/17.                                  |          |                               |  |
|                          | was signed by the NF          |   |                    |  | Responsible Party: RN Service line   |          |                               |  |
|                          | was signed by the M           | •   |                    |  | educator and RN facility educator  |          |                               |  |
|                          | Review of an MD ord           | er dated 10/27/17 read to   |                    |  | Head-to-toe skin assessments complete  | ed       |                               |  |
|                          | clean the resident's le       |   |                    |  | by a Registered Nurse for all residents  |          |                               |  |
|                          | antiseptic and apply v        | wet gauze packing daily.  |                    |  | ensure all wounds identified and wound   |          |                               |  |
|                          |                               |   |                    |  | orders are appropriate. Date Certain:  |          |                               |  |
|                          |                               | sident #2 was made on   |                    |  | 11/30/17. Responsible Party: DON   |          |                               |  |
|                          |                               | I with concurrent interview of  |                    |  | The facility will establish a weekly risk  |          |                               |  |
|                          | ,                             | irse (WN). Nurse #1 was   |                    |  | meeting to be conducted by the   |          |                               |  |
|                          |                               | the WN upon entering  |                    |  | interdisciplinary team, and any other  |          |                               |  |
|                          | Resident #2's room tl         | -   |                    |  | members that the Administrator or  | 4:       |                               |  |
|                          | completed Resident #          | #2's dressing change to his   | 1                  | - 1                                    | Director of Nursing include as consulta  | uve      | 1                             |  |

Facility ID: 923277

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| CENTER                   | S FOR MEDICARE &   | MEDICAID SERVICES  |                    |     |  | OMR M                                   | <i>).</i> 0938-0391        |
|--------------------------|--|--|--------------------|-----|--|---|----------------------------|
|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | I ` ′              |     | CONSTRUCTION   |   | PLETED                     |
|                          |  | 345096   | B. WING            |     |  |   | C<br><b>02/2017</b>        |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | •                  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |                            |
|                          |  |  |                    | 12  | 2019 VERHOEFF DRIVE  |   |                            |
| HUNTERS                  | SVILLE OAKS  |  |                    | Н   | IUNTERSVILLE, NC 28078   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
| F 309                    | Continued From page left hand because he it had gotten wet, so a completed the dressil entered Resident #2's on his right side and glove) to each lower a noted to loop over the the first finger and that to the elbow. The WI on Resident #2's left dressing that Nurse # shower. As the WN r dressing that was bet finger came off. The 11/01/17 and was a distating she would red correct treatment of sordered. The WN coordered, applied a nedated 11/01/17 and releft hand. After the cothe WN was observed and inform Nurse #1 to the area was and to treatment. The WN in that the geri sleeve he Resident #2's left hard to the MD. The right removed and the hand area between the firs | had gone to the shower and she just went ahead and ing change. When the WN is room he was resting in bed had a geri sleeve (protective arm. The geri sleeve was enthumb and rest between lumb and then extended up in it is in the later of la |                    | 309 |  | o This o d at l/or less of rith all eat |                            |
|                          | 11/01/17 at 1:50 PM.<br>area to Resident #2's<br>the private duty sitter<br>The WN stated that w<br>wound the NP was al  | ducted with the WN on The WN stated initially the left hand was discovered by and reported to the staff. when she went to assess the ready in the room. She ally wanted the area stitched  |                    |     |  |   |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |                             | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|---|---|---|--|-----------------------------|-------------------------------|--|--|
|                          |   | 345096  | B. WING                                 |  |                             | C<br>1 <b>1/02/2017</b>       |  |  |
|                          | ROVIDER OR SUPPLIER   | 1   |   | STREET ADDRESS, CITY, STATE, ZIP COL<br>12019 VERHOEFF DRIVE<br>HUNTERSVILLE, NC 28078     |                             | 1102/2017                     |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>EAPPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |  |
| F 309                    | how long the wound agreed to allow the f WN confirmed that s what the correct treath and was then proce treatment to the wou private duty sitter habathed him on 10/20 present. She added the geri sleeves ever facility since May 20 An interview was condirector of Nursing (APM. The ADON indinotified of the wound NP was already in the when she went to as the end of first shift and who stated that the previous day. The wound was discover the treatment orderedecided to leave the because of Resident as he now had the position that no investigation the cause.  An interview was consister on 11/01/17 at she was hired by Reensure he ate, was consortable. The word was comfortable. | e was no determination as to had been present, family acility to treat the area. The he had informed Nurse #1 tment to Resident #2's left edded to apply the correct nd. The WN added that the d told her that when she /17 the wound was not that Resident #2 had worn r since she had worked at the | F 3(                                    | 09   |                             |                               |  |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '              | MULTIPLE CONSTRUCTION UILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--------------------|-------------------------------|--|--|-------------------------------|--|
|                          |  | 345096  | B. WING            |                               |  |  | 02/2017                       |  |
|                          | ROVIDER OR SUPPLIER  |   | ·                  | 12                            | TREET ADDRESS, CITY, STATE, ZIP CODE<br>2019 VERHOEFF DRIVE<br>UNTERSVILLE, NC 28078                                 |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE    |  |
| F 309                    | finger and thumb and on 10/27/17 when she the area was open at The sitter stated that facility to care for Reshave on the geri slees see the staff remove were on all the time. Resident #2 was conhim down by talking twould relax his hand full wound, but if he word difficult to see the An interview was consisted as if the skin I geri sleeve rested be thumb. She stated the 10.2 centimeters (cm) odor and no signs of that she completed the on Resident #2 week clothes around to vis routinely removing the assessment to visual stated that she had dressing to his left has shower and the old distated she applied the dressing, but would here sing, but would here sing, but would here sing, but would here sing to his left has shower and the old distated she applied the dressing, but would here sing, but would here sing, but would here sing to his left has shower and the old distated she applied the dressing, but would here. | ea between his left first I the skin was intact and then e returned she discovered nd reported it to Nurse #1. when she arrived at the sident #2 he would already ves and it was very rare to or apply them because they The sitter further stated that tracted and she had to calm to him, at which point he and she was able to see the vas tightly contracted it was | F                  | 309                           |  |  |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | PLE CONSTRUCTION  G | ' '   | (X3) DATE SURVEY COMPLETED |                            |  |
|---|--|---|---------------------|---|----------------------------|----------------------------|--|
|   |  | 345096  | B. WING             |   |                            | C<br><b>11/02/2017</b>     |  |
|   | ROVIDER OR SUPPLIER                        |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078               |                            | 11/02/2017                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN                             | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |  |
| F 309   |  | ge 10<br>rder dated 11/02/17 directed<br>ere to be worn at all times and                      | F 30                | 09  |                            |                            |  |
|   |  | or daily skin checks during   |                     |   |                            |                            |  |
|   | 11/02/17 at 9:29 AM routinely cared for F  | onducted with NA #1 on<br>1. NA #1 stated that she<br>Resident #2. She stated that            |                     |   |                            |                            |  |
|   | Wednesday and Fri care and that on the     | ns at the facility on Monday,<br>day and they provided his<br>nose days hospice staff were    |                     |   |                            |                            |  |
|   | added that the priva                       | e provided the care. NA #1  ate duty sitters were also time to assist with feeding            |                     |   |                            |                            |  |
|   | NA #1 added that R                         | panionship to Resident #2.<br>esident #2 wore his geri<br>ne day and she would remove         |                     |   |                            |                            |  |
|   | stated that she had                        | nd then reapply them. NA #1<br>last visualized the area<br>t2's left first finger and thumb   |                     |   |                            |                            |  |
|   | staff would have pro                       | e skin was intact, then hospice ovided the care to him on /17. She stated on 10/27/17         |                     |   |                            |                            |  |
|   |  | open area to his left hand and  |                     |   |                            |                            |  |
|   | Practitioner (NP) on                       | onducted with the Nurse<br>11/02/17 at 10:21 AM. The  |                     |   |                            |                            |  |
|   | wound to Resident                          | asked by the WN to assess a<br>#2's hand which was a little<br>uired a nurse to open his hand |                     |   |                            |                            |  |
|   | up for visualization. family knew how lor  | She stated no one including ng the wound was present  |                     |   |                            |                            |  |
|   | stated she collabora<br>and decided second | d not very granulated. She ated with the Medical Doctor dary healing would be the             |                     |   |                            |                            |  |
|   | like a laceration but                      | She stated the wound looked as to the cause she could not ons or presumptions.                |                     |   |                            |                            |  |

| ' '                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | · I · · ·           |  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---------------------|--|--------------------------------|-------------------------------|--|
|                          |   | 345096   | B. WING             |  |                                | C<br><b>I1/02/2017</b>        |  |
|                          | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078        |                                |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 309                    | Nurse (HN) on 11/02 stated that she visited and the NAs visited had Monday, Wednesday on Monday and Frida full bed bath and on Nesident #2 to the shad the NAs were trained and if they noticed ar unusual they were to and she would follow actually applied Resi Tuesday 10/24/17 ar not see any wound to was difficult to assess contracture.  An interview was con Nursing (DON) on 11 DON stated that she since Monday 10/30/a comprehensive wo The DON stated she checks to be done we sometime during the removed and the skir reported. The DON stated that she staff to follow woo ordered. The DON stated that she removed and the skir reported. The DON stated that she checks to be done we sometime during the removed and the skir reported. The DON stated that she could not fin sleeves and therefore had been in place. States | aducted with the Hospice (17 at 10:31 AM. The HN digneral Resident #2 twice a week him 3 times a week on and Friday. She added that ay the NAs provide him with a Wednesdays they took hower. The HN stated that it to look at the resident's skin hy changes or anything report that directly to her up. She added that she had dent #2's geri sleeves on and Thursday 10/26/17 and did to his left hand, but stated it is his skin due to his his skin due to his his skin due to his his early wanted to build and program at the facility. Would expect for skin eekly as ordered, then day the geri sleeves to be in inspected and any changes further stated she expected and orders exactly as tated that she had been desident #2's medical record dan order for the geri e had no idea how long they she added that she had he geri sleeves on 11/02/17 | F 30                | 09   |                                |                               |  |

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|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′     |   | CONSTRUCTION                         | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|--|--|---------|---|--------------------------------------|-------------------|----------------------------|
|                          |  | 345096   | B. WING |   |                                      | l                 | -C<br><b>02/2017</b>       |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  |         | S   | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 11/             | 02/2017                    |
| HUNTERS                  | VILLE OAKS   |  |         | 12  | 2019 VERHOEFF DRIVE                  |                   |                            |
|                          | 71122 07110  |  |         | Н   | UNTERSVILLE, NC 28078                |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | I       | ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY) |                                      |                   | (X5)<br>COMPLETION<br>DATE |
| {F 225}<br>SS=D          | (i) Have been found gexploitation, misappromistreatment by a counciliation, mistreatments aide registry control exploitation, mistreatments appropriation of the control of | MIDUALS (4)(c)(1)-(4)  must- erwise engage individuals  guilty of abuse, neglect, or priation of property, or ourt of law;  gentered into the State oncerning abuse, neglect, ment of residents or neir property; or  y action in effect against his ense by a state licensure finding of abuse, neglect, ment of residents or esident property.  e nurse aide registry or any knowledge it has of aw against an employee, unfitness for service as a cility staff.  egations of abuse, neglect, atment, the facility must:  egged violations involving itation or mistreatment, nknown source and | {F 2    | 225}  | DEFICIENCY)                          |                   | 11/30/17                   |
|                          | after the allegation is  | made, if the events that nvolve abuse or result in   |         |   |                                      |                   |                            |
| APORATORY                |  | SUPPLIER REPRESENTATIVE'S SIGNATUR   | DE      |   | TITI F                               |                   | (X6) DATE                  |

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

11/27/2017

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.

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

**Electronically Signed** 

|                          | OF DEFICIENCIES  CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | PLE CONSTRUCTION  | (X3) DATE SURVEY COMPLETED         |
|--------------------------|--|---|---------------------|---|------------------------------------|
|                          |  | 345096  | B. WING             |   | R-C<br><b>11/02/2017</b>           |
|                          | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  12019 VERHOEFF DRIVE  HUNTERSVILLE, NC 28078   | 11/02/2017                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)  | BE COMPLETION                      |
| {F 225}                  | the events that cause abuse and do not rest the administrator of to officials (including to adult protective servifor jurisdiction in long accordance with State procedures.  (2) Have evidence the thoroughly investigated (3) Prevent further procedures (4) Report the results administrator or his correpresentative and to with State law, including Agency, within 5 wor if the alleged violation corrective action must his REQUIREMENT by:  Based on staff intervifacility failed to notify within the required 2 frame for an allegation resident property and Survey Agency within time frame of the investigation of the invest | or not later than 24 hours if a the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ces where state law provides green care facilities) in the law through established at all alleged violations are ed.  Otential abuse, neglect, the atment while the or her designated to other officials in accordance ling to the State Survey king days of the incident, and the is verified appropriate at be taken.  This not met as evidenced wiews and record reviews the other state Survey Agency 4 hour initial report time on of misappropriation of a failed to report to the State of the required 5 working day the estigation of an allegation of esident property for 1 of 1 desident #4). | {F 22               | F225 The plan correcting the specific deficiency. The plan should address processes that led to the deficiency on 10/23/17, Resident #4 reported to facility staff that he had money missing grievance report for the missing mon was filed, however, the administrator the time did not think the incident should be reported using the appropriate 24 and 5-working day reports to the Staff Agency. Instead, the administrator must be determination that this was a | cited o the ng. A ey at ould chour |

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|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | LE CONSTRUCTION  |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|--|---|-------------------------------|--|
|                          |  |   |                     |  |   | R-C                           |  |
|                          |  | 345096  | B. WING             |  | 1   | 1/02/2017                     |  |
| NAME OF PI               | ROVIDER OR SUPPLIER  | •   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |                               |  |
|                          |  |   |                     | 12019 VERHOEFF DRIVE   |   |                               |  |
| HUNTERS                  | VILLE OAKS   |   |                     | HUNTERSVILLE, NC 28078   |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COP<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | SHOULD BE   | (X5)<br>COMPLETION<br>DATE    |  |
| {F 225}                  | Continued From page  | e 2   | {F 225              | 5}   |   |                               |  |
|                          |  | DS) dated 10/17/17  nt #4 was cognitively intact assistance with activities of  |                     | grievance and did not constitu reportable event. The adminis time of this incident is no longer at the facility.   | trator at the   |                               |  |
|                          | 10/23/17 read in part he was missing \$389 located in his night staken to investigate r looked all over reside sheets, under the benot locate the money that Resident #4 was verified that he was go to the facility. Summ in part that on 10/23/lock box to keep the maintenance request the night stand drawer.  | that Resident #4 on that Resident #4 reported 1.00 out of his wallet that was tand drawer. The steps ead in part that facility staff ent's room including the bed d and in drawers and could 1. Staff called the hospital of discharged from and given \$445.00 upon transfer ary of pertinent findings read 17 Resident #4 was given a remaining \$56.00 in and a 1.5 was made to get the key to be so Resident #4 could keep as signed by Social Worker |                     | The interim administrator instruction DON to complete the 24-hour 5-working day reports and to a investigative materials to the a State Agency. Determining who constitutes as a concern, griever reportable event has been included education for all staff. The facility department heads have been bring all concerns to the mornimeeting and the IDT can make recommendations as to wheth incident needs to be reported Agency, however, the Administration DON will be responsible for reallegations of abuse, neglect, misappropriation, and exploitations.  | and attach the appropriate at vance, or a luded in illity s instructed to ing stand-up e er an to the State strator and porting all |                               |  |
|                          | in part that Resident came into the facility his wallet and as of 1 left. The resident fur have the night stand because he did not he A brief interview was Administrator on 11/0 stated that the facility hour/5 working day read that the facility has the facility has been described as the facility has the facil | conducted with the 01/17 at 10:00 AM who what had not submitted any 24 eports since 10/23/17.   |                     | The procedure for implementing acceptable POC for the specific cited. All active grievances within the 90 days as of 11/15/17 will be action will be taken to close all to the satisfaction of the resided Grievances opened after date follow new grievance process Certain: 11/15/17. Responsible Consulting Administrator. A Resident Council Meeting we ducate the residents on the figrievance process. Date Certain Responsible Person: Consulting Responsible Person: Cons | ng the ic deficiency e previous reviewed, I grievances ent. certain will flow. Date e Person: as held to acility□s ain 11/15/17.    |                               |  |

Facility ID: 923277

PRINTED: 11/29/2017 FORM APPROVED

| CENTERS FOR MEDICARE & MEDICAID SERVICES |                               |  |                       |            | OMB NO  | <u> </u> |                            |
|--|-------------------------------|--|-----------------------|------------|---|----------|----------------------------|
|  | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                             | (X2) MUL<br>A. BUILDI |            | CONSTRUCTION  | ` '/     | E SURVEY<br>PLETED         |
|  |                               | 345096   | B. WING               |            |   | 1        | R-C<br>/ <b>02/2017</b>    |
| NAME OF P                                | ROVIDER OR SUPPLIER           |  |                       | S          | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1        | 102/2017                   |
| NAME OF T                                | NOVIDER OR GOLT EIER          |  |                       |            | 2019 VERHOEFF DRIVE   |          |                            |
| HUNTERS                                  | VILLE OAKS                    |  |                       |            | IUNTERSVILLE, NC 28078  |          |                            |
|  |                               |  |                       | <u>'</u> ' | T TOWN TERS VILLE, NO. 20070  |          |                            |
| (X4) ID<br>PREFIX<br>TAG                 | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG    |            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |          | (X5)<br>COMPLETION<br>DATE |
| {F 225}                                  | Continued From page           | e 3  | {F 2                  | 225}       |   |          |                            |
| ()                                       |                               | ould not walk to the bus   | 2 ا                   |            | Administrator   |          |                            |
|  | _                             | agent at his complex had   |                       |            | All current interviewable residents as o  | √f.      |                            |
|  | _                             | to take him to the hospital.   |                       |            | 11/16/17 were interviewed to identify a   |          |                            |
|  |                               | at when the taxi came to   |                       |            | additional outstanding grievance issue  | •        |                            |
|  |                               | the driver to take him to an   |                       |            | that need further investigation. Date   | 3        |                            |
|  |                               | hine (ATM) to withdraw   |                       |            | Certain: 11/16/17. Responsible Persor   | ١٠       |                            |
|  |                               | e he had no idea when or if  |                       |            | Consulting Administrator  |          |                            |
|  | _                             | to his apartment. Resident   |                       |            | All-staff will participate in   |          |                            |
|  |                               | v \$500.00 which was enough  |                       |            | education/training to include policies,   |          |                            |
|  |                               | and to have some extra   |                       |            | procedures, and appropriate handling  | of       |                            |
|  |                               | when he arrived at the   |                       |            | grievances, concerns, questions, or   |          |                            |
|  | hospital he paid the d        | river \$55.00, the hospital  |                       |            | service opportunities to include definiti   | ons      |                            |
|  |                               | ing \$445.00 and before he   |                       |            | and access locations for resources. T   |          |                            |
|  | •                             | e facility the money was   |                       |            | education will also include training on   |          |                            |
|  | returned. He added th         | nat when he arrived at the   |                       |            | policies, procedures, and appropriate   |          |                            |
|  | facility he counted the       | e money and had \$445.00.  |                       |            | reporting of  |          |                            |
|  | After counting the mo         | ney Resident #4 stated he  |                       |            | abuse-neglect-misappropriation  |          |                            |
|  | wrote the amount on           | a small piece of paper,  |                       |            | allegations with a concentration on   |          |                            |
|  |                               | ey which was mostly \$20.00  |                       |            | misappropriation of funds. Any staff  |          |                            |
|  | •                             | ill fold in the night stand  |                       |            | members who do not receive the traini   | -        |                            |
|  |                               | k on it but no key was in the  |                       |            | by the specified date (due to FMLA, le  |          |                            |
|  |                               | on 10/22/17 he wanted to   |                       |            | etc.) will be required to completed train   | -        |                            |
|  | , ,                           | get a few items so he took   |                       |            | prior to working a scheduled shift. Date  |          |                            |
|  |                               | inted his money and there  |                       |            | Certain: 11/30/17. Responsible Persor   |          |                            |
|  |                               | mostly the \$20.00 bills but   |                       |            | RN Facility Educator and RN Service I   | ₋ine     |                            |
|  |                               | e piece of paper folded in   |                       |            | Educator The new DON and interim administrate   | or.      |                            |
|  | · ·                           | look like it had not been  |                       |            | The new DON and interim administrate  |          |                            |
|  |                               | 4 stated he reported it to the   |                       |            | have reviewed the facility policies on the  |          |                            |
|  |                               | e could do was report it and the room. He added that he                        |                       |            | expectations of reporting allegations of misappropriation. Date Certain: 11/17/                             |          |                            |
|  |                               | ssumed this place was safe   |                       |            | Responsible Person: Administrator and   |          |                            |
|  |                               | stand. Resident #4 stated  |                       |            | DON   | J        |                            |
|  |                               | W that there was no key to   |                       |            | The monitoring procedure to ensure the  | at       |                            |
|  | -                             | rawer. The SW provided a   |                       |            | the POC is effective and that specific  | ut       |                            |
|  | _                             | #4 and maintenance placed  |                       |            | deficiency cited remains corrected and  | l/or     |                            |
|  |                               | to the night stand. Resident   |                       |            | in compliance with the regulatory   | <b></b>  |                            |
|  | -                             | ne admitted to the facility no   |                       |            | requirements  |          |                            |
|  |                               | s belongings up and he   |                       |            | Consulting Administrator is responsible   | e for    |                            |
|  |                               | ate in the day and really did  |                       |            | the overall implementation of this plan   |          |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                    | , ,                 | LE CONSTRUCTION   | · /  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---------------------|---|--|-------------------------------|--|
|  |  |   | 71. BOILBING        |   |  | R-C                           |  |
|  |  | 345096  | B. WING             |   |  | 1/02/2017                     |  |
| NAME OF PROVIDER   | OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP COD  |  |                               |  |
| LUINTEDOVULLE (  | AKO  |   |                     | 12019 VERHOEFF DRIVE  |  |                               |  |
| HUNTERSVILLE C   | JAKS   |   |                     | HUNTERSVILLE, NC 28078  |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | SHOULD BE  | (X5)<br>COMPLETION<br>DATE    |  |
|  | Continued From page 4  |   | {F 225              | •   |  |                               |  |
| An interval and the state of th | e anyone until erview was con istrator on 11/0 istrator stated ing allegations int property to the property to the property to the added that each #4 even had each #4 even had a drawer at as provided to that if the facil int had valuable up, but it was nounts to lock up the facility for a f |   |                     | correction. Consulting Admini monitor 100% of grievances f compliance daily. Any identification be corrected at that time. Resident monitoring will be shared with Administrator and Director of weekly basis and with QAPI report QAPI committee will only condiscontinuing monitoring if susurveys through the annual resurvey results in no repeat cit | or ed issues will sults of the the nursing on a nonthly. sider bsequent ecertification |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|--|------------------------------|-------------------------------|--|
|   |  | 345096   | B. WING             |  |                              | R-C                           |  |
|   | ROVIDER OR SUPPLIER  | 34000  |                     | STREET ADDRESS, CITY, STATE, ZIP COE  12019 VERHOEFF DRIVE  HUNTERSVILLE, NC 28078         |                              | 11/02/2017                    |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| {F 225}   | later that day and stated the also stated that had the money when #2 stated that Reside out of the ATM on the had called the hospit locked up \$446.00 at upon discharge to the had given him a lock maintenance had repakey to the night stated swap was mission.  An interview was cor 11/02/17 at 11:59 AM Resident #4 had con and stated he was mission when he left the hospine did not have that stated she asked "an it?" and he replied the vending machine a containing swap was missing. SW #1 stated the staff do an in initiated a grievance, she went to Resident there was no key to the stand so she had man he could lock the renewould go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the stated that when the would go to the Admi Nursing (DON) and it was the stated that when the stated the stated that when the stated that when the stated that when the stated that | #4 had stopped by her office ted he had \$389.00 missing. e had not told anyone that he he came to the facility. SW ent #4 had gotten the money e way to the hospital and she al and confirmed that he had had was given the money e facility. She added that she box to use and then when blaced the lock and given him nd,he returned the lock box. e police were not notified that ing. | {F 22               | 25}  |                              |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |      | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                     |
|--------------------------|--|---|-------------------|------|--|-------------------|----------------------------|
|                          |  |   | 71. 50125         | _    |  | R                 | -C                         |
|                          |  | 345096  | B. WING           |      |  | 11/               | 02/2017                    |
|                          | ROVIDER OR SUPPLIER  |   |                   | 1:   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>2019 VERHOEFF DRIVE<br>IUNTERSVILLE, NC 28078                                  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)                                 | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| {F 225}                  | Continued From page  | e 6   | {F 2              | 225} |  |                   |                            |
| F 226<br>SS=D            | PM was unsuccessful  | T ABUSE/NEGLECT, ETC  | F                 | 226  |  |                   | 11/30/17                   |
|                          | 483.12<br>(b) The facility must d<br>written policies and pr | levelop and implement rocedures that:   |                   |      |  |                   |                            |
|                          |  | ent abuse, neglect, and nts and misappropriation of   |                   |      |  |                   |                            |
|                          | (2) Establish policies investigate any such a                |   |                   |      |  |                   |                            |
|                          | (3) Include training as §483.95,                             | required at paragraph   |                   |      |  |                   |                            |
|                          | the freedom from aburequirements in § 483                    | nd exploitation. In addition to use, neglect, and exploitation 3.12, facilities must also hir staff that at a minimum |                   |      |  |                   |                            |
|                          |  | onstitute abuse, neglect, appropriation of resident § 483.12.   |                   |      |  |                   |                            |
|                          |  | reporting incidents of abuse, or the misappropriation of  |                   |      |  |                   |                            |
|                          | (c)(3) Dementia mana<br>prevention.                          | agement and resident abuse  |                   |      |  |                   |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:             | 1 ` ′                         | (X2) MULTIPLE CONSTRUCTION A. BUILDING                      |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|---|------------------------|--|-------------------------------|---|------------------------------|-------------------------------|--|
|   |                        | 345096   | B. WING _                     |   |                              | R-C<br><b>11/02/2017</b>      |  |
| NAME OF P   | ROVIDER OR SUPPLIER    |  |                               | STREET ADDRESS, CITY, STATE, ZIP COI                        |                              | 11/02/2017                    |  |
|   |                        |  |                               | 12019 VERHOEFF DRIVE  |                              |                               |  |
| HUNTERS   | SVILLE OAKS            |  |                               | HUNTERSVILLE, NC 28078                                      |                              |                               |  |
| (X4) ID   | SUMMARY S              | STATEMENT OF DEFICIENCIES                                      | ID                            | PROVIDER'S PLAN OF CO                                       | (X5)                         |                               |  |
| PREFIX<br>TAG   | ,                      | ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG                 |   | N SHOULD BE<br>E APPROPRIATE | COMPLETION DATE               |  |
| F 226   | Continued From page    | ge 7   | F 2                           | 26  |                              |                               |  |
|   | This REQUIREMEN        | NT is not met as evidenced                                     |                               |   |                              |                               |  |
|   | by:                    |  |                               |   |                              |                               |  |
|   | Based on record re     | eview, resident, and staff                                     |                               | F226  |                              |                               |  |
|   | interviews the facilit | y failed to follow its "Abuse,                                 |                               | The plan correcting the spec                                | ific                         |                               |  |
|   |                        | n, or Mistreatment, including                                  |                               | deficiency. The plan should a                               |                              |                               |  |
|   | _                      | source, and Misappropriation                                   |                               | processes that led to the def                               | •                            |                               |  |
|   |                        | y" policy by failing to notify the                             |                               | On 10/23/17, Resident #4 re                                 |                              |                               |  |
|   |                        | es of an allegation of   |                               | facility staff that he had mone                             |                              |                               |  |
| misappropriation of resident property for 1 of 1 residents sampled (Resident #4). |                        |  | grievance report for the miss | •   |                              |                               |  |
|   | residents sampled (    | Resident #4).  |                               | was filed, however, the admi                                |                              |                               |  |
|   | The Findings Includ    | led:   |                               | be reported using the approp                                |                              |                               |  |
|   | The findings includ    | eu.  |                               | and 5-working day reports to                                |                              |                               |  |
|   | Review of a facility   | policy titled Prohibit and                                     |                               | Agency. Instead, the adminis                                |                              |                               |  |
|   |                        | of Resident Abuse, Neglect,                                    |                               | the determination that this wa                              |                              |                               |  |
|   |                        | treatment, including Injuries of                               |                               | grievance and did not constit                               |                              |                               |  |
|   | 1                      | and Misappropriation of  |                               | reportable event. The admini                                |                              |                               |  |
|   | Resident Property,     | dated as issued on 02/09 and                                   |                               | time of this incident is no lon-                            | ger employed                 |                               |  |
|   | most recently updat    | ted 11/16, read in part "the                                   |                               | at the facility.  |                              |                               |  |
|   | -                      | ovide to the person in charge                                  |                               |   |                              |                               |  |
|   |                        | a completed copy of the 24                                     |                               | The interim administrator ins                               |                              |                               |  |
|   | I -                    | rom and any supporting   |                               | DON to complete the 24-hou                                  |                              |                               |  |
|   |                        | to the alleged incident." The                                  |                               | 5-working day reports and to                                |                              |                               |  |
|   | 1 -                    | l "the investigator will give a                                |                               | investigative materials to the                              |                              |                               |  |
|   |                        | ed 5 Working Day Report  |                               | State Agency. Determining w                                 |                              |                               |  |
|   |                        | trator with 5 working days of<br>nt." The policy also directed |                               | constitutes as a concern, grie reportable event has been in |                              |                               |  |
|   | 1                      | stigation reveal that  |                               | education for all staff. The fa                             |                              |                               |  |
|   |                        | theft/misappropriation of                                      |                               | department heads have been                                  | -                            |                               |  |
|   | 1                      | ccurred, the Administrator or                                  |                               | bring all concerns to the mor                               |                              |                               |  |
|   | 1                      | ort such findings to the                                       |                               | meeting and the IDT can ma                                  |                              |                               |  |
|   |                        | tative and appropriate   |                               | recommendations as to when                                  |                              |                               |  |
|   | agencies.              |  |                               | incident needs to be reported                               | d to the State               |                               |  |
|   |                        |  |                               | Agency, however, the Admin                                  | istrator and                 |                               |  |
|   | Review of the admis    | ssion comprehensive  |                               | DON will be responsible for r                               | reporting all                |                               |  |
|   |                        | MDS) dated 10/17/17  |                               | allegations of abuse, neglect                               |                              |                               |  |
|   |                        | ent #4 was cognitively intact                                  |                               | misappropriation, and exploi                                |                              |                               |  |
|   |                        | assistance with activities of                                  |                               | 24-hour and 5-working day re                                | eports.                      |                               |  |
|   | daily living.          |  |                               |   |                              |                               |  |

PRINTED: 11/29/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:              | ' '           | IPLE CONSTRUCTION   | , ,               | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---------------------|---|---------------|---|-------------------|-------------------------------|--|
|   |                     |   |               |   |                   | R-C                           |  |
|   |                     | 345096  | B. WING _     |   | 11                | /02/2017                      |  |
| NAME OF P   | ROVIDER OR SUPPLIER |   |               | STREET ADDRESS, CITY, STATE, ZIP C                        | ODE               |                               |  |
|   |                     |   |               | 12019 VERHOEFF DRIVE                                      |                   |                               |  |
| HUNTERS   | SVILLE OAKS         |   |               | HUNTERSVILLE, NC 28078                                    |                   |                               |  |
| (X4) ID   | SUMMARY             | Y STATEMENT OF DEFICIENCIES                                     | ID            | PROVIDER'S PLAN OF  | CORRECTION        | (X5)                          |  |
| PRÉFIX<br>TAG                                       | ,                   | ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG | ( (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO DEFICIENCE  | THE APPROPRIATE   | COMPLETION<br>DATE            |  |
| F 226   | Continued From p    | age 8   | F 2           | 226   |                   |                               |  |
|   |                     |   |               | The procedure for impleme                                 | enting the        |                               |  |
|   | Review of a grieva  | ance filed by Resident #4 on                                    |               | acceptable POC for the sp                                 | ecific deficiency |                               |  |
|   |                     | art that Resident #4 reported                                   |               | cited   |                   |                               |  |
|   | _                   | out of his wallet that was in his                               |               | A new process flow to help                                |                   |                               |  |
|   | _                   | r. The steps taken to   |               | determine what constitutes                                |                   |                               |  |
|   | _                   | part that facility staff looked all                             |               | grievance, or reportable iss                              |                   |                               |  |
|   |                     | om including the bed sheets,<br>I in drawers and could they not |               | Survey Agency will be inclued education for all staff mem |                   |                               |  |
|   |                     | Staff called the hospital that                                  |               | Certain: 11/30/17. Respons                                |                   |                               |  |
|   |                     | discharged from and verified                                    |               | RN Facility Educator and F                                |                   |                               |  |
|   |                     | \$445.00 upon transfer to the                                   |               | Educator  | tit ooivioo Eirio |                               |  |
|   |                     | of pertinent findings read in                                   |               | All active grievances within                              | the previous      |                               |  |
|   |                     | /17 Resident #4 was given a                                     |               | 90 days as of 11/15/17 will                               |                   |                               |  |
|   |                     | ne remaining \$56.00 in and a                                   |               | action will be taken to close                             |                   |                               |  |
|   | maintenance requ    | est was made to get the key to                                  |               | to the satisfaction of the re                             | sident. This will |                               |  |
|   | _                   | awer so Resident #4 could keep                                  |               | ensure that the facility□s p                              |                   |                               |  |
|   |                     | n was signed by Social Worker                                   |               | followed. Grievances open                                 |                   |                               |  |
|   | (SW) #1.            |   |               | certain will follow new griev                             |                   |                               |  |
|   | D                   | 1                         |               | flow. Date Certain: 11/15/1                               | •                 |                               |  |
|   |                     | lent report dated 10/26/17 read                                 |               | Person: Consulting Admini                                 |                   |                               |  |
|   |                     | ent #4 reported that when he<br>lity he had \$446.00 in cash in |               | A Resident Council Meetin educate the residents on the    |                   |                               |  |
|   |                     | of 10/23/17 he only had \$56.00                                 |               | grievance process. Date C                                 | •                 |                               |  |
|   |                     | cumented that he did not have                                   |               | Responsible Person: Cons                                  |                   |                               |  |
|   |                     | awer locked at bedside because                                  |               | Administrator   | aning             |                               |  |
|   | he did not have a   |   |               | All-staff will participate in                             |                   |                               |  |
|   |                     | •   |               | education/training to include                             | le policies,      |                               |  |
|   | A brief interview w | as conducted with the   |               | procedures, and appropria                                 | te handling of    |                               |  |
|   |                     | 1/01/17 at 10:00 AM who   |               | grievances, concerns, que                                 |                   |                               |  |
|   | stated that the fac | ility had not submitted any 24                                  |               | service opportunities to inc                              | lude definitions  |                               |  |
|   | hour/5 working da   | y reports since 10/23/17.                                       |               | and access locations for re                               |                   |                               |  |
|   |                     |   |               | education will also include                               | Ū                 |                               |  |
|   |                     | conducted with Resident #4 on                                   |               | policies, procedures, and a                               | ippropriate       |                               |  |
|   |                     | M. Resident #4 stated that on                                   |               | reporting of  | iation            |                               |  |
|   |                     | or to his admission to the facility                             |               | abuse-neglect-misappropri<br>allegations with a concentr  |                   |                               |  |
|   |                     | .00 which was enough to pay to have some extra cash. He         |               | misappropriation of funds.                                |                   |                               |  |
|   |                     | ne arrived at the hospital he paid                              |               | members who do not recei                                  | -                 |                               |  |
|   |                     | nital locked up the remaining                                   |               | by the specified date (due                                | J                 |                               |  |

Facility ID: 923277

|               | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST IDENTIFICATION NUMBER: A. BUILDING |              |     |   | (X3) DATE SURVEY<br>COMPLETED |                    |
|---------------|-------------------------------|--|--------------|-----|---|-------------------------------|--------------------|
|               |                               |  | A. BOILDI    | _   | <del></del>   | _                             | -C                 |
|               |                               | 345096   | B. WING      |     |   |                               | 02/2017            |
| NAME OF PI    | ROVIDER OR SUPPLIER           |  |              | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 11/                         | 02/2017            |
|               |                               |  |              | 1:  | 2019 VERHOEFF DRIVE   |                               |                    |
| HUNTERS       | VILLE OAKS                    |  |              | Н   | IUNTERSVILLE, NC 28078  |                               |                    |
| (X4) ID       | SUMMARY ST                    | ATEMENT OF DEFICIENCIES  | ID           |     | PROVIDER'S PLAN OF CORRECTION   |                               | (X5)               |
| PREFIX<br>TAG | ,                             | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                         | PREFI<br>TAG |     | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | COMPLETION<br>DATE |
| F 226         | Continued From page           | e 9  | F            | 226 |   |                               |                    |
|               | · -                           | ne was discharged to the   |              |     | etc.) will be required to completed trair   | ina                           |                    |
|               |                               | s returned. He added when  |              |     | prior to working a scheduled shift. Date  |                               |                    |
|               |                               | ity he counted his money   |              |     | Certain: 11/30/17. Responsible Person   |                               |                    |
|               |                               | After counting the money   |              |     | RN Facility Educator and RN Service L   |                               |                    |
|               |                               | e wrote the amount on a  |              |     | Educator  |                               |                    |
|               | small piece of paper.         | folded it with the money   |              |     | The new DON and interim administrate  | or                            |                    |
|               |                               | 0.00 bills and placed the bill   |              |     | have reviewed the facility policies on the  |                               |                    |
|               | ·                             | d drawer that had a lock on it   |              |     | expectations of reporting allegations of  |                               |                    |
|               |                               | room. He stated that on  |              |     | misappropriation. Date Certain: 11/17/  |                               |                    |
|               | 10/22/17 he recounte          | ed his money and there was   |              |     | Responsible Person: Administrator and   | į l                           |                    |
|               | \$389.00 missing, mos         | stly the \$20.00 bills, but  |              |     | DON   |                               |                    |
|               | whoever took it left th       | ne piece of paper folded in  |              |     | The monitoring procedure to ensure th   | at                            |                    |
|               | the money to make it          | look like it had not been  |              |     | the POC is effective and that specific  |                               |                    |
|               | touched. Resident #4          | 4 stated he reported it to the   |              |     | deficiency cited remains corrected and  | /or                           |                    |
|               |                               | stated all she could do was  |              |     | in compliance with the regulatory   |                               |                    |
|               | T                             | re it was not in the room.   |              |     | requirements  |                               |                    |
|               |                               | e explained to the SW that   |              |     | The Consulting Administrator is   |                               |                    |
|               |                               | ock the night stand drawer.  |              |     | responsible for the overall implementa  | ion                           |                    |
|               | -                             | ock box to Resident #4 and   |              |     | of this plan of correction. Consulting  |                               |                    |
|               |                               | a new lock with a key to the   |              |     | Administrator will monitor 100% of  |                               |                    |
|               |                               | t #4 stated that when he   |              |     | grievances for compliance daily. Any identified issues will be corrected at the     |                               |                    |
|               |                               | y no one offered to lock his   |              |     |   | 11                            |                    |
|               | belongings up.                |  |              |     | time. Results of the monitoring will be shared with the Administrator and Dire      | ctor                          |                    |
|               | An interview was con          | ducted with the  |              |     | of Nursing on a weekly basis and with   | 5.01                          |                    |
|               |                               | 01/17 at 4:28 PM. The  |              |     | QAPI monthly. QAPI committee will on  | lv                            |                    |
|               |                               | that he was responsible for  |              |     | consider discontinuing monitoring if  | '9                            |                    |
|               |                               | of misappropriation of   |              |     | subsequent surveys through the annua  | al                            |                    |
|               | resident property to the      | • • •  |              |     | recertification survey results in no repe   |                               |                    |
|               |                               | did not report Resident #4's   |              |     | citations.  |                               |                    |
|               |                               | e Agency/law enforcement.  |              |     |   |                               |                    |
|               |                               | ad a facility policy that stated   |              |     |   |                               |                    |
|               |                               | sible for missing items. He  |              |     |   |                               |                    |
|               |                               | ot confident that Resident #4  |              |     |   |                               |                    |
|               | even had that money           | coming into the facility. He   |              |     |   |                               |                    |
|               |                               | V #1 had interviewed him   |              |     |   |                               |                    |
|               |                               | the missing item policy. The   |              |     |   |                               |                    |
|               |                               | that every room had a  |              |     |   |                               |                    |
|               |                               | at locked and the key was  |              |     |   | ļ                             |                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDII   | TIPLE CONSTRUCTION  NG                    |  | (X3) DATE SURVEY<br>COMPLETED |  |                              |                            |
|---|--|---|---|--|-------------------------------|--|------------------------------|----------------------------|
|   |  | 345096  | B. WING _                                 |  |                               | R-C<br>11/02/2017  |                              |                            |
|   | ROVIDER OR SUPPLIER  |   |   | STREET ADDRESS, CITY, STATE, ZIP COL<br>12019 VERHOEFF DRIVE<br>HUNTERSVILLE, NC 28078 | DE                            | 11/02/2017   |                              |                            |
| (X4) ID<br>PREFIX<br>TAG  | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL |  | ID<br>PREFII<br>TAG           | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 226   | not sure if he had the "he did not believe to resident property be out of the facility for things in the commutate he had not report Agency/law enforce.  An interview was considered that Resider missing. She stated notified that Resider missing. She stated supervisor, SW #1, initiated a grievance to her as well. SW and stopped by her stated he had \$389. That Resident #4 had ATM on the way to the called the hospital and locked up \$446.00 and upon discharge to the shead given him and when maintenance given him a key to the lock box. SW #2 stanotified that the more and stated he was rewhen he left the hospital that the more was considered that the m | admission. The that in this case they were e money to begin with and his was misappropriation of cause Resident #4 had been appointments and other inity." He again confirmed orted this to the State ment.  Inducted with SW #2 on W. She stated she was off for to work on 10/25/17 and was hit #4 had some money I she went and talked to her and was told that she had because he had reported it #2 stated that Resident #4 office later that day and 00 missing. SW #2 stated digotten the money out of the he hospital and she had and confirmed that he had and was given the money he facility. She added that lock box to use and then had replaced the lock and he night stand he returned the ated that the police were not | F2  | 226  |                               |  |                              |                            |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | , ,                |     | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|---|---|--------------------|-----|--|-------------------|----------------------------|
|                          |   |   | 7 50.25.           |     |  | R                 | -C                         |
|                          |   | 345096  | B. WING            |     |  | 11/               | 02/2017                    |
|                          | ROVIDER OR SUPPLIER   |   |                    | 12  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>2019 VERHOEFF DRIVE<br>UNTERSVILLE, NC 28078                                   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 226  {F 309}           | have spent over \$300 missing. SW #1 state out to doctor appointr if he had taken it with happened to the mon the staff do an incider grievance. SW #1 stareport was filed it wou and Director of Nursir to them to report the is State Agency.  PROVIDE CARE/SEF WELL BEING  CFR(s): 483.24, 483.24  483.24 Quality of life Quality of life is a funcapplies to all care and residents. Each residents. Each residents. Each residents. Each residents are incomprehensive assessment of a staff applies to all treatment facility residents. Bas assessment of a residents receive accordance with profespractice, the comprehensive control of the comprehensive accordance with profespractice, the comprehensive accordance with profespractice. | ouple of time but would not which was what was dight that Resident #4 had been ments and she did not know him and lost it or what had ey. She added that she had not report and she initiated a lated that when the incident ald go to the Administratoring (DON) and it would be upssue to the police and/or RVICES FOR HIGHEST  25(k)(l)  damental principle that discrives provided to facility lent must receive and the he necessary care and maintain the highest mental, and psychosocial that with the resident's esment and plan of care.  Indiamental principle that must receive and the he necessary care and maintain the highest mental, and psychosocial that the resident's esment and plan of care.  Indiamental principle that must ensure the treatment and care in essional standards of the sidents' choices, including following: | F:                 | 09} |  |                   | 11/30/17                   |

|                          | OF DEFICIENCIES<br>CORRECTION   | L IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |
|--------------------------|---|--|---------------------|---|--|
|                          |   | 345096   | B. WING             |   | R-C<br><b>11/02/2017</b>   |
|                          | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078   | 111022311  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)  | D BE COMPLETION  |
| {F 309}                  | provided to residents consistent with profes the comprehensive p and the residents' go  (I) Dialysis. The facil residents who require services, consistent to of practice, the comp care plan, and the repreferences.  This REQUIREMENT by:  Based on observation private duty sitter, How Practitioner interview the cause of a wound identified failed to ap the wound for 1 of 3 well-being (Resident  The findings included Resident #2 was adnowledged with diagnowledged are depression, hyperlipidemia.  Review of the most redata set (MDS) dated Resident #2 was seviced daily decision making assistance of 1 to 2 sed aily living. The MDS | ure that pain management is who require such services, ssional standards of practice, erson-centered care plan, als and preferences.  Ity must ensure that e dialysis receive such with professional standards rehensive person-centered sidents' goals and  It is not met as evidenced ons, record review, staff, perior Nurse, and Nurse is the facility failed to identify it to the left hand and once ply the correct treatment to residents sampled for #2).  It:  Initted to the facility on sees that included coronary intia, history of right hip anemia, hypertension, and  eccent quarterly minimum if 09/27/17 revealed that erely cognitively impaired for grand required total staff members for activities of also indicated that Resident dial impairments to | {F 309              | F309 Preparation and/or execution of this of Correction does not constitute admission or agreement by the provide truth of the facts alleged or conclusions set forth in this stateme deficiencies. The Plan of Correction prepared and/or executed solely bed it is required by the provisions of Ferand State law.  The plan correcting the specific deficiency. The plan should address processes that led to the deficiency. During the survey ending 11/2/17, a surveyor and wound treatment nurse conducting treatment observations of Resident #2. When they arrived at the patient had already completed Resident #2 before applying wout treatments. Correct treatments were immediately applied by the wound treatment nurse. The Registered Nurse failed to verify the treatments were immediately applied by the wound treatment nurse. The Registered Nurse failed to verify the treatments were immediately applied by the wound treatment nurse. The Registered Nurse failed to verify the treatments were immediately applied by the wound treatment nurse. The Registered Nurse failed to verify the treatments were immediately applied by the wound treatment nurse. The Registered Nurse failed to verify the treatments were immediately applied by the wound treatment nurse. The Registered Nurse failed to verify the treatments were immediately applied by the wound treatment nurse. | rider of  nt of n is cause deral  the cited e were for ne ple for he priders and |

|                          | OF DEFICIENCIES<br>CORRECTION                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                      | (X2) MULT          |     | CONSTRUCTION   | (X3) DATE |                            |
|--------------------------|--|--|--------------------|-----|--|-----------|----------------------------|
|                          |  |  |                    |     |  | R-        | .c                         |
|                          |  | 345096   | B. WING            |     |  | 11/0      | 02/2017                    |
| NAME OF PR               | ROVIDER OR SUPPLIER                                  |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                            |
|                          |  |  |                    | 1:  | 2019 VERHOEFF DRIVE  |           |                            |
| HUNTERS                  | VILLE OAKS   |  |                    | Н   | IUNTERSVILLE, NC 28078   |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                     | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)       | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)      |           | (X5)<br>COMPLETION<br>DATE |
| {F 309}                  |  | actitioner (NP) visit note   | {F 3               | 09} | who applied the wrong treatment during   | -         |                            |
|                          | seen at the request or new wound to his left         | n part that Resident #2 was<br>f nursing staff who noted a<br>hand of unknown duration     |                    |     | the survey was immediately provided w<br>re-education from the DON and receive<br>written counseling. Re-education include | ed        |                            |
|                          | The wound was noted                                  | d on the day of this visit.  |                    |     | wound evaluation, reporting and documentation expectations, and  |           |                            |
|                          | recent trauma to the h                               | ing staff reported no obvious<br>nand. Family at his bedside<br>ed they were unsure of its |                    |     | importance of following provider orders related to wound treatments. Education   |           |                            |
|                          | onset or indication as                               | well. The impression and Resident #2 was noted with  |                    |     | provided to all nurses on verifying treatment orders prior to applying wour treatments.                                    | nd        |                            |
|                          | a significant laceration                             | n of skin at his left thumb<br>quite significant. The note                                 |                    |     | The procedure for implementing the   |           |                            |
|                          | local or systemic infed                              | is no indication or obvious ction, the majority of the                                     |                    |     | acceptable POC for the specific deficie cited  | ncy       |                            |
|                          | was no obvious drain                                 | ared to be granulated, there age and it appeared as  |                    |     | All nurses will receive wound in-service education that includes: Prevention,  |           |                            |
|                          | discussion with the M                                | t. The note documented a edical Doctor (MD) and care                                       |                    |     | identification, reporting, documentation and treatments options. CNAs will   |           |                            |
|                          | wound, holding off on                                | econdary healing of the<br>surgical/suturing at that<br>mented the cause of the            |                    |     | receive in-service education related to identification of wounds found during routine care. Date Certain: 11/27/17.        | ıne       |                            |
|                          | •  | to the cause and the note  |                    |     | Responsible Party: RN Service line educator and RN facility educator   |           |                            |
|                          | Review of an MD orde clean the resident's le         | er dated 10/27/17 read to  |                    |     | Head-to-toe skin assessments complet<br>by a Registered Nurse for all residents<br>ensure all wounds identified and wound  | to        |                            |
|                          |  | vet gauze packing daily.   |                    |     | orders are appropriate. Date Certain: 11/30/17. Responsible Party: DON   |           |                            |
|                          | 11/01/17 at 11:00 AM                                 | sident #2 was made on with concurrent interview of   |                    |     | The facility will establish a weekly risk meeting to be conducted by the   |           |                            |
|                          | observed to report to                                | rse (WN). Nurse #1 was<br>the WN upon entering   |                    |     | interdisciplinary team, and any other members that the Administrator or  |           |                            |
|                          |  | nat she had already<br>f2's dressing change to his<br>had gone to the shower and           |                    |     | Director of Nursing include as consulta experts. Date Certain: 11/21/17. Responsible Party: DON                            | uve       |                            |
|                          | it had gotten wet, so so completed the dressing      | she just went ahead and<br>ng change. When the WN  |                    |     | The Informatics and Analytics Services (IAS) team has formatted a report that  |           |                            |
| ORM CMS-256              | entered Resident #2's 7(02-99) Previous Versions Obs | s room he was resting in bed olete Event ID: X5G612  | 2                  | Fac | can be run for the previous 24 hours to  |           | Page 14 of 26              |

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| OL: TI                   | O I OIL MEDICAILE &   | MEDICAID SERVICES   |                        |     |   | OIVID INC                                     | <del>7. 0936-039 i</del>   |
|--------------------------|---|---|------------------------|-----|---|---|----------------------------|
|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDI |     | CONSTRUCTION  | (X3) DATE<br>COMP                             | SURVEY<br>LETED            |
|                          |   |   |                        |     |   | R   | -C                         |
|                          |   | 345096  | B. WING                |     |   | 11/   | 02/2017                    |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                        | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                            |
| HIINTERS                 | SVILLE OAKS   |   |                        | 12  | 2019 VERHOEFF DRIVE   |   |                            |
| HONTEN                   | WILLE OAKO  |   |                        | Н   | UNTERSVILLE, NC 28078   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG     |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  |   | (X5)<br>COMPLETION<br>DATE |
| {F 309}                  | glove) to each lower a noted to loop over the the first finger and the to the elbow. The WI on Resident #2's left dressing that Nurse # shower. As the WN r dressing that was bet finger came off. The 11/01/17 and was a d stating she would red correct treatment of sordered. The WN coordered, applied a nedated 11/01/17 and releft hand. After the country that the geri sleeve had inform Nurse #1 to the area was and the treatment. The WN in that the geri sleeve had the first appearing red and means and the hand area between the first appearing red and means and the hand area to Resident #2's the private duty sitter. The WN stated that wound the NP was all stated the family actual up but because there | had a geri sleeve (protective arm. The geri sleeve was e thumb and rest between umb and then extended up N removed the geri sleeve hand to visualize the 11 had completed after his removed the sleeve, the tween the thumb and first dressing was dated for the dressing with the WN to the dressing using the saline soaked gauze as impleted the treatment as ew dressing that was again eplaced the geri sleeve to his correct treatment was applied to step out into the hallway what the correct treatment that she had performed the indicated that she believed and caused the area to and and she had reported that geri sleeve was also ind was visualized with the | {F 3                   | 09} | capture new wound treatment orders. will be run daily and brought to the morning stand-up and PPS meetings to ensure appropriate documentation and follow up is completed. Date Certain: 11/24/17. Responsible Party: DON The monitoring procedure to ensure the the POC is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements DON will assess all wounds and treatments weekly to validate nursing competencies around wound care and understanding of the in-services and education provided. Any identified issu will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and w QAPI monthly. QAPI committee will on consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repectitations. The DON has the responsibility for implementation, monitoring, and oversight of this care area. | oo<br>I<br>at<br>/or<br>es<br>of<br>ith<br>ly |                            |

WN confirmed that she had informed Nurse #1

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN  |                    |       | STRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|--|--------------------|-------|--|-------------------------------|----------------------------|--|
|  |   | 345096   | B. WING            |       |  |                               | -C<br><b>02/2017</b>       |  |
|  | ROVIDER OR SUPPLIER   |  |                    | 12019 | T ADDRESS, CITY, STATE, ZIP CODE VERHOEFF DRIVE ERSVILLE, NC 28078   | 1 117                         | 02/2017                    |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |  |
| {F 309}  | hand was then proce treatment to the would private duty sitter had bathed him on 10/20/present. She added the geri sleeves ever facility since May 2014. An interview was combirector of Nursing (APM. The ADON indice notified of the wound NP was already in the when she went to asset the end of first shift an NA who stated that the previous day. The wound was discovered the treatment ordered decided to leave the because of Resident as he now had the process of the skin and the geri to leave them in placed they were not sure he that no investigation with the cause.  An interview was consister on 11/01/17 at 2 she was hired by Resensure he ate, was cowas comfortable. The provided care to Reshad visualized the antinger and thumb and on 10/27/17 when she | ement to Resident #2's left eded to apply the correct and. The WN added that the did told her that when she 117 the wound was not that Resident #2 had worn since she had worked at the 7.  Iducted with the Assistant ADON) on 11/01/17 at 2:43 cated that when she was and went to assess it the eroom. She stated that sees the wound it was near and she had only spoken to 1 he wound was not present er ADON stated that after the ed the focus was on getting did and in place, that they had | {F 3               | 09}   |  |                               |                            |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MUL <sup>-</sup><br>A. BUILDI | TIPLE CONSTR | RUCTION   |              | PLETED                     |
|--------------------------|--|---|------------------------------------|--------------|---|--------------|----------------------------|
|                          |  | 345096  | B. WING                            |              |   |              | -C<br><b>02/2017</b>       |
|                          | ROVIDER OR SUPPLIER  |   |                                    | 12019 VEF    | DDRESS, CITY, STATE, ZIP CODE<br>RHOEFF DRIVE<br>SVILLE, NC 28078   | <u>, 11/</u> | 02/2017                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                 |              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |              | (X5)<br>COMPLETION<br>DATE |
| {F 309}                  | facility to care for Rehave on the geri slesse the staff remove were on all the time. Resident #2 was conhim down by talking would relax his handfull wound, but if he very difficult to see the very di | t when she arrived at the esident #2 he would already eves and it was very rare to or apply them because they. The sitter further stated that intracted and she had to calm to him, at which point he and she was able to see the was tightly contracted it was | {F 3                               | 09}          |   |              |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                | TIPLE CONS | STRUCTION  | · '    | ATE SURVEY<br>OMPLETED     |
|--------------------------|--|---|--------------------|------------|--|--------|----------------------------|
|                          |  | 345096  | B. WING            |            |  |        | R-C                        |
| NAME OF P                | ROVIDER OR SUPPLIER  | 043030  |                    | STREE      | T ADDRESS, CITY, STATE, ZIP CODE   |        | 11/02/2017                 |
| TED                      | N/II I E 0 A I/O   |   |                    | 12019 \    | VERHOEFF DRIVE   |        |                            |
| HUNTERS                  | SVILLE OAKS  |   |                    | HUNTI      | ERSVILLE, NC 28078   |        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | ×          | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE | (X5)<br>COMPLETION<br>DATE |
| {F 309}                  | Continued From pa  | age 17  | {F 3               | 09}        |  |        |                            |
|                          | 11/02/17 at 9:29 A routinely cared for the hospice staff w Wednesday and F care and that on the not at the facility stadded that the privipersent most of the and to provide con NA #1 added that sleeves all during them for his bath a stated that she had between Resident on 10/24/17 and the staff would have provided the sitter noted the they started treatm. An interview was a wound to Resident contracted and recup for visualization family knew how low which was deep as stated she collaborand decided second treatment choice. Like a laceration but make any assump. | conducted with the Nurse in 11/02/17 at 10:21 AM. The is asked by the WN to assess a it #2's hand which was a little iquired a nurse to open his hand is. She stated no one including ing the wound was present ind not very granulated. She irrated with the Medical Doctor indary healing would be the She stated the wound looked it as to the cause she could not itions or presumptions. |                    |            |  |        |                            |
|                          | 1 '  | 02/17 at 10:31 AM. The HN ited Resident #2 twice a week   |                    |            |  |        |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '              | TIPLE CONSTRUCTION  |           | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|--|---|--------------------|---|-----------|-------------------|----------------------------|
|                          |  | 345096  | B. WING _          |   |           |                   | -C<br><b>02/2017</b>       |
|                          | ROVIDER OR SUPPLIER VILLE OAKS   |   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078 |           |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |   | SHOULD BE |                   | (X5)<br>COMPLETION<br>DATE |
| {F 309}                  | on Monday and Frida full bed bath and on Nesident #2 to the shifth the NAs were trained and if they noticed an unusual they were to and she would follow actually applied Resid Tuesday 10/24/17 an not see any wound to was difficult to assess contracture.  An interview was con Nursing (DON) on 11 DON stated that she since Monday 10/30/3 a comprehensive wood the DON stated she checks to be done we sometime during the removed and the skir reported. The DON of the staff to follow wood ordered. The DON stated she could not find sleeves and therefore had been in place. S | im 3 times a week on and Friday. She added that y the NAs provide him with a Vednesdays they took ower. The HN stated that to look at the resident's skin y changes or anything report that directly to her up. She added that she had dent #2's geri sleeves on d Thursday 10/26/17 and did his left hand, but stated it is his skin due to his  ducted with the Director of 1/02/17 at 3:13 PM. The had only been at the facility 1/17 and really wanted to build and program at the facility. It would expect for skin teekly as ordered, then day the geri sleeves to be a inspected and any changes auther stated she expected and orders exactly as tated that she had been the esident #2's medical record day an order for the geri she had no idea how long they the added that she had the geri sleeves on 11/02/17 | {F 3               | 609}  |           |                   |                            |
| {F 520}<br>SS=D          | QAA COMMITTEE-M<br>QUARTERLY/PLANS<br>CFR(s): 483.75(g)(1)(g) Quality assessme   | (i)-(iii)(2)(i)(ii)(h)(i)   | {F 5               | 520}  |           |                   | 11/30/17                   |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |      | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|--------------------|------|--|-------------------------------|----------------------------|
|                          |   | 345096  | B. WING            |      |  |                               | -C<br><b>02/2017</b>       |
|                          | ROVIDER OR SUPPLIER   |   |                    | 1    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12019 VERHOEFF DRIVE<br>HUNTERSVILLE, NC 28078                      | ,                             | <u></u>                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| {F 520}                  | Continued From page   | e 19  | {F 5               | 520} |  |                               |                            |
|                          | (1) A facility must mai<br>and assurance comm<br>minimum of:  | intain a quality assessment<br>iittee consisting at a   |                    |      |  |                               |                            |
|                          | (i) The director of nur   | sing services;  |                    |      |  |                               |                            |
|                          | (ii) The Medical Direc  | tor or his/her designee;  |                    |      |  |                               |                            |
|                          | staff, at least one of w  | a board member or other   |                    |      |  |                               |                            |
|                          | (g)(2) The quality ass committee must :   | essment and assurance   |                    |      |  |                               |                            |
|                          | coordinate and evalua   | respect to which quality  |                    |      |  |                               |                            |
|                          |   | ement appropriate plans of tified quality deficiencies;   |                    |      |  |                               |                            |
|                          | Secretary may not rec<br>records of such comm<br>such disclosure is rela                            | rmation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this |                    |      |  |                               |                            |
|                          | (i) Sanctions. Good facommittee to identify deficiencies will not b sanctions. This REQUIREMENT by: | and correct quality   |                    |      |  |                               |                            |

|                          | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                  | 1 ` ′               |     | CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|----------------------------|---|---------------------|-----|---|-------------------|----------------------------|
|                          |                            | 345096  | B. WING _           |     |   | 1                 | -C<br><b>02/2017</b>       |
| NAME OF P                | ROVIDER OR SUPPLIER        | <u> </u>  |                     | ST  | REET ADDRESS, CITY, STATE, ZIP CODE   | 1 11/             | 02/2017                    |
|                          |                            |   |                     |     | 019 VERHOEFF DRIVE  |                   |                            |
| HUNTERS                  | VILLE OAKS                 |   |                     |     | UNTERSVILLE, NC 28078   |                   |                            |
|                          |                            |   |                     |     | ·   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN             | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID<br>PREFI)<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| {F 520}                  | Continued From pag         | ne 20   | {F 5                | 20} |   |                   |                            |
| , ,                      |                            | views and staff interviews the  | (, 0,               | _,  | F 520   |                   |                            |
|                          |                            | essment and Assurance   |                     |     | Preparation and/or execution of this Pl   | an                |                            |
|                          |                            | maintain implemented  |                     |     | of Correction does not constitute   | uii               |                            |
|                          |                            | nitor these interventions that  |                     |     | admission or agreement by the provide   | er of             |                            |
|                          | •                          | to place in October 05, 2017  |                     |     | the truth of the facts alleged or   | ,1 01             |                            |
|                          | ·                          | and complaint survey,   |                     |     | conclusions set forth in this statement   | of                |                            |
|                          |                            | d in November 02, 2017 on   |                     |     | deficiencies. The Plan of Correction is   |                   |                            |
|                          |                            | complaint survey. The   |                     |     | prepared and/or executed solely becau   |                   |                            |
|                          |                            | vere in the area of resident  |                     |     | it is required by the provisions of Feder   |                   |                            |
|                          | behaviors and facility     | y practices (F225) and  |                     |     | and State law.  |                   |                            |
|                          | provide care to main       | itain well-being (F309).  |                     |     | F225 was a repeat citation for failing to   | )                 |                            |
|                          | These deficiencies v       | vere recited during the   |                     |     | report an allegation of misappropriation  | ١.                |                            |
|                          | facility's current follo   | w up complaint survey. The  |                     |     | The allegation was not communicated   |                   |                            |
|                          | continued failure of t     | the facility during 2 federal   |                     |     | with the QAPI committee. Instead, the   |                   |                            |
|                          |                            | ow a pattern of the facility's  |                     |     | administrator at the time of the allegati   | on                |                            |
|                          | inability to sustain ar    | n effective Quality Assurance   |                     |     | made the determination that it did not  |                   |                            |
|                          | Program.                   |   |                     |     | constitute as a reportable incident.  |                   |                            |
|                          |                            |   |                     |     | Instead, the administrator investigated   |                   |                            |
|                          | The findings include       | d:  |                     |     | allegation through the facility s grieva process.   | nce               |                            |
|                          | This tag is cross refe     | erred to:   |                     |     | On 10/23/17, Resident #4 reported to t facility staff that he had money missing                             |                   |                            |
|                          | 1a. F225: Based on         | staff interviews and record   |                     |     | grievance report for the missing money  |                   |                            |
|                          | reviews the facility fa    | ailed to notify the State   |                     |     | was filed, however, the administrator a   |                   |                            |
|                          | _                          | n the required 24 hour initial  |                     |     | the time did not think the incident shou  | ld                |                            |
|                          | report time frame for      | an allegation of  |                     |     | be reported using the appropriate 24-h  | our               |                            |
|                          | misappropriation of i      | resident property and failed to   |                     |     | and 5-working day reports to the State  |                   |                            |
|                          | report to the State S      | urvey Agency within the   |                     |     | Agency. Instead, the administrator made   | de                |                            |
|                          | required 5 working d       | lay time frame of the   |                     |     | the determination that this was a   |                   |                            |
|                          | investigation of an a      | llegation of misappropriation   |                     |     | grievance and did not constitute a  |                   |                            |
|                          |                            | for 1 of 1 sampled residents  |                     |     | reportable event. The administrator at  | the               |                            |
|                          | (Resident #4).             |   |                     |     | time of this incident is no longer emplo at the facility.   | yed               |                            |
|                          | During the follow up       | complaint survey of   |                     |     | The interim administrator instructed the  | •                 |                            |
|                          |                            | ition was cited for failing to  |                     |     | DON to complete the 24-hour and   |                   |                            |
|                          |                            | vey Agency with the required  |                     |     | 5-working day reports and to attach the   | •                 |                            |
|                          | , ,                        | time frame for an allegation  |                     |     | investigative materials to the appropria  |                   |                            |
|                          |                            | esidents (Resident #5) and  |                     |     | State Agency. Determining what  |                   |                            |
|                          |                            | tate Survey Agency within the   |                     |     | constitutes as a concern, grievance, or   | a                 |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDII |     | CONSTRUCTION   | (X3) DATE<br>COMP                       | SURVEY<br>LETED            |
|--------------------------|--|--|-------------------------|-----|--|---|----------------------------|
|                          |  |  |                         | _   |  | R.                                      | -c                         |
|                          |  | 345096   | B. WING _               |     |  | l                                       | 02/2017                    |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                         | S1  | FREET ADDRESS, CITY, STATE, ZIP CODE   |   |                            |
| UUNTEDO                  | VILLE OAKS   |  |                         | 12  | 2019 VERHOEFF DRIVE  |   |                            |
| HUNTERS                  | VILLE OARS   |  |                         | Н   | UNTERSVILLE, NC 28078  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |   | (X5)<br>COMPLETION<br>DATE |
| {F 520}                  | Continued From page required 5 working da abuse investigation for abuse allegations (Ref. 1b. F309: Based on or staff, private duty sitted Nurse Practitioner into investigate a wound to identified failed to app the wound for 1 of 3 rowell-being (Resident in the wound for 1 of 3 rowell-being (Resident in the wound for 1 of 3 rowell-being (Resident in the wound for 1 of 3 rowell-being (Resident in the wound for 1 of 1 resident with the physician's ordereadmitted to the host drainage and revision wound infection of the for 1 of 1 resident with the wound infection of the for 1 of 1 resident with the wound fo | ey time frame of allegation of or 2 of 7 residents with esident #5 and #2).  Observations, record review, er, Hospice Nurse, and erviews the facility failed to on the left hand and once only the correct treatment to esidents sampled for #2).  Complaint survey of ion was cited for failing to sion on a resident's lower dressing changes according ers who had to be pital for an incision and in of the incision due to a eir lower back (Resident #2) in a surgical incision.  ducted with the 2/17 at 3:35 PM. The hat the Quality Assurance of Nursing, Dietitian, armacist, Social Worker, Educator and anyone else do that they had not yet had revious follow up complaint A program. The hat he believed the conducted with the ent #4 filed was sufficient | {F 5                    | 20} | reportable event has been included in education for all staff. The facility selection department heads have been instructed bring all concerns to the morning stand meeting and the IDT can make recommendations as to whether an incident needs to be reported to the State Agency, however, the Administrator and DON will be responsible for reporting a allegations of abuse, neglect, misappropriation, and exploitation on the 24-hour and 5-working day reports. The new interim administrator and new DOI understand the requirement to report allegations to the QAPI committee for further guidance.  F309 was also a repeat citation. During the survey ending 11/2/17, a surveyor a wound treatment nurse were conducting treatment observations for Resident #2 When they arrived at the patient should reast the nurse responsible for the patient has already completed Resident #2 should dreatment orders for Resident before applying wound treatments.  Correct treatments were immediately applied by the wound treatment nurse. The Registered Nurse who applied the wrong treatment during the survey was immediately provided with re-education from the DON and received written counseling. Re-education included would evaluation, reporting and documentation expectations, and importance of following the survey follows. | -up ate d II ne e N I and g .m, id t #2 |                            |
|                          | misappropriation of rewas why he had not f   | e that the allegation was not esident property and that illed the required 24/5 e State Agency. He added   |                         |     | provider orders related to wound<br>treatments. Education provided to all<br>nurses on verifying treatment orders pr<br>to applying wound treatments. The QAI  |   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                               | (X2) MULT<br>A. BUILDI |                                       | CONSTRUCTION   | (X3) DATE<br>COMP                | SURVEY                     |
|--------------------------|-------------------------------|--|------------------------|---------------------------------------|--|----------------------------------|----------------------------|
|                          |                               | 245006   | P WING                 |                                       |  |                                  | -C                         |
|                          |                               | 345096   | B. WING                |                                       |  | 11/                              | 02/2017                    |
| NAME OF PF               | ROVIDER OR SUPPLIER           |  |                        | S                                     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                                  |                            |
| HUNTERS                  | VILLE OAKS                    |  |                        | 12                                    | 2019 VERHOEFF DRIVE  |                                  |                            |
| HONTENO                  | VILLE OAKO                    |  |                        | Н                                     | UNTERSVILLE, NC 28078  |                                  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG     | FIX (EACH CORRECTIVE ACTION SHOULD BE |  |                                  | (X5)<br>COMPLETION<br>DATE |
| {F 520}                  | hospital's resources          | oing to use the associated<br>to gain substantial<br>ward and he believed that   | {F 5                   | (20)                                  | committee soriginal recommendations to the DON were not followed. The previous DON was responsible for auditing wound treatments and failed to do so adequately. The new DON has implemented a weekly risk meeting to discuss current residents with wounds, and is also assessing wounds and treatments on a weekly basis. The procedure for implementing the acceptable POC for the specific deficie cited All active grievances within the previous 90 days as of 11/15/17 will be reviewed action will be taken to close all grievance to the satisfaction of the resident. Grievances opened after date certain whollow new grievance process flow. Dat Certain: 11/15/17. Responsible Person: Consulting Administrator A Resident Council Meeting was held to educate the residents on the facility squievance process. Date Certain 11/15/17. Responsible Person: Consulting Administrator All current interviewable residents as of 11/16/17 were interviewed to identify an additional outstanding grievance issues that need further investigation. Date Certain: 11/16/17. Responsible Person: Consulting Administrator All-staff will participate in education/training to include policies, procedures, and appropriate handling of grievances, concerns, questions, or service opportunities to include definition and access locations for resources. The education will also include training on | ncy s d, ces vill de 177. f ny s |                            |

|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                    | ` ′                 | IPLE CONSTRUCTION  | (X3) DATE<br>COMF  | SURVEY<br>PLETED           |
|--------------------------|-------------------------------|---|---------------------|--|--|----------------------------|
|                          |                               | 345096  | B. WING _           |  |  | R-C<br><b>(02/2017</b>     |
|                          | ROVIDER OR SUPPLIER           |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078  | ·  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIV  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROI  DEFICIENCY)   | ) BE   | (X5)<br>COMPLETION<br>DATE |
| {F 520}                  | Continued From page           | ; 23  | {F 5                | reporting of abuse-neglect-misappropriation allegations with a concentration on misappropriation of funds. Any staff members who do not receive the traby the specified date (due to FMLA, etc.) will be required to completed training to working a scheduled shift. Detain: 11/30/17. Responsible Persent RN Facility Educator and RN Service Educator  The new DON and interim administration and the reviewed the facility policies of expectations of reporting allegations misappropriation. Date Certain: 11/18 Responsible Person: Administrator and DON  All nurses will receive wound in-serveducation that includes: Prevention identification, reporting, documentat and treatments options. CNAs will receive in-service education related identification of wounds found during routine care. Date Certain: 11/27/17 Responsible Party: RN Service line educator and RN facility educator Head-to-toe skin assessments comply a Registered Nurse for all resides ensure all wounds identified and woorders are appropriate. Date Certain: 11/30/17. Responsible Party: DON The facility will establish a weekly rismeeting to be conducted by the interdisciplinary team, and any othe members that the Administrator or Director of Nursing include as consulexperts. Date Certain: 11/21/17. Responsible Party: DON The Informatics and Analytics Service. | leave, aining ate on: e Line ator of 7/17. and ice on, to the of the other of the o |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED  |  |
|---|--------------------|---|---|--|---|--|--|
|   |                    | 345096  | B. WING                                 |  |   | R-C  |  |
| NAME OF PROVIDER OR SUPPLIER                        |                    |   | B. WING                                 | STREET ADDRESS, CITY, STATE, ZIP CODE  |   | 11/02/2017   |  |
| HUNTERSVILLE OAKS                                   |                    |   |   | 12019 VERHOEFF DRIVE<br>HUNTERSVILLE, NC 28078   |   |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC    | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |   | DATE   |   |  |  |
| {F 520}   | Continued From pag | e 24  | {F 5                                    | (IAS) team has format can be run for the preversible run daily and be morning stand-up and ensure appropriate do follow up is completed 11/24/17. Responsible The monitoring process the POC is effective and deficiency cited remain in compliance with the requirements F225 - Consulting Administrator will mon grievances for compliation identified issues will be time. Results of the moshared with the Admin of Nursing on a weekly QAPI monthly. QAPI consider discontinuing subsequent surveys the recertification survey retaitions.  F309 - DON will assess treatments weekly to we competencies around understanding of the interval of the most of the most of the most of the interval of the i | vious 24 hours to eatment orders. Tought to the PPS meetings to cumentation and I. Date Certain: Party: DON dure to ensure the district of the regulatory ministrator is erall implementation. Consulting itor 100% of ance daily. Any ecorrected at the onitoring will be distrator and Directly basis and with committee will on a monitoring if the properties of the committee will on the properties and my identified issurant time. Results on the ekly basis and with committee will on the properties and my identified issurant time. Results on the ekly basis and with the ekly basis and | This  Delicat  Art  Art  Cortor  Ity  Bal  Bat  Cd  Cd  Ces  If  Ith  Ith  Ith  Ith  Ith  Ith  Ith |  |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  | (X3) DATE SURVEY<br>COMPLETED         |
|---|---------------------------------------|
| 345096 B. WING  | R-C                                   |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, Z  | 11/02/2017                            |
| 12019 VERHOEFF DRIVE  | LII CODE                              |
| HUNTERSVILLE OAKS HUNTERSVILLE, NC 28078  |                                       |
|   | LOE CORRECTION (VE)                   |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED DEFICI         | TO THE APPROPRIATE DATE               |
| (F 520) Continued From page 25  (F 520) Continued From page 25  (F 520) Citations. The DON has for implementation, more oversight of this care and the interim Administrator (responsibility of monitor of this citation. | nitoring, and<br>rea.<br>or will have |