PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345096	B. WING		R-C 12/22/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
HUNTERS	VILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION	
{F 282} SS=D	SERVICES BY QUAL CARE PLAN CFR(s): 483.21(b)(3)(1)(b)(3) Comprehensive The services provided as outlined by the commust- (ii) Be provided by qui accordance with each care. This REQUIREMENT by: Based on record revifacility failed to includ with a history of fall the body lift for transfer at and size of the sling to resident fell from the liskin tear to his head, right arm, a skin tear teeth for 1 of 5 reside interventions on care facility also failed to a care planned for 1 of 5 reside interventions on 1 of 5 reside interventions on 1 of 5 reside interventions on 1 of 5 reside interventions of 1 of 5 reside interventions of 1 of 5 reside interventions of 1 of	LIFIED PERSONS/PER (iii) E Care Plans d or arranged by the facility, imprehensive care plan, alified persons in in resident's written plan of is not met as evidenced ews and staff interviews the e in a care plan of a resident iat the resident needed a full and did not specify the type	{F 28	DEFICIENCY)	an er of of use ral	
	Findings included:			During the annual/follow-up survey en	ding	
	08/24/16 with diagnost disease, depression a review of the most red Set (MDS) dated 09/2 had short term and lo and was severely imp decision making. The	admitted to the facility on sees which included heart and Alzheimer's disease. A cent quarterly Minimum Data 27/17 indicated Resident #22 ang term memory problems saired in cognition for daily & MDS further indicated ally dependent on staff for		12/22/17, surveyors reviewed Residen #22 and Resident #56. Resident #22's Baseline Care Plan was reviewed and was determined the facility did not hav process to capture the appropriate transfer status and failed to identify the specific sling type. As of the 11/28/17 regulatory requirements, the facility's Baseline Care Plan format was update	it it e a	
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	•	TITLE	(X6) DATE	

01/17/2018

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G		
		345096	B. WING			R-C 12/22/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	I DE	12/22/2017
				12019 VERHOEFF DRIVE		
HUNTERS	VILLE OAKS			HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 282}	Continued From page	e 1	{F 28	2}		
	bed mobility and trans	sfers.		include transfer status and sl addition, the Resident Profile		
	A review of a physica	I therapy initial assessment		Nursing Assistants for care h		
		ited Resident #22 was 100		updated to reflect the approp		
		1 1 or more persons for bed		status and sling type.		
	mobility and transfers	· · · · · · · · · · · · · · · · · · ·		3 71		
	,			Resident #56's Physician Or	ders were	
	A review of a Care Ar	ea Assessment dated		reviewed and it was determin	ned the facility	
09/04/16 indicated falls triggered and was addressed in the care plan.		lls triggered and was		did not have an updated Res		
		e plan.		to reflect the application of the		
				wrist/hand splint, which was		
		nterdisciplinary Care Plan		the morning and removed in	_	
	dated 08/25/16 indicated a potential for falls due			as ordered. The Resident Pro		
	to pain, generalized v			by Nursing Assistants for car		
		of multiple fractures. There or interventions to indicate		updated to reflect the approp	•	
	• •	be transferred with a full		application schedule. Once in during the survey, the sling w		
		s no indication of the type or		as ordered.	vas applicu	
	size of sling to be use			do ordered.		
		a canning and a concrete		The procedure for implement	ting the	
	A review of a hospice	and palliative care visit		acceptable plan of correction	-	
		at 2:17 PM, documented by		specific deficiency cited:		
	Hospice Nurse #1 ind	licated Resident #22 fell				
	-	he notes revealed the sling		On 1/3/18, a new Interdiscipl	•	
		transfer Resident #22 in the		(IDT) Rounds process was ir		
		rt his bottom and they would		Members of the IDT included		
	attempt to get a differ	ent type of sling for		Physician, a representative f		
	transfers.			Social Worker, Clinical Nurse	•	
	A massiasse of an impidas	at last data d 11/10/10		DON, Activity Representative		
	A review of an incider	11 log dated 11/19/16 2 was in a total body lift and		Informatics and Analytics Sel		
		The document indicated		a representative from Therap front-line Nursing Assistants.	-	
		of the sling attached to the		process included the develop		
		tom first and hit his head on		template for the IDT to utilize		
		ly lift. The report further		performing the meetings with		
		mber called a week later		residents present to ensure a		
		ticed Resident #22 was		information was captured. Ph		
	-	ont teeth that were broken		orders, resident profile, and		
	with the roots still in p			were revised/updated to refle	•	

OLITICIT	OT OIL WEDIONILE &	T CERTIFICATION OF THE PROPERTY OF THE PROPERT				T T	2. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R	k-C
		345096	B. WING			12/	22/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UUNTEDO	WILL CAKE			12	2019 VERHOEFF DRIVE		
HUNIERS	SVILLE OAKS			HUNTERSVILLE, NC 28078			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		COMPLETION DATE
{F 282}	Continued From page	e 2	{F 2	82}			
	A ravious of the Initial	Interdisciplinary Care Plan			resident status, and any discrepancies		
		Interdisciplinary Care Plan led Resident #22 had a fall			were resolved prior to leaving the resident's room. In the event a piece o	f	
		a full body lift. A section			equipment/supply was not able to be fi		
	_	had a hand written note that			or obtained immediately, a work order	лоч	
	a new sling was orde	red but there were still no			was initiated. The resident profile for a	II	
	approaches or interve	entions to use a full body lift			residents was updated to reflect the		
	for transfer or the type	e of sling or size of sling to			specific needs of the resident, to include		
		but not limited to, transfer status, type/					
					of sling for residents transferred via Ho	-	
	-	an with a revised date of			lift, and splint application. During the II)	
		esident #22 was totally vities of daily living and was			rounds, the team was responsible for matching the Resident Profile with the		
	•	a mechanical lift but had a			Care Plan, and the Physician ensured	all	
	recent fall from the lif				orders were entered appropriately. A	uii	
		-			member from IAS was included to veri	fv	
	During an interview o	n 12/21/17 at 3:28 PM the			the information was entered accurately	-	
	Director of Nursing (E	OON) confirmed there was			since the Electronic Medical Record		
		ons or approaches on the			(EMR) is new to the facility. During the		
		care plan prior to Resident			IDT rounds, the team Date certain:		
		or after the fall from the lift			1/12/18		
		was revised on 11/28/16.			Orientation for new teamerates will		
	•	ould want physical therapy rapy to screen a resident			Orientation for new teammates will include updating the resident profile,		
	and make the safest				accessing the resident profile, and		
		ould be care planned for			resident care plan implementation. Da	te	
	staff to follow their red				certain 1/15/18		
	During an interview o	on 12/22/17 at 9:27 AM with			The monitoring procedure to ensure th	at	
	the Administrator she				the plan of correction is effective and the		
		resident's transfer status on			specific deficiency cited remains corre		
		xplained physical therapy or			and/or in compliance with the regulator	ry	
	occupational therapy				requirements		
	_	nt's transfer status and once rmination there should be			Reginning 1/15/18 the Administrator		
	-	rsing staff on how to provide			Beginning 1/15/18, the Administrator selected a group of Leadership members.	ere.	
		stated interim care plans			as Zone Owners, to focus on monitorir		
	could be updated as				the updates completed during IDT	· ସ	
					rounding to ensure continued compliar	nce.	

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CENTER	S FUR MEDICARE &	MEDICAID SERVICES			0	MB NO. 0938-0391
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		345096	B. WING _			R-C 12/22/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE .	-
	VIII - 0 4 4 6			12019 VERHOEFF DRIVE		
HUNTERS	VILLE OAKS			HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 282}	Continued From page During an interview o	e 3 n 12/22/17 at 12:50 PM with	{F 2	82} Each Zone Owner has recei	ved a specifi	С
	screened every reside	he explained therapy staff ent when they were admitted		assignment of residents to massignments include a back-	nonitor. The up person to	
	for safe transfers. Sh	de recommendations to staff ne stated Resident #22 was		cover if the individual is out of for the day. Zone owners we	ere trained or	
	would have expected	staff for everything and she for staff to include a total lift		accessing and utilizing the R Profile found on Care Tracket	er to ensure	
	2. Resident #56 was	ntion on his care plan. admitted to the facility on sis that included progressive		residents have appropriate s splints as outlined in the Res Rounding assignments are o	sident Profile	
	multiple sclerosis and	I spastic hemiplegia, a rause muscles on one side		extensive and include auditing residents rights, physical environments	ng of	
	of the body to be in a contraction.	constant state of		and individualized resident n amongst other areas. To mo rounds, the facility will add a	nitor the IDT	
	plan updated on 01/0	of daily living (ADL) care 3/17 addressed functional		Down" meeting to provide fir Zone Owners of Resident Pr	ndings of the rofiles and	
	ADL with approaches	to continue to participate in that included a left hand		Care Plans that need to be used areas of discrepancy will be	immediately	
	every evening.	ery morning and removed		addressed during the stand by the IDT. IDT Zone Owner required to complete rounds	s will be	lg
	orders, an order date			assigned residents Monday Friday for 4 weeks and atten	through id the stand	
	wrist/hand orthosis ap remove in the evening			down meeting each day. On weekends for 4 weeks, the c supervisor and manager on	clinical	
	(MDS) assessment d			responsible for auditing 100° who require slings and splint	% of resident t application	to
	Interview for Mental S	nitively impaired, with a Brief Status (BIMS) of 5 and as airment with limited range of left hand.		determine the appropriate ty slings for residents transferre lift and splint application. Da 1/15/18	ed via Hoyer	
	profile for Resident #	g Assistant's (NAs) resident 56 noted a left wrist hand n the morning and remove in		Service Line Nurse Educator Facility Educator provided in MDS Coordinators, nursing nursing assistants on the pro	-services to staff and	

expectations for verification of orders,

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R-C	
		345096	B. WING		1	2/22/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				12019 VERHOEFF DRIVE			
HUNTERS	VILLE OAKS			HUNTERSVILLE, NC 28078			
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PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLÉTION DATE	
{F 282}	Continued From page	e 4	{F 28	2}			
	Record (MAR) for Rehand splint to be don removed in the eveni splint was documente and 12/19/17. Observations made of	17 Medication Administration sident #56 indicated a left ned in the morning and ng. Refusal of the hand ed on the MAR for 12/6/17		care plan updates, and care plan implementation. Any required somewhers who do not receive the specified date (due to Fetc.) will be required to comple prior to working a scheduled short certain: 1/15/18	staff he training MLA, leave, te training nift. Date		
	12:15 PM, 12/21/17 a	at 10:52 AM, 12/20/17 at at 11:18 AM, and 12/22/17 at left hand splint being worn.		The IDT rounding team conduction audit of matching the Resident with the Care Plans, as the Physical P	Profiles, ysician		
	3:15 pm, she stated streatment for her left An interview with NA she stated Resident #	Resident #56 on 12/18/17 at she was not receiving any hand but would like to. #5 on 12/22/17 at 9:06 am, #56 used to have a splint but		ensured all orders were entere appropriately. MDS Coordinated designee, will conduct weekly of scheduled quarterly and annual plans being conducted in resid to ensure Resident Profiles, Caland Physician Orders matter.	or or 100% audit nual care ent's rooms are Plans Audits will		
	where it is was at this Resident didn't want The NA explained if a ordered it would be o	a while and didn't know s time. She reported the to wear it most of the time. a resident had a splint n the resident profile to alert ident refused to wear their		time the QAPI committee will d further auditing is needed. Any	for a period of 90 days, at which QAPI committee will determine if uditing is needed. Any identified ill be corrected at that time. Date 1/12/18		
	splint it would be reported the nurses document	orted to the nurse because ed it on their MAR.		Floor nurses will update the re- profile with any new orders. Cli supervisors will be responsible	inical		
	9:15 am, he stated he	vith Nurse #3 on 12/22/17 at e had seen therapy work any times but was not sure I for her left hand.		ensuring the floor nurse has up resident profiles appropriately of their shift. The clinical super bring the 24-hour order report stand-up and be prepared to display the stand-up and the sta	upon start visors will to morning		
	12/22/17 at 1:15 pm i hand splint was in pla			updates. The MDS Coordinato responsible for verifying the responsible was updated accurately the care plan is reflective of an	rs will be sident and that y changes.		
	3:10 pm, revealed sh	ew with NA #5 on 12/22/17 at e had found the left hand 6 in the corner of her room		On weekends, the clinical super pull the 24-hour order report are the resident profiles have been	nd ensure		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G		R-C	
		345096	B. WING _			12/22/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	12/22/2011	
	W. I. = 0.140			12019 VERHOEFF DR	IVE		
HUNTERS	SVILLE OAKS			HUNTERSVILLE, N	C 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)	5.475	
{F 282}	Continued From page	: 5	{F 28	2}			
(* 202 _j	under some things an hand. In a subsequent interview 12/22/17 at 3:46 pm, documented splint do MAR. During an interview w Therapist (OT) on 12/reported Resident #56 time ago and a left had idn't know the status Resident #56 was not A telephone interview at 4:13 pm, revealed needed (PRN) basis a say if she has ever se hand splint. She could	view with Nurse #3 on the reported that the nurses nning and doffing on the ith the Occupational 22/17 at 4:00 pm, she is was on her caseload some and splint was ordered. She of the hand splint since currently on her caseload. with Nurse #4 on 12/22/17	ξ1 Z6	appropriately. Or responsible for report on Monor the normal professor to morning star MDS Coordina IDT rounds will rooms on a quato be incorporate existing schedulof the monitorin Administrator at weekly basis a period of 90 day of monitoring with QAPI Committee.	Clinical supervisors are pulling the 72-hour orded ay mornings and follow cess of bringing the repond-up meeting to give to stors. Date certain 1/17/1 be conducted in reside arterly basis going forwated into the already ule for care plans. Resuling will be shared with the and Director of Nursing ond with QAPI monthly for ays at which time frequential be determined by the ee. Date certain: 1/17/18 person responsible for he acceptable plan of	ing port 18 nt ard, lts e on a or a ncy	
	An interview was con Nursing (DON) on 12 stated her expectation positioning/mobility de	ducted with the Director of /22/17 at 6:29 pm. The DON on regarding splints and evices is that they would be per physician orders and as		The DON will he for oversight of MDS Coordina ensuring the R of changes maplan. MDS Coolin-room assess meetings which visualize any o	nave overall responsibility the care plan process. Itors will be responsible esident Profile is reflecting to a resident's care ordinators will maintain the sments during care plan in will allow the team to proportunities to enhance fronment or plan of care.	for ve he the	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345096	B. WING _				-C 22/2017
	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078		, , ,	22/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
{F 520} SS=D	QUARTERLY/PLANS CFR(s): 483.75(g)(1)(g) Quality assessme (1) A facility must mai and assurance comm minimum of: (i) The director of nur (ii) The Medical Direct (iii) At least three other staff, at least one of vadministrator, owner, individual in a leaders (g)(2) The quality ass committee must: (i) Meet at least quart coordinate and evaluation in the coordinate	cii)-(iii)(2)(i)(ii)(h)(i) nt and assurance. intain a quality assessment intereconsisting at a sing services; tor or his/her designee; er members of the facility's who must be the a board member or other ship role; and essment and assurance erly and as needed to ate activities such as a respect to which quality arance activities are ement appropriate plans of tified quality deficiencies; ermation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this	{F 5.	20}			1/17/18

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

01/17/2018

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

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		345096	B. WING		R-C 12/22/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	IZIZZIZOTI		
				12019 VERHOEFF DRIVE			
HUNTERS	SVILLE OAKS			HUNTERSVILLE, NC 28078			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP			
{F 520}	Continued From page	e 1	{F 520)}			
		e used as a basis for is not met as evidenced					
	interviews the facility' Assurance Committed implemented procedu interventions that the November 30, 2017 fromplaint survey and December 22, 2017 of survey. The repeat docare plan implementation was recited during the recertification survey facility during 2 federa pattern of the facility's effective Quality Assurant The findings included This tag is cross referenced as 20 Resident Assareviews and staff interviews and staff interviews.	committee put into place on collowing a follow up and subsequently recited on on the current recertification eficiency was in the areas of ation (F656). This deficiency is facility's current. The continued failure of the all surveys of record show a sinability to sustain an arrance Program.		DISCLAIMER: 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 statement deficiencies. The Plan of Correction prepared and/or executed solely bed it is required by the provisions of Fed and State law. F 520 The plan of correcting the specific deficiency. The plan should address processes that lead to the deficiency cited; During the survey ending 11/2/17, the facility received a citation related to a following a resident's plan of care. Definition that the survey ending 12/22/17, surveyors reviewed Resident 12/22 and Decident 150.	ider of nt of is cause deral the / ne not ouring ent		
	of fall that the resider transfer and did not s the sling to use on the the lift sling which res head, bruising to his l tear to his right knee residents sampled for care plans (Resident	_		#22 and Resident #56. Resident #22 Baseline Care Plan was reviewed ar was determined the facility did not he process to capture the appropriate transfer status and failed to identify t specific sling type. As of the 11/28/1' regulatory requirements, the facility's Baseline Care Plan format was upda include transfer status and sling type addition, the Resident Profile utilized Nursing Assistants for care has beer updated to reflect the appropriate tra status and sling type.	and it ave a the 7 s ated to e. In d by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345096	B. WING _		12	2/22/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE .		
				12019 VERHOEFF DRIVE			
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(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION DATE	
{F 520}	Continued From page	ge 2	{F 52	20}			
		p and complaint survey of					
		tion was cited for failure to		Resident #56's Physician Or			
	apply a palm guard	as directed by the care plan.		reviewed and it was determined did not have an updated Res	•		
	During the current r	ecertification survey this		to reflect the application of the			
	_	I for failure to include in a care		wrist/hand splint, which was			
		a history of fall that the		the morning and removed in			
	resident needed a f	ull body lift for transfer and did		as ordered. The Resident Pr	ofile utilized		
		and size of the sling to use on		by Nursing Assistants for car			
		apply a left hand splint as		updated to reflect the approp	•		
	directed by the care	e plan.		application schedule. Once i			
	An intensional	and until all with the		sling was applied as ordered	1.		
	An interview was co	/22/17 at 6:23 PM. The		The QAPI committee's plan	of correction		
		that the Quality Assurance		for monitoring care plans fro			
		t monthly and included the		previous citation was very na			
		al Doctor (MD), attending		focused on palm guards and			
		of Nursing (DON), quality		comprehensive to include sp			
		department heads. She		status, and type of sling			
	added that since the	e last follow up complaint					
	survey they have ac	dded additional members to		The procedure for implemen			
	· ·	hat included the Chief Medical		acceptable plan of correction	n for the		
		ursing Executive. In addition		specific deficiency cited:			
		s of the committee they have		On 4/0/40 - nous lateralisation			
		uency of the meeting to		On 1/3/18, a new Interdiscip			
		cent survey results and audits. tated that the have essentially		(IDT) Rounds process was in Members of the IDT included			
		und program and the DON		Physician, a representative f			
		y wound in the building and		Social Worker, Clinical Nurs			
		staffing on the weekend to		DON, Activity Representative	•		
		e covering the wound protocol		Informatics and Analytics Se			
	1	correct treatments were		a representative from Therap			
	initiated. She added	that the current wound nurse		front-line Nursing Assistants			
	was also coming in	on the weekends to help		process included the develo	pment of the		
		program. Another key		template for the IDT to utilize			
		ON had initiated was a weekly		performing the meetings with			
		m (IDT) meeting and they		residents present to ensure	•		
		e new admission, weights,		information was captured. P	•		
	wounds and etc. an	d then that all that information		orders, resident profile, and	care plan		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345096	B. WING			R-C	
	ROVIDER OR SUPPLIER	340000		12019	ET ADDRESS, CITY, STATE, ZIP CODE VERHOEFF DRIVE TERSVILLE, NC 28078	12/22/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
{F 520}	stated that currently sway for the facility to was to go room to rocomprehensive meet and find out what we resident. She added was stable at the facilitied an assistant dir	A meeting. The Administrator she believed that the only identify the resident's needs	{F 5	ree ree economic r	ere revised/updated to reflect current sident status, and items identified as quiring a "fix" to meet the resident's reds were resolved prior to leaving the sident's room. In the event a piece of quipment/supply was not able to be fix obtained immediately, a work order as initiated. The resident profile for alsidents was updated to reflect the recific needs of the resident, to include at not limited to, transfer status, type/sizeling for residents transferred via host, and splint application. During the ID runds, the team was responsible for atching the Resident Profile with the lare Plan, and the Physician ensured and the reflect of the eigenformation was entered accurately need the Electronic Medical Record (EMR) is new to the facility. During the part of correction is effective and the period of the regulator of the eigenformation was entered accurately need the Electronic Medical Record (EMR) is new to the facility. During the part of correction is effective and the period of the regulator of the eigenformation was entered accurately need to deficiency cited remains corrected a group of Leadership members and/or in compliance with the regulator of the eigenformation of the eigenformation of the second of the eigenformation of the eigenformation of the second of the facility of the individual is out of the facility of the individual is out of the facility of the facility of the individual is out of the facility of the facility of the individual is out of the facility of the facility of the individual is out of the facility of the facility of the facility of the facility of the individual is out of the facility of the facili	e of xed I le, size yer OT all ry ers g ace. oific e to	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345096	B. WING			R-C	
NAME OF D	ROVIDER OR SUPPLIER	0-10000	1	STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	12/22/2017	
NAME OF PI	ROVIDER OR SUPPLIER				<i>,</i> _		
HUNTERS	VILLE OAKS			12019 VERHOEFF DRIVE			
				HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		DATE	
{F 520}	Continued From page	÷ 4	{F 52	for the day. Zone owners wer accessing and utilizing the Re Profile found on Care Tracker residents have appropriate slissplints as outlined in the Resi Rounding assignments are quextensive and include auditing residents rights, physical enviand individualized resident neamongst other areas. To mon rounds, the facility will add a 'Down' meeting to provide find Zone Owners of Resident Procease Plans that need to be upareas of discrepancy will be in addressed during the stand down the IDT. IDT Zone Owners required to complete rounds assigned residents Monday the Friday for 4 weeks and attend down meeting each day. On tweekends for 4 weeks, the clisupervisor and manager on down require slings and splint determine the appropriate type slings for residents transferre lift and splint application. Date 1/15/18 Service Line Nurse Educator Facility Educator provided in-MDS Coordinators, nursing sinursing assistants on the processing assis	esident r to ensure lings and ident Profile uite g of ironment, eeds, nitor the ID "Stand dings of the ofiles and pdated. An mmediately down meeti s will be on their hrough d the stand the linical duty will be of resider application be and size ed via hoyer e Certain: and the eservices to staff and cess flow of orders, plan embers who the specifi	e. T e y y y ng I nts n to e of r	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED						
			D MANO				R-C	
		345096	B. WING _			12/	22/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIINTEDO	VILLE OAKS			12	2019 VERHOEFF DRIVE			
HUNTERS	WILLE OAKS			Н	UNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	MMARY STATEMENT OF DEFICIENCIES JD PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
{F 520}	Continued From page	e 5	{F 5	520}	required to complete training prior to working a scheduled shift. Date certain 1/15/18 The IDT rounding team conducted 100 audit of matching the Resident Profiles with the Care Plans, as the Physician ensured all orders were entered appropriately. MDS Coordinator or designee, will conduct weekly 100% audif scheduled quarterly and annual care plans being conducted in resident's root to ensure Resident Profiles, Care Plans and Physician Orders match. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Direct of Nursing on a weekly basis and with QAPI monthly for a period of 90 days a which time frequency of monitoring will determined by the QAPI Committee. Described in the profile with any new orders. Clinical supervisors will be responsible for ensuring the floor nurse has updated the resident profiles appropriately upon stated of their shift. The clinical supervisors we bring the 24-hour order report to morning stand-up and be prepared to discuss the updates. The MDS Coordinators will the responsible to verify the resident profile was updates accurately and that the caplan is reflective of any changes. On weekends, the clinical supervisors will p the 24-hour order report and ensure the resident profiles have been updated appropriately. Clinical supervisors are	% , udit e oms s at ctor it be oate are undit e oms s at ctor undit e oms s at undi		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	345096	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	22/2017
	SVILLE OAKS			12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 520}	Continued From page	e 6	{F 5	520}	responsible for pulling the 72-hour ordereport on Monday mornings and follow the normal process of bringing the repot to morning stand-up meeting to give to MDS Coordinators. Date certain 1/17/1 IDT rounds will be conducted in resider rooms on a quarterly basis going forwat to be incorporated into the already existing schedule for care plans. Date certain: 1/17/18. The title of the person responsible for implementing the acceptable plan of correction. The DON will have overall responsibilit for oversight of the care plan process. MDS Coordinators will be responsible ensuring the Resident Profile is reflection of changes made to a resident's care plan. MDS Coordinators will maintain to in-room assessments during care plan meetings which will allow the team to visualize any opportunities to enhance residents' environment or plan of care. Date certain: 1/17/18	ing ort 8 nt urd, y for ve	

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NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE OAKS CAUTURE CAUTU		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
HUNTERSVILLE OAKS (XA) ID PREFIX TAG (SA) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 SS=D Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) S483.21(b) Comprehensive Care Plans S483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at \$483.10(c)(2) and \$483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mential and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that would otherwise be required under \$483.24, \$483.25 or \$483.40; and (ii) Any services that would otherwise be required under \$483.24, \$483.25 or \$483.40 but are not			345096	B. WING _			12/22/2017
PRÉFIX REGULATORY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 SS=D Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b) (1) §483.21(b) Comprehensive Care Plans §483.21(b) (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40 but are not					12019 VERHOEFF DRIVE)E	
CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	SS=D	S483.21(b) Compre §483.21(b) (1) The fimplement a compre care plan for each resident rights set fo §483.10(c)(3), that is objectives and time medical, nursing, an needs that are idential assessment. The confective the following (i) The services that or maintain the resident ander §483.10, inclusive and time medical, mental, and required under §483.10, inclusive and the under §483.10, inclusive	hensive Care Plans acility must develop and chensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's ind mental and psychosocial diffied in the comprehensive comprehensive care plan must ing - is are to be furnished to attain dent's highest practicable ind psychosocial well-being as 3.24, §483.25 or §483.40; and it would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 33.10(c)(6). services or specialized es the nursing facility will of PASARR if a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the ative(s)- oals for admission and reference and potential for acilities must document it's desire to return to the essed and any referrals to des and/or other appropriate dose. Sin the comprehensive care				1/17/18

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

Electronically Signed 01/17/2018

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345096	B. WING _			12/22/2017
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078)E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	
F 656	requirements set for section. This REQUIREMEN by: Based on record refacility failed to including with a history of fall the body lift for transfer and size of the sling resident fell from the skin tear to his head right arm, a skin tear teeth for 1 of 5 reside interventions on care facility also failed to care planned for 1 or limited range of motified range of motified with diagnod disease, depression review of the most reset (MDS) dated 09/had short term and leand was severely implication making. The Resident #22 was to be mobility and transfer mobility and transf	in accordance with the th in paragraph (c) of this T is not met as evidenced views and staff interviews the de in a care plan of a resident that the resident needed a full and did not specify the type to use on the lift. The lift sling which resulted in a pruising to his head and to his right knee and broken ents sampled for transfer e plans (Resident #22). The apply a left hand splint as f 4 residents sampled with on/contractures (Resident #32). The apply a left hand splint as f 4 residents sampled with on/contractures (Resident #32). The apply a left hand splint as f 4 residents sampled with on/contractures (Resident #32) and Alzheimer's disease. A excent quarterly Minimum Data (27/17 indicated Resident #32) and the MDS further indicated tally dependent on staff for insfers.	F 6	DISCLAIMER: Preparation and/or execution of Correction does not constite admission or agreement by the truth of the facts alleged conclusions set forth in this set deficiencies. The Plan of Corprepared and/or executed so it is required by the provision and State law. F656 The plan of correcting the specificiency. The plan should a processes that lead to the decited; During the annual/follow-up set 12/22/17, surveyors reviewed #22 and Resident #56. Reside Baseline Care Plan was reviewed was determined the facility diprocess to capture the approprants of the plan format was include transfer status and failed to it in addition, the Resident Professional Nursing Assistants for care hupdated to reflect the appropratus and sling type/size.	tute he provide or statement of rection is elely becau s of Feder ecific eddress the efficiency survey end d Resident dent #22 sewed and i id not have priate dentify the i the 11/28/ facility s as updated ing type/si file utilized as been	er of of ise al e ding t s it e a //17 d to ize. I by

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		345096	B. WING _			12	/22/2017
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				12	019 VERHOEFF DRIVE		
HUNTERS	VILLE OAKS			нι	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pag	ge 2	F 6	656			
		alls triggered and was			Resident #56□s Physician Orders we	re	
	addressed in the cal				reviewed and it was determined the fa		
	addressed in the sa	io pian.			did not have an updated Resident Pro	-	
			to reflect the application of the left	, o			
		cated a potential for falls due			wrist/hand splint, which was not appli-	ed in	
		weakness, decreased			the morning and removed in the even		
	mobility and a histor	y of multiple fractures. There			as ordered. The Resident Profile utiliz	ed	
	were no approaches	or interventions to indicate			by Nursing Assistants for care was		
		be transferred with a full			updated to reflect the appropriate spli	nt	
	•	as no indication of the type or			application schedule. Once identified		
	size of sling to be us	sed during the transfer.			during the survey, the sling was applias ordered.	ed	
		e and palliative care visit					
		at 2:17 PM, documented by			The procedure for implementing the		
	•	idicated Resident #22 fell			acceptable plan of correction for the		
		The notes revealed the sling			specific deficiency cited:		
		to transfer Resident #22 in the			On 1/2/19 a new Interdisciplinary Too		
		ort his bottom and they would erent type of sling for			On 1/3/18, a new Interdisciplinary Tea (IDT) Rounds process was initiated.	1111	
	transfers.	sterit type of sillig for			Members of the IDT included, a		
	transiers.				Physician, a representative from MDS	;	
	A review of an incide	ent log dated 11/19/16			Social Worker, Clinical Nurse Supervi		
		22 was in a total body lift and			DON, Activity Representative, Dietitia		
		. The document indicated			Informatics and Analytics Services (IA		
	· · · · · · · · · · · · · · · · · · ·	it of the sling attached to the			a representative from Therapy, and	,	
	lift, onto the floor, bo	ottom first and hit his head on			front-line Nursing Assistants. The IDT	•	
	a pole of the total bo	ody lift. The report further			process included the development of	the	
		ember called a week later			template for the IDT to utilize while		
		oticed Resident #22 was			performing the meetings with the		
	_	front teeth that were broken			residents present to ensure all pertine	ent	
	with the roots still in	place.			information was captured. Physician		
	A rovious of the Leiti-	I Interdicciplines, Care Dian			orders, resident profile, and care plan		
		II Interdisciplinary Care Plan aled Resident #22 had a fall			were revised/updated to reflect currer		
		h a full body lift. A section			resident status, and any discrepancie were resolved prior to leaving the	5	
	•	s had a hand written note that			resident □s room. In the event a piece	of	
		ered but there were still no			equipment/supply was not able to be		
	•	ventions to use a full body lift			or obtained immediately, a work order		
		pe of sling or size of sling to			was initiated. The resident profile for a		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345096	B. WING _			12/	22/2017
NAME OF P	ROVIDER OR SUPPLIER		· I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UUNTEDO	VILLEOAKS			12	2019 VERHOEFF DRIVE		
HUNIERS	VILLE OAKS			Н	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	11/28/16 indicated R dependent for all act to be transferred with recent fall from the lift puring an interview of Director of Nursing (no transfer intervential interdisciplinary #22's fall from the lift until a new care plans She explained she wand occupational the and make the safest transfers and that sh staff to follow their results of the Administrator she expectations to see a the care plan. She expectational therapy determining a reside they made their detection on the care. She further could be updated as During an interview of a physical therapist staff.	an with a revised date of resident #22 was totally ivities of daily living and was in a mechanical lift but had a ft. On 12/21/17 at 3:28 PM the DON) confirmed there was ions or approaches on the cy care plan prior to Resident it or after the fall from the lift in was revised on 11/28/16. If yould want physical therapy erapy to screen a resident recommendations for rould be care planned for ecommendations. On 12/22/17 at 9:27 AM with the stated it was her a resident's transfer status on explained physical therapy or were involved in int's transfer status and once ermination there should be ursing staff on how to provide in stated interim care plans	F6	656	residents was updated to reflect the specific needs of the resident, to include but not limited to, transfer status, type/s of sling for residents transferred via Holift, and splint application. During the IE rounds, the team was responsible for matching the Resident Profile with the Care Plan, and the Physician ensured orders were entered appropriately. A member from IAS was included to verificate information was entered accurately since the Electronic Medical Record (EMR) is new to the facility. During the IDT rounds, the team Date certain: 1/12/18 Orientation for new teammates will include updating the resident profile, accessing the resident profile, and resident care plan implementation. Data certain 1/15/18 The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements Beginning 1/15/18, the Administrator selected a group of Leadership members as Zone Owners, to focus on monitoring the updates completed during IDT rounding to ensure continued compliant Each Zone Owner has received a specific deficiency of the specific deficiency continued compliant Each Zone Owner has received a specific deficiency of the specific deficiency continued compliant Each Zone Owner has received a specific deficiency of the specific deficiency continued compliant Each Zone Owner has received a specific deficiency of the specific deficiency continued compliant Each Zone Owner has received a specific deficiency of the specific deficienc	e e at nat cted y	
	to the facility and ma for safe transfers. S totally dependent on would have expected	tide recommendations to staff he stated Resident #22 was staff for everything and she d for staff to include a total lift ention on his care plan.			assignment of residents to monitor. The assignments include a back-up person cover if the individual is out of the facili for the day. Zone owners were trained accessing and utilizing the Resident	e to ty	

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345096	B. WING _			12/:	22/2017
			12	2019 VERHOEFF DRIVE	•	-
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	X			(X5) COMPLETION DATE
2. Resident #56 was 07/28/16 with diagnor multiple sclerosis an condition which can of the body to be in a contraction. Review of the activity plan updated on 01/0 limitations with a goa ADL with approache splint to be applied every evening. During a review of the orders, an order date wrist/hand orthosis a remove in the evening. A review of the most (MDS) assessment of Resident #56 as cogniterview for Mental having functional improfile for Resident #56 as cogniterview of the Nursir profile for Resident #50 as apply the evening. A review of the 12/20 Record (MAR) for Rehand splint to be dor removed in the even splint was document	s admitted to the facility on osis that included progressive d spastic hemiplegia, a cause muscles on one side a constant state of y of daily living (ADL) care 03/17 addressed functional al to continue to participate in sthat included a left hand every morning and removed The Resident #56's physician and 10/17/17 read: left applied in morning and and and and and and and are cent minimum data set dated 10/18/17 coded antitively impaired, with a Brief Status (BIMS) of 5 and as pairment with limited range of left hand. The Assistant's (NAs) resident #56 noted a left wrist hand in the morning and remove in 1017 Medication Administration esident #56 indicated a left and in the morning and ing. Refusal of the hand	F	656	residents have appropriate slings and splints as outlined in the Resident Profit Rounding assignments are quite extensive and include auditing of residents rights, physical environment, and individualized resident needs, amongst other areas. To monitor the IE rounds, the facility will add a Stand Domeeting to provide findings of the Zone Owners of Resident Profiles and Care Plans that need to be updated. Any are of discrepancy will be immediately addressed during the stand down meet by the IDT. IDT Zone Owners will be required to complete rounds on their assigned residents Monday through Friday for 4 weeks and attend the stand down meeting each day. On the weekends for 4 weeks, the clinical supervisor and manager on duty will be responsible for auditing 100% of reside who require slings and splint application determine the appropriate type and sizislings for residents transferred via Hoy lift and splint application. Date Certain: 1/15/18 Service Line Nurse Educator and the Facility Educator provided in-services the MDS Coordinators, nursing staff and nursing assistants on the process flow expectations for verification of orders, care plan updates, and care plan implementation. Any required staff members who do not receive the training the specified date (due to FMLA, least the process of the process of the process of the specified date (due to FMLA, least the process of the process of the process of the specified date (due to FMLA, least the process of the process o	le. OT wn eas ting d ents n to e of er	
				by the specified date (due to FMLA, leadetc.) will be required to complete training	ive, ig	
	Continued From page 2. Resident #56 was 07/28/16 with diagnor multiple sclerosis and condition which can of the body to be in a contraction. Review of the activity plan updated on 01/0 limitations with a goa ADL with approache splint to be applied every evening. During a review of the orders, an order date wrist/hand orthosis a remove in the evening. A review of the most (MDS) assessment of Resident #56 as cogniterview for Mental having functional important (ROM) in the Review of the Nursir profile for Resident #56 as cogniterview for Mental having functional important (ROM) in the Review of the Nursir profile for Resident #50 as apply the evening. A review of the 12/20 Record (MAR) for Rehand splint to be dor removed in the even splint was document	A review of the activity of daily living (ADL) care plan updated on 01/03/17 addressed functional limitations with a populate overy evening. During a review of the Resident #56's physician orders, an order dated 10/17/17 read: left wrist/hand orthosis applied in morning and remove in the evening. A review of the Nursing Assistant's (NAs) resident profile for Resident #56 noted a left wrist hand splint to be donned in the morning and remove in the evening. A review of the Nursing Assistant's (NAs) resident profile for Resident #56 noted a left wrist hand splint or be donned in the morning and remove in the evening. A review of the Nursing Assistant's (NAs) resident profile for Resident #56 noted a left wrist hand splint orthosis apply in the morning and remove in the evening. A review of the Nursing Assistant's (NAs) resident profile for Resident #56 noted a left wrist hand splint orthosis apply in the morning and remove in the evening. A review of the Nursing Assistant's (NAs) resident profile for Resident #56 noted a left wrist hand splint orthosis apply in the morning and remove in the evening. A review of the 12/2017 Medication Administration Record (MAR) for Resident #56 indicated a left hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint was documented on the MAR for 12/6/17	A BUILDII 345096 B. WING ROVIDER OR SUPPLIER VILLE OAKS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 2. Resident #56 was admitted to the facility on 07/28/16 with diagnosis that included progressive multiple sclerosis and spastic hemiplegia, a condition which can cause muscles on one side of the body to be in a constant state of contraction. Review of the activity of daily living (ADL) care plan updated on 01/03/17 addressed functional limitations with a goal to continue to participate in ADL with approaches that included a left hand splint to be applied every morning and removed every evening. During a review of the Resident #56's physician orders, an order dated 10/17/17 read: left wrist/hand orthosis applied in morning and remove in the evening. A review of the most recent minimum data set (MDS) assessment dated 10/18/17 coded Resident #56 as cognitively impaired, with a Brief Interview for Mental Status (BIMS) of 5 and as having functional impairment with limited range of motion (ROM) in the left hand. Review of the Nursing Assistant's (NAs) resident profile for Resident #56 noted a left wrist hand splint orthosis apply in the morning and remove in the evening. A review of the 12/2017 Medication Administration Record (MAR) for Resident #56 indicated a left hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint was documented on the MAR for 12/6/17	A BUILDING B	NOVIDER OR SUPPLIER VILLE OAKS SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Condition which can cause muscles on one side of the body to be in a constant state of contraction. Review of the activity of daily living (ADL) care plan updated on 01/03/17 addressed functional limitations with a goal to continue to participate in ADL with approaches that included a left hand splint to be applied every morning and removed every evening. During a review of the Resident #56's physician orders, an order dated 10/17/17 read: left wrist hand remove in the evening. A review of the Nursing Assistant's (NAs) resident profile so conditional impairment with limited range of motion (RCM) in the left hand. Review of the 12/2017 Medication Administration Record (MAR) for Resident #56 indicated a left hand splint to be donned in the morning and remove in the evening. A review of the 12/2017 Medication Administration Record (MAR) for Resident #56 indicated a left hand splint to be donned in the morning and remove in the evening. A review of the 12/2017 Medication Administration Record (MAR) for Resident #56 indicated a left hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint to be donned in the morni	STREET ADDRESS, CITY, STATE, ZIP CODE 12/2

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345096	B. WING			12/22/2017	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		12/22/2017	
				12019 VERHOEFF DRIVE			
HUNTERS	VILLE OAKS			HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 656 Continued From page		e 5	F 65	66			
	Observations made of Resident #56 on 12/18/17 at 3:47 PM, 12/19/17 at 10:52 AM, 12/20/17 at			certain: 1/15/18			
	12:15 PM, 12/21/17 a	it 11:18 AM, and 12/22/17 at		The IDT rounding team condu	ucted 100%		
	9:00 AM revealed no	left hand splint being worn.		audit of matching the Resider	nt Profiles,		
				with the Care Plans, as the P	hysician		
	In an interview with R	esident #56 on 12/18/17 at		ensured all orders were enter	red		
	3:15 pm, she stated s	she was not receiving any		appropriately. MDS Coordina	tor or		
	treatment for her left	hand but would like to.		designee, will conduct weekly			
				of scheduled quarterly and ar			
		#5 on 12/22/17 at 9:06 am,		plans being conducted in resi			
		#56 used to have a splint but		rooms to ensure Resident Pro			
		a while and didn't know		Plans and Physician Orders r			
		time. She reported the		will continue for a period of 90	-		
		to wear it most of the time.		which time the QAPI committee			
	The NA explained if a			determine if further auditing is			
		n the resident profile to alert dent refused to wear their		Any identified issues will be c that time. Date certain: 1/12/1			
		orted to the nurse because		that time. Date certain. 1/12/1	10		
	the nurses document			Floor nurses will update the re	esident		
	the harses accament	ed it off their wirds.		profile with any new orders. C			
	During an interview w	ith Nurse #3 on 12/22/17 at		supervisors will be responsible			
	_	e had seen therapy work		ensuring the floor nurse has u			
		any times but was not sure		resident profiles appropriately	•		
	what they were doing	•		of their shift. The clinical supe			
				bring the 24-hour order report	t to morning		
	A subsequent observ	ation of Resident #56 on		stand-up and be prepared to	discuss any		
	12/22/17 at 1:15 pm i	evealed resident had a left		updates. The MDS Coordinat	ors will be		
	hand splint was in pla	ice.		responsible for verifying the re			
				profile was updated accuratel			
	-	ew with NA #5 on 12/22/17 at		the care plan is reflective of a			
	•	e had found the left hand		On weekends, the clinical sup			
		6 in the corner of her room		pull the 24-hour order report a			
		nd had applied it to her left		the resident profiles have bee	•		
	hand.			appropriately. Clinical supervi			
	In a subassuant inter	viow with Nurses #2 cs		responsible for pulling the 72-			
		view with Nurse #3 on he reported that the nurses		report on Monday mornings a the normal process of bringing			
	· ·	nning and doffing on the		to morning stand-up meeting			
	MAR.	and doming on the		MDS Coordinators. Date certa	•		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	L . COI		(X3) DATE COMP	SURVEY PLETED
		345096	B. WING _			12/	22/2017
	ROVIDER OR SUPPLIER VILLE OAKS			12	TREET ADDRESS, CITY, STATE, ZIP CODE 2019 VERHOEFF DRIVE UNTERSVILLE, NC 28078	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	9 6	F 6	356			
	reported Resident #5 time ago and a left ha didn't know the status Resident #56 was no A telephone interview at 4:13 pm, revealed needed (PRN) basis a say if she has ever se hand splint. She could documented splint pla Resident #56. An interview was con Nursing (DON) on 12 stated her expectation positioning/mobility de	22/17 at 4:00 pm, she 6 was on her caseload some and splint was ordered. She a of the hand splint since a currently on her caseload. with Nurse #4 on 12/22/17 she worked on an as at the facility and could not been Resident #56 wear a left d not remember if she had accement on the MAR for ducted with the Director of			IDT rounds will be conducted in resider rooms on a quarterly basis going forward to be incorporated into the already existing schedule for care plans. Result of the monitoring will be shared with the Administrator and Director of Nursing of weekly basis and with QAPI monthly for period of 90 days at which time frequer of monitoring will be determined by the QAPI Committee. Date certain: 1/17/18 The title of the person responsible for implementing the acceptable plan of correction. The DON will have overall responsibility for oversight of the care plan process. MDS Coordinators will be responsible to ensuring the Resident Profile is reflection of changes made to a resident scare plan. MDS Coordinators will maintain the in-room assessments during care plan meetings which will allow the team to visualize any opportunities to enhance residents environment or plan of care Date certain: 1/17/18	ts e on a or a ncy 3. y for ve ne	
F 677 SS=D	ADL Care Provided for CFR(s): 483.24(a)(2)	or Dependent Residents	F 6	677	Bate sertain: 1/1//10		1/17/18
	out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio	ent who is unable to carry iving receives the necessary good nutrition, grooming, and piene; is not met as evidenced ans, record review and terviews the facility failed to			DISCLAIMER: Preparation and/or execution of this Pla	an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
		345096	B. WING	·····	12	2/22/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				12019 VERHOEFF DRIVE		
HUNTERS	VILLE OAKS			HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From page	e 7	F 67	77		
	incontinence care for for incontinence care Findings included: Resident #22 was ad	or a perineal cleanser during 1 of 4 residents observed (Resident #22). mitted to the facility on ses which included heart		of Correction does not constitute admission or agreement by the truth of the facts alleged conclusions set forth in this sideficiencies. The Plan of Corprepared and/or executed so it is required by the provision and State law.	he provider of or statement of crection is olely because	
	disease, depression a review of the most re- Set (MDS) dated 09/2 had short term and lo and was severely imp decision making. The	and Alzheimer's disease. A cent quarterly Minimum Data 27/17 indicated Resident #22 ing term memory problems paired in cognition for daily e MDS further indicated ally dependent on staff for		F677 The plan of correcting the sp deficiency. The plan should a processes that lead to the decited:	address the	
	toileting, hygiene and incontinent of bladder	bathing and was always		During the annual/follow-up s 12/22/17, a surveyor observe failing to perform a basic nur- The nurse aide made a perso	ed NA #3 se aide skill.	
	12/22/17 at 11:32 AV #4 entered Resident bed. NA #3 checked	Nurse Aide (NA) #3 and NA #22's room and raised his Resident #22's brief and		use water and not include so perineal cleaner, when perfor perineal care for Resident #2	ap or rming 22. NA #4 was	
	NA #4 washed their h #3 ran water in a sink stated it was warm ar	pe changed and NA #3 and ands and put on gloves. NA in Resident #22's room and and took a clean bath towel of the towel under the faucet		present and had an opportun NA #3 was properly providing care but failed to do so. NA # received inservice training or care based on current policy.	g perineal #3 and NA #4 n perineal	
	to wet one end with w draped over the side #3 then carried the to	or the torse and the control of the sink and was dry. NA wel to Resident #22's bed or a perineal cleanser on the		NA #3 and NA #4 were couns of the progressive disciplinar Following this observation, R received perineal care based	seled as part y process. lesident #22	
	wet end of the towel. on his left side and N which was wet and pl bag. NA #3 then use	Resident #22 was turned A #3 removed his brief aced it into a clear plastic d the wet end of the towel //een Resident #22's legs		policy. The procedure for implement acceptable plan of correction specific deficiency cited:	ting the	
	from front to back wh side but did not separ	ile he was still on his left rate his legs. NA #3 then the same wet end of the		Service Line Nurse Educator Facility Educator provided in-		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345096	B. WING _		12/22/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, 2	•
				12019 VERHOEFF DRIVE	
HUNTERS	SVILLE OAKS			HUNTERSVILLE, NC 28078	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAI	N OF CORRECTION (X5)
PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COMPLETION DATE DATE
F 677	Continued From p	age 8	F	677	
	towel. She then to	irned the towel to the dry end		nursing staff and nursir	ng assistants on
	and wiped down his buttocks while he was still on his left side and then inside his legs again and			perineal care based on	current policy.
				Competency was evalu	lated using a return
		nto a clear plastic bag. NA #3		demonstration on a ma	•
	then put a clean brief on Resident #22 and pulled			direct patient care obse	-
his pants up. During an interview on 12/22/17 at 11:46 AM with			members who do not re	•	
			by the specified date (d		
			etc.) will be required to	-	
	NA #3 she confirmed she only used water to clean Resident #22 and had not used any soap or perineal cleanser. She stated there was periwash in Resident #22's closet and said she			prior to working a sche	duled shift. Date
				Certain. 1/12/17	
				Orientation for new tea	mmates will
	1 '	ause she guessed she was a		include training and cor	
		confirmed she did not open		peri-care. Date certain:	
		n during incontinence care		•	
	because she clear	ned him all from one side. She		The monitoring procedu	ure to ensure that
	then stated she tri	ed not to turn him too much		the plan of correction is	
	_	vere contracted and she did not		specific deficiency cited	
	want to hurt him.			and/or in compliance w requirements;	ith the regulatory
		w on 12/22/17 at 12:15 PM, the			
		g (DON) stated it was her		Service Line Nurse Edu	
		rse Aides to use soap and		Facility Educator will co	-
	_	tinence care and they should		observations of the Nu	
		back to prevent urinary tract		perineal care to validate	
		ated use of only water during		competency. Observati	
	incontinence care	was unacceptable.		conducted on 5 CNAs on week, 3 CNAs on second	
	During an interviev	w 12/22/17 at 3:40 PM with		on third shift for a perio	
		ysician who was also the facility		identified issues will be	
		e stated use of water only		time they are identified.	
		e care was unacceptable. He		monitoring will be share	
		xpectations for procedures to		Administrator and Direct	
	be followed during	incontinence care.		weekly basis and with 0	-
				period of 90 days at wh	
		w on 12/22/17 at 2:59 PM, the		of monitoring will be de	termined by the
		irmed she had been made		QAPI Committee.	
	_	of the incontinence care			
	provided to Reside	ent #22 She stated use of		The title of the person r	esponsible for

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345096	B. WING		12/22/2017
	ROVIDER OR SUPPLIER VILLE OAKS		•	STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 677	Continued From page water only during incoming have happened.	e 9 ontinence care should not	F 67	implementing the acceptable plan of correction. The DON will be responsible for over for this plan of correction. Date certain	
F 689 SS=D	CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensi §483.25(d)(1) The re as free of accident has	i.	F 68	1/17/18 F 689	
	supervision and assist accidents. This REQUIREMENT by: Based on observation physician and staff in safely transfer a residuse the correct sling from sliding out of the resulted in a skin teat head and right arm, a and broken teeth and complete neurologicate for 1 of 5 sampled reprevent accidents (RFindings included: Resident #22 was ad 08/24/16 with diagnod disease, depression review of the most reset (MDS) dated 09/3	is not met as evidenced ins, record review and iterviews the facility failed to dent with a total body lift and size to prevent the resident e sling onto the floor which in to his head, bruising to his a skin tear to his right knee I the facility failed to all assessments after the fall sidents for supervision to		DISCLAIMER: Preparation and/or execution of this for Correction does not constitute admission or agreement by the provision the truth of the facts alleged or conclusions set forth in this statement deficiencies. The Plan of Correction is prepared and/or executed solely becaute it is required by the provisions of Fed and State law. F689 The plan of correcting the specific deficiency. The plan should address processes that lead to the deficiency cited: During the annual/follow-up survey es 12/22/17, surveyors reviewed Resides #22 and determined the facility did not survey the surveyors reviewed Resides #22 and determined the facility did not survey the surveyors reviewed Resides #22 and determined the facility did not survey the surveyors reviewed Resides #22 and determined the facility did not survey the surveyors reviewed Resides #22 and determined the facility did not survey the surveyors reviewed Resides #22 and determined the facility did not survey the surveyors reviewed Resides #22 and determined the facility did not survey the surveyors reviewed Resides #22 and determined the facility did not survey the surveyors reviewed Resides #22 and determined the facility did not survey the surveyors reviewed Resides #22 and determined the facility did not survey the survey that survey the survey the surveyors reviewed Resides #22 and determined the facility did not survey the survey the survey that survey the survey the survey that survey the surve	der of at of s ause eral the

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345096	B. WING			12/	22/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 121	22/2017
					2019 VERHOEFF DRIVE		
HUNTERS	VILLE OAKS				IUNTERSVILLE, NC 28078		
					, 		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	Continued From page	e 10	F	689			
	and was severely impaired in cognition for daily have a process to captu		have a process to capture the appropr	iate			
		e MDS further indicated			transfer status and failed to identify the		
	_	ally dependent on staff for			specific sling type. Following a fall, vita		
	bed mobility and tran				signs were documented q shift for 72		
					hours per physician orders. However,		
	A review of a fall risk	assessment dated 11/16/16			neuro checks were not included as pa	rt of	
	revealed Resident #2	22 had a total risk score of 20			the documentation. The facility's policy	/ at	
	which indicated he wa	as high risk for falls.			the time of the fall did not include that		
					neuro checks should be conducted on	а	
		note dated 11/19/16 at 11:20			resident who fell. The falls policy has		
		Nurse #1 revealed Resident			since been updated to include neuro		
	_	erred by a total body lift by 2			checks for all unwitnessed falls and	_	
		hen Resident #22 slipped			suspected head injuries following a fal		
		ell to the floor. The notes			Transfer status and sling type are now		
		22 hit his head on the bar of			included with the baseline/interim care	i	
	· ·	rter size skin tear on top of a was cleaned with normal			plan completion within 24 hours of admission. The transfer status for		
		(foam) border dressing was			Resident #22 and type of sling approp	riato	
	· ·	urther indicated Resident			for transfers has been updated in the		
		en but was non-verbal with			plan and resident profile.	,aic	
		otes revealed Resident #22			plan and resident preme.		
		bed with the total body lift			The procedure for implementing the		
		tioner (NP) and responsible			acceptable plan of correction for the		
	party (RP) were notifi				specific deficiency cited:		
		e on call note dated 11/19/16			Falls policy has been updated to reflect	t	
		d a report was received that			the Medical Director's expectations in		
		sident #22 up with a total			regards to neurological monitoring,		
	_	ut of the sling onto the floor.			post-fall. New parameters developed f	or	
		icated Resident #22 hit his			documenting neuro checks after all		
	-	some bleeding from his ose consciousness and a			unwitnessed and/or suspected head injury, post-fall. Date certain 1/12/18		
		make a visit to assess him.			injury, post-iaii. Date certaiii 1/12/16		
	Hospice Hurse Would	mane a visit to assess IIIII.			Service Line Nurse Educator and the		
	A review of a hospice	and palliative care visit note			Facility Educator provided inservices t	0	
		7 PM documented by			nursing staff related to the new		
		dicated a visit was made to			parameters and documentation		
	•	sident #22 fell from a total lift.			requirements in the EMR. Any nurses	who	
	·	Pesident #22 was alert hut			do not receive training by the specified		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345096	B. WING			2/22/2017	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C	•	ZIZZIZOTI	
	10 115211 011 001 1 21211			12019 VERHOEFF DRIVE	001		
HUNTERS	VILLE OAKS						
				HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From page	e 11	F 68	39			
	nonverbal and was in	no acute distress. The		date will not be allowed to	work a shift		
		d Resident #22 had a 3.0		until training/education has			
		h x 1.5 cm width x 0.5 cm		completed. Date certain 1/1			
		e top of his head, a 2.5 cm					
	•	ruised knot on his parietal		On 12/21/17, MDS Coordin	ators and		
	_	nis head) and a 2.5 cm		Nurse Supervisors conduct			
		ruised knot on his occipital		facility-wide audit of resider			
		s head), a 4 cm length x 2		via lift to ensure proper slin			
	T	s right arm and a 1 cm		place. This audit was utilize			
		right knee. The notes		new Interdisciplinary Team			
	revealed the sling typ	e that was used to transfer		process, to observe that the			
	Resident #22 in the total lift did not support his			transfer status was identifie	ed and the		
	bottom and they would	d attempt to get a different		specific sling type was bein	g utilized. On		
	type of sling for transf	fers.		1/3/18, a new Interdisciplina	ary Team (IDT)		
				Rounds process was initiat	ed. Members		
	A review of a post fall	risk assessment dated		of the IDT included, a Phys			
	11/19/16 revealed Re	sident #22 had a total risk		representative from MDS, S			
		icated he was high risk for		Clinical Nurse Supervisor, I	•		
	falls.			Representative, Dietician, I Analytics Services (IAS), a			
	A review of an incider	nt log dated 11/19/16		from Therapy, and front-line	e Nursing		
	revealed Resident #2	2 was in a total body lift and		Assistants. The IDT proces	s included the		
		The document indicated		development of the templat			
		of the sling attached to the		utilize while performing the	•		
		tom first and hit his head on		the residents to ensure all p			
		ly lift. The report further		information was covered. P	•		
	-	mber called a week later		orders, resident profile, and	•		
	_	ticed Resident #22 was		were revised/updated to re			
	_	ont teeth that were broken		resident status, and any dis	•		
	with the roots still in p	lace.		were resolved prior to leavi			
				resident's room. In the ever			
	_	locument titled Skilled		equipment/supply was not a			
		ation completed by Nurse #1		or obtained immediately, a		 	
		22 had a fall on 11/19/16 at		was initiated. Another temp			
		from a total body lift. A		created to use for the Resid			
		iption of fall activity revealed		outline to ensure each resident	•		
		o the floor from a total body		contained the same information the IDT rounds, the team w			
		n 2 NAs present. The		the IDT rounds, the team w			
	aocament lattrer mai	cated Resident #22 had		for matching the Resident F	TOTHE WILL LIFE		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345096	B. WING _		12/22/2017
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP	•
				12019 VERHOEFF DRIVE	
HUNTERS	VILLE OAKS			HUNTERSVILLE, NC 28078	
	0,1111112	V OTATEMENT OF REFIGIENCIES			- CORDECTION
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION DATE
F 689	Continued From p	page 12	F 6	889	
	poor safety aware	ness and the injury type was		Care Plan, and the Physic	cian ensured all
		nd abrasion at the top of his		orders were entered appro	
	head. The docum	nent revealed the NP and RP		member from IAS was inc	luded to verify
	were notified. The	e document further revealed a		the information was entere	ed accurately
	section labeled ide	entification of cause of the fall		since the Electronic Medic	cal Record
	indicated Residen	t #22 was assisted 100 percent		(EMR) is new to the facility	y. Date certain:
	by total body lift a	nd he slipped out of the sling		1/12/18	
		A section labeled immediate			
		cated the NA's involved were		The baseline care plan ha	
	instructed on patie	ent safety.		to reflect the new regulator	
				effective 11/28/17, with a	
		ial interdisciplinary care plan		to identify the transfer stat	us and sling
	•	/16 indicated no transfer method		type of all admissions.	
		nowever, hand written notes		The monitoring procedure	to anoure that
		n fall during transfer with a total w total body sling was ordered.		The monitoring procedure the plan of correction is ef	
	body ilit alid a liev	w total body sillig was ordered.		specific deficiency cited re	
	A review of a phys	sician's order dated 11/19/16 at		and/or in compliance with	
		I for Resident #22 to remain in		requirements;	and regulatory
	bed until Monday				
	,			Beginning 1/15/18, the Ad	ministrator
	A review of a nurs	e's note summary dated		selected a group of Leade	
		:00 PM to 11:00 PM shift		as Zone Owners, to focus	on monitoring
	documented by N	urse #2 indicated vital signs as		the updates completed du	
	follows: blood pre	essure 143/92, pulse 80,		rounding, to ensure contin	nued
	respirations 18, ox	xygen saturation percentage		compliance. Zone owners	were trained on
		ir and temperature 98.5		accessing and utilizing the	
		eit (F). The notes revealed		Profile found on Care Trac	
		alert and responsive but there		residents have appropriate	
	were no neurologi	ical assessments.		outlined in the Resident P	<u> </u>
	A	ala mata aumanam. U. U. U		assignments are quite ext	
		e's note summary dated		include auditing of resider	-
		1:00 PM to 7:00 AM shift		physical environment, and	
		urse #2 indicated Resident #22		resident needs, amongst of monitor the IDT rounds, the	
	neurological asset	shift but there were no		add a "Stand Down" meet	-
	neurological asset	33HEH3.		findings of the Zone Own	
	Δ review of a phys	sician's order dated 11/20/16 at		Profiles and Care Plans th	
		I strict bed rest until new total		updated. Any areas of dis	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345096	B. WING		12	2/22/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	10:00 AM documenter Resident #22 awaker notes revealed vital spressure 130/54, pulloxygen saturation per and temperature 98.8 no neurological asses A review of a nurse's 11/20/16 for the 3:00 documented by Nurse follows: blood pressurespirations 18, oxygon room air and temperature distress but the assessments. A review of a nurse's 11/20/16 for the 11:00 documented by Nurse follows: blood pressurespirations 18 oxygon room air and temperature by Nurse follows: blood pressurespirations 18 oxygon room air and temperature to make the period of the surface of	note dated 11/20/16 at ed by Nurse #1 indicated ned to verbal stimuli. The signs as follows: blood se 65, respirations 20, reentage was 98 on room air 8 degrees F but there were ssments. note summary dated PM to 11:00 PM shift e #2 revealed vital signs as re 117/65, pulse 75, en saturation percentage 95 perature 98.3 degrees F. Resident #22 had no pain or ere were no neurological note summary dated 0 PM to 7:00 AM shift e #2 revealed vital signs as re 120/60, pulse 60, en saturation percentage 91 perature 98.3 degrees F. realed Resident #22 was in a closed and his chest was with each breath but there	F 689	immediately addressed during down meeting by the IDT. Date 1/15/18 Service Line Nurse Educator a Facility Educator provided in-sequence nursing staff and nursing assist safe Hoyer lift transfers and how identify the appropriate sling. A orientees will receive the outline education. Any staff members are receive the training by the spece (due to FMLA, leave, etc.) will be to complete training prior to woo scheduled shift. Date certain 1/2 Observations on Hoyer lift transponded on 5 CNAs on day so week, 3 CNAs on second shift, on third shift for a period of 90. The IDT rounding team conduct audit of matching the Resident with the Care Plans, as the Phyensured all orders were entered appropriately. Any identified issuppropriately. Any identified issuppropriately. Any identified issuppropriately basis and with QAPI more period of 90 days at which time of monitoring will be determined QAPI Committee. The clinical supervisors will be responsible for bringing the corbaseline care plan to morning someeting for all new admissions with the IDT. A 100% audit will	e Certain: and the ervices to tants on we to all new ed who do not cified date be required orking a (11/18) and 1 CNA days. ated 100% Profiles, ysician desue was of the elursing on a conthly for a efrequency dept to discuss		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		E SURVEY IPLETED
		345096	B. WING _			1:	2/22/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 689	on room air and tempontes further revealer and responsive but the assessments. A review of a nurse's AM indicated Resider with eyes closed. The as follows: blood presponsive but the spirations 20, oxygon room air and temponters were no neuroled. A review of a hospice indicated they were stained for Resident #25 lift. A review of a docume Report dated 12/02/1 was located at upper indicated roots were broken off. A review of a physicial indicated it was okay broda chair (tilting an body sling for a maxil from a Social Worker	re 119/58, pulse 81, en saturation percentage 94 perature 98 degrees F. The d Resident #22 was alert here were no neurological note dated 11/22/16 at 3:45 int #22 was in bed resting e notes revealed vital signs essure 109/53, pulse 86, en saturation percentage 94 perature 98.7 degrees F but ogical assessments.	F	689	conducted of all baseline care plans for new admissions with a special focus of the transfer status and type of sling. According to the manufacturer's guidelines for the slings used within the facility, the weight of a resident determines which size of sling is most appropriate. The monthly weights spreadsheet populated by the register dietitian has been formatted to automatically identify the most appropesling based off the resident's weight pet the manufacturer's guidelines. Once the monthly weights are completed, the R responsible to complete the spreadsheard send to the IDT. The clinical supervisors will then determine if a different size of sling is needed. If a new sling is needed based off the weight, the clinical supervisor will replace the sling and update the resident profile. MDS were be responsible for updating the care public plan of correction. The title of the person responsible for implementing the acceptable plan of correction. DON will be responsible for implement the acceptable plan of correction.	e ed riate er he D is eet ew he G will lan.	
	some decay from the indicated no medical	22 was not in pain but had missing teeth. The email interventions were planned see Resident #22 during the 2017.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345096	B. WING			12/	22/2017	
	ROVIDER OR SUPPLIER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 2019 VERHOEFF DRIVE UNTERSVILLE, NC 28078	1 12/	22/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	During an interview Nurse #1 she stated transferring Resider get him up for lunch called to the room. S walked into the room bed and Resident # on the floor. She st recalled he had a bu recall skin tears and and did not lose cor after they took his vi sling under him he f body lift to transfer h stated she called the to inform them of Re they used a standar because that was th Resident #22 fell the longer sling for him. resident had a fall a supposed to do neu checks) every 15 m then every 30 minut hourly and the stand assessments was fo stated she could not checks but she thou during routine round	on 12/21/17 at 10:48 AM with I NA #1 and NA #2 were at #22 with a total body lift to on 11/19/16 and she was She explained when she at the total lift was beside the 22 was lying beside the bed ated she assessed him and tump on his head but did not I he did not seem to be in pain asciousness. She explained ital signs they put the same tell from and used the total anim back to bed. She further the hospice nurse, NP and RP the sident #22's fall. She stated at sling for Resident #22 the only size they had but after the hospice nurse ordered a she explained when a and hit their head they were rological assessments (neuro inutes for a period of time then dard time for post fall for 72 hours after the fall. She the remember doing neuro aght they checked on him dis.		689				
	fell from a total body she was not present was reported to her 11/21/16 but she did She explained she r	rvisor explained Resident #22 y lift on Saturday 11/19/16 but t in the facility. She stated it on the following Monday d not recall why it happened. recalled after the fall hospice ger sling for him. She stated						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345096	B. WING		,	2/22/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	•	2/22/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	bumped their head on ursing staff should passessments for 72 hexplained neurologic supposed to be docuthe resident's medical. During an interview of NA #1 she explained #22's room to assist from the bed to a brown had already put the listing up in bed whe explained they hooked the hooks on the lift abed. She further explained the lift work that was under his bed the other side of the away from the lift who whole body jerked ar through a hole in the sling as full length with bottom was suppose extended straight out were hooked onto the Resident #22 fell right sling. She explained made the decision for	n if a resident had a fall and r if a fall was not witnessed perform neurological nours after a fall. She al assessments were mented on a specific form in	F 68	,			
	was supposed to use she thought the sling from was too big for I the sling he landed a did not recall he burn	rought that was the sling she for the resident. She stated Resident #22 had fallen him and when he slid out of the side of the lift and she ped his head on the lift.					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345096	B. WING _			12/22/2017	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COL 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	power cord was cauglift and so they could and she thought thes fall from the lift sling. #22 fell out of the slir and she came in and he did not speak and so she turned him ov She stated she thought to transfer him from the was difficult to rement was on the other should not move into the chair or back she could not move into the chair or back she could not reach the from where she was the lift were opened. realized Resident #25 sling to the floor but the dot ostop him from fabed and a nightstand explained Resident # sling and after he land was still attached to the could have saved him cord under the bed himoving the lift. She complain of pain whe	ants of his whole body and the that against the wheels of the not transfer him to the chair the things contributed to his she stated after Resident ag they called for Nurse #1 asked if he was in pain but did not making any noises for and checked for bruises. That they got a different sling the floor back to bed but that aber. In 12/21/17 at 12:03 PM, NA alled when Resident #22 slid 1/19/16. She further anding next to the lift and NA side of the lift and as they was a power cord under the ne lift were caught on it and the lift to lower Resident #22 over the bed. She stated the power cord to move it standing because the legs of She further stated she was sliding out of the lift here was nothing they could alling and he fell between the	F6	89			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345096	B. WING _		,	12/22/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 18 on 12/21/17 at 12:17 PM the	F6	89			
	Director of Nursing (I not find documentation	OON) confirmed she could on of neurological ological flow sheets after					
	Nurse #2 she confirm third shifts and it was change on 11/19/16 t from a lift earlier that	on 12/21/17 at 02:50 PM with ned she worked second and reported to her during shift that Resident #22 had fallen day. She explained the					
	fall occurred was sup of information regard contained a form for	ned to the resident when a sposed to complete a packet ing the fall and the packet the documentation of nents. She stated she did					
	his head on the lift bu would be a reason to assessments. She s	stated she did not recall					
	#22 fell from the lift b	ssessments after Resident ut she did recall family had g after he slid out of the lift					
	PM, the DON explain the facility when Resi sling on 11/19/16. Si transfer method on the	erview on 12/21/17 at 03:28 led she was not employed in ident #22 slid out of the lift ne confirmed there was no ne initial interdisciplinary care expect for physical therapy					
	and occupation thera make the safest reco	py to screen a resident and mmendations for transfer at for staff to follow the care					
	Corporate Nurse Cor	on 12/21/17 at 03:50 PM, the insultant explained she had 22's fall from the lift sling on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(>	(X3) DATE SURVEY COMPLETED	
		345096	B. WING			12/22/2017	
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP (12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	had lodged on a pobed and Resident # during the transfer he slid out from the explained Resident top of his head whe bar but there was not time of the fall and the fall but it was not had determined the were the power concaused the lift to be #22's jerking mover support him when hexplained after the ordered for Resider counseled. During an interview Administrator statelleave of absence whift and did not partition investigation. During a follow up in PM, the Corporate an expectation for ma resident after a fathead. During an observation of the stated Resident #22 back of the bathroom the the back of the door and pulled a barries.	mined the wheels of the lift ower cord under the resident's #22 had jerking movements and drew his legs up and then if lift sling. She further #22 had an abrasion to the en he bumped his head on lift to notation of missing teeth at the probably lost them during of noticed. She stated she e possible causes of the fall d under the resident's bed ecome lodged and Resident ments and the lift sling did not the drew his legs up. She fall a new lift sling was not #22 and the NAs were of on 12/21/17 at 4:01 PM, the d she had just returned from a when Resident #22 fell from the cipate in the post fall interview on 12/21/17 at 5:45 Nurse Consultant stated it was hourses to do neuro checks for all when they had hit their ion and interview on 12/22/17 wound/treatment nurse she 2's sling was usually on the of the door but when she looked are was no sling hanging on or. She then opened the closet blue full body sling that was ic from the top shelf and	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345096	B. WING			12/	22/2017	
	ROVIDER OR SUPPLIER		1	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2019 VERHOEFF DRIVE IUNTERSVILLE, NC 28078	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	She confirmed there labels and an area walong the piping and label had been remother. It to come to the roothe sling was not the She stated she was was supposed to be #22 was located and with a hole in the cenurse then called NAResident #22 to come confirmed the sling was a lighter blue mandidle and color confirmed the sling was a lighter blue mandidle and color confirmed the sling was a lighter blue mandidle and color confirmed the sling was a lighter blue mandidle and color confirmed the sling was a lighter blue mandidle and color confirmed the sling was a lighter blue mandidle and color confirmed the sling to use for the sling the wound/treat Resident #22's close sure where that lift sexplained it was posit may have come for Resident #22 was as stated she was not sated she	the sling they currently used. It was no size on any of the was noted with white strings is she stated it looked like a loved. She then called Nurse om and Nurse #1 confirmed to one staff currently used. Inot sure where the sling that used to transfer Resident is described it as a mesh sling inter. The wound/treatment is was not the correct sling to be to the room and she was not the correct sling to be to the room and she was not the correct sling to be to the room and she was not the correct sling to be to the room and she was a large size and was the for Resident #22's transfers. In and interview on 12/22/17 is DON she observed the blue timent nurse had found in the et and stated she was not ling had come from. She is sible family had brought it or to me the hospital when dimitted to the facility. She sure if that was the sling llen out of but stated it was staff to use the sling assigned there should not have been is room. She then removed ent #22's room and stated turn it to his family so it would or for any other resident.	F	689				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST			E SURVEY PLETED
		345096	B. WING _			12	/22/2017
	ROVIDER OR SUPPLIER		•	12019 V	ADDRESS, CITY, STATE, ZIP CODE ERHOEFF DRIVE RSVILLE, NC 28078	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE	(X5) COMPLETION DATE
F 865 SS=D	Administrator stated NAs to transfer Resid She stated she expethat was assigned to look to be the correct the nurse to get the scorrect size. During an interview of a Physical Therapist evaluated residents of residents. She stated from a lift during a transfer residents. She stated to assess the therapy screen to evaluate there was screen after Resident An attempt on 12/22/2 Hospice Nurse #1 was a screen after Resident #22's physimal Medical Director he stor lifts to be function were competent to ushe expected for the princluded slings to be should be followed. QAPI Prgm/Plan, Discorrect to get the state of the princluded slings to be should be followed.	it was her expectation for 2 dent #22 safely with a lift. cted for NAs to use the sling him and if the sling did not it size they should report it to sling switched out for the on 12/22/17 at 12:50 PM with she explained therapy staff when they were admitted and ons to staff for safe transfers ated if a resident had a fall ansfer the nurse was he resident and request a aluate the resident. She no referral for a therapy it #22 fell from the lift. in 12/22/17 at 3:20 PM to contact as unsuccessful. in 12/22/17 at 3:40 PM with cian who was also the facility stated it was his expectation al and used by staff who se them. He further stated proper equipment which used and proper procedures sclosure/Good Faith Attmpt		365			1/17/18
	§483.75(a) Quality as improvement (QAPI)	ssurance and performance program.					

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345096	B. WING_			12/	22/2017
	ROVIDER OR SUPPLIER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 2019 VERHOEFF DRIVE UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 865	Continued From pag	e 22	F	865			
	Survey Agency no la promulgation of this shadown and state or the Secret disclosure of the recept in so far as so the compliance of surrequirements of this shadown and correct quality do a basis for sanctions. This REQUIREMENT by: Based on observation interviews the facility Assurance Committed interventions that the November 30, 2017 complaint survey and December 22, 2017 survey. The repeat do care plan implements was recited during the recertification survey.	re of information. reary may not require ords of such committee uch disclosure is related to ch committee with the section. by the committee to identify reficiencies will not be used as in is not met as evidenced ons, record reviews, and staff 's Quality Assessment and refailed to maintain res and monitor those recommittee put into place on following a follow up and disubsequently recited on on the current recertification reficiency was in the areas of reation (F656). This deficiency refacility's current recontinued failure of the			DISCLAIMER: Preparation and/or execution of this Platof Correction does not constitute admission or agreement by the provide the truth of the facts alleged or conclusions set forth in this statement deficiencies. The Plan of Correction is prepared and/or executed solely becaut it is required by the provisions of Federand State law. F 865 The plan of correcting the aposition	er of of se	
	facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.				The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;	е	
	The findings included This tag is cross refe				During the survey ending 11/2/17, the facility received a citation related to not		
		essment: Based on record			following a resident□'s plan of care. During the annual/follow-up survey end		

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345096	B. WING			12/	22/2017	
NAME OF PROVIDER OR SUPPLIER				S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/		
					2019 VERHOEFF DRIVE			
HUNTERSVILLE OAKS				HUNTERSVILLE, NC 28078				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 865	Continued From page	e 23	F	865				
		erviews the facility failed to			12/22/17, surveyors reviewed Residen	t		
		of a resident with a history			#22 and Resident #56. Resident #22			
	· ·	nt needed a full body lift for			Baseline Care Plan was reviewed and			
		specify the type and size of			was determined the facility did not hav	-		
		e lift. The resident fell from			process to capture the appropriate			
		sulted in a skin tear to his			transfer status and failed to identify the	ا		
		head and right arm, a skin			specific sling type/size. As of the 11/28			
	_	and broken teeth for 1 of 5			regulatory requirements, the facility :			
		r transfer interventions on			Baseline Care Plan format was update			
	care plans (Resident #22). The facility also failed				include transfer status and sling type/s	ize.		
	to apply a left hand s	plint as care planned for 1 of			In addition, the Resident Profile utilized	d by		
	4 residents sampled	with limited range of			Nursing Assistants for care has been	-		
	motion/contractures (Resident #56). updated to reflect the appropriate		updated to reflect the appropriate transstatus and sling type/size.	sfer				
	During the follow up							
		on was cited for failure to			Resident #56□s Physician Orders wer			
	apply a palm guard a	is directed by the care plan.			reviewed and it was determined the fa	-		
					did not have an updated Resident Pro	ile		
	During the current re			to reflect the application of the left				
		for failure to include in a care			wrist/hand splint, which was not applie			
	l ·	a history of fall that the			the morning and removed in the eveni	•		
		Il body lift for transfer and did			as ordered. The Resident Profile utilize	d l		
	not specify the type a			by Nursing Assistants for care was				
	directed by the care	pply a left hand splint as			updated to reflect the appropriate splir application schedule. Once identified,			
	directed by the care p	piari.			sling was applied as ordered.	.HE		
	An interview was cor	nducted with the			Sing was applied as oldered.			
		22/17 at 6:23 PM. The			The QAPI committee⊟s plan of correc	lion		
		that the Quality Assurance			for monitoring care plans from the			
		monthly and included the			previous citation was very narrowly	ĺ		
	1	I Doctor (MD), attending			focused on palm guards and was not			
	physicians, Director of Nursing (DON).				comprehensive to include splints, trans	sfer		
	1 * *				status, and type/size of sling	-		
	department, and all department heads. She added that since the last follow up complaint				-,, -, -, -,			
		ded additional members to			The procedure for implementing the	ĺ		
		at included the Chief Medical			acceptable plan of correction for the	ĺ		
		rsing Executive. In addition			specific deficiency cited:			
		of the committee they have			•	ĺ		
		ancy of the meeting to			On 1/3/18, a new Interdisciplinary Tea	n		

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		345096 B. WING		12/	12/22/2017		
NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 865	The Administrator state over hauled the wour was observing every they had increased s make sure they were and to ensure that coinitiated. She added was also coming in o oversee the wound pelement that the DON interdisciplinary team discussed things like wounds and etc. and was rolled into the Quistated that currently sway for the facility to was to go room to rocomprehensive meet and find out what we resident. She added was stable at the facilited an assistant dir	ent survey results and audits. Inted that the have essentially and program and the DON awound in the building and taffing on the weekend to acovering the wound protocol prect treatments were that the current wound nurse in the weekends to help arogram. Another key in (IDT) meeting and they new admission, weights, then that all that information in the weekends. The Administrator is the believed that the only identify the resident's needs	F	865	(IDT) Rounds process was initiated. Members of the IDT included, a Physician, a representative from MDS, Social Worker, Clinical Nurse Supervis DON, Activity Representative, Dietitian Informatics and Analytics Services (IAS a representative from Therapy, and front-line Nursing Assistants. The IDT process included the development of the template for the IDT to utilize while performing the meetings with the residents present to ensure all pertiner information was captured. Physician orders, resident profile, and care plan were revised/updated to reflect current resident status, and items identified as requiring a fix to meet the resident sa requiring a fix to meet the resident so needs were resolved prior to leaving the resident sroom. In the event a piece equipment/supply was not able to be fix or obtained immediately, a work order was initiated. The resident profile for all residents was updated to reflect the specific needs of the resident, to include but not limited to, transfer status, type/s of sling for residents transferred via hor lift, and splint application. During the ID rounds, the team was responsible for matching the Resident Profile with the Care Plan, and the Physician ensured orders were entered appropriately. A member from IAS was included to verifithe information was entered accurately since the Electronic Medical Record (EMR) is new to the facility. During the IDT rounds, the team Date certain: 1/12/18 The monitoring procedure to ensure the IDT rounds, the team Date certain: 1/12/18	e of xed I lee, size yer DT all	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 865	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	365	the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements Beginning 1/15/18, the Administrator selected a group of Leadership members as Zone Owners, to focus on monitoring the updates completed during IDT rounding to ensure continued compliant Each Zone Owner has received a special assignment of residents to monitor. The assignments include a back-up person cover if the individual is out of the facility for the day. Zone owners were trained accessing and utilizing the Resident Profile found on Care Tracker to ensur residents have appropriate slings and splints as outlined in the Resident Profile found in the Resident Profile found in the Resident Profile founding assignments are quite extensive and include auditing of residents rights, physical environment, and individualized resident needs, amongst other areas. To monitor the ID rounds, the facility will add a Stand Domeeting to provide findings of the Zone Owners of Resident Profiles and Care Plans that need to be updated. Any are of discrepancy will be immediately addressed during the stand down mee by the IDT. IDT Zone Owners will be required to complete rounds on their assigned residents Monday through Friday for 4 weeks and attend the stand down meeting each day. On the weekends for 4 weeks, the clinical supervisor and manager on duty will be responsible for auditing 100% of reside who require slings and splint application who require slings and splint application.	cted ry ers ng nce. cific e to tty on e iile. OT wn e eas ting d		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED			
		345096	B. WING _			12/22/2017		
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	EEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					
F 865	Continued From page	26	F8	determine the appropriat slings for residents trans lift and splint application. 1/15/18 Service Line Nurse Educ Facility Educator provide MDS Coordinators, nursing assistants on the expectations for verificat care plan updates, and complementation. Any stands do not receive the training date (due to FMLA, leaver required to complete trais working a scheduled shift 1/15/18 The IDT rounding team conducted in the Care Plans, as the ensured all orders were appropriately. MDS Coordesignee, will conduct word scheduled quarterly all plans being conducted in rooms to ensure Resider Plans and Physician Ordidentified issues will be conducted with the Administ of Nursing on a weekly be QAPI monthly for a period which time frequency of determined by the QAPI certain: 1/12/18 Floor nurses will update profile with any new order.	cator and the ed in-services to ing staff and e process flow ion of orders, care plan ff members whing by the specifie, etc.) will be ning prior to ft. Date certain conducted 100 esident Profiles the Physician entered redinator or eekly 100% aund annual care in resident soft Profiles, Carders match. Any corrected at the itoring will be trator and Direct passis and with od of 90 days a monitoring will Committee. Dut the resident	o o fied : %, , , , , , , , , , , , , , , , , ,		

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HUNTERSVILLE OAKS				12019 VERHOEFF DRIVE			
				HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 865	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F8	supervisors will be responsible ensuring the floor nurse has u resident profiles appropriately of their shift. The clinical supe bring the 24-hour order report stand-up and be prepared to cupdates. The MDS Coordinate be responsible to verify the rewas updates accurately and the plan is reflective of any chang weekends, the clinical supervistes the 24-hour order report and eresident profiles have been up appropriately. Clinical supervistes responsible for pulling the 72-report on Monday mornings at the normal process of bringing to morning stand-up meeting the MDS Coordinators. Date certain IDT rounds will be conducted rooms on a quarterly basis go to be incorporated into the alrest existing schedule for care plan certain: 1/17/18. The title of the person responsimplementing the acceptable procession. The DON will have overall rest for oversight of the care plan plan. MDS Coordinators will be responsing the Resident Profile of changes made to a resident plan. MDS Coordinators will min-room assessments during of meetings which will allow the responsive any opportunities to evisualize any opportunities to evisualize any opportunities to the supervision of the care plan in the plan of the	indicated the rupon start envisors will at the morning discuss the ors will then sident profile that the care less. On isor will pull ensure the odated sors are shour order and following the report to give to ain 1/17/18 in resident sing forward, eady ans. Date sible for plan of esponsible for is reflective to sain the care plan team to		

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NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE OAKS				12	REET ADDRESS, CITY, STATE, ZIP CODE 019 VERHOEFF DRIVE JNTERSVILLE, NC 28078		
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F 865	Continued From page	÷ 28	F8	365	residents□ environment or plan of care Date certain: 1/17/18		