STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		8/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 1	F 166		

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and family, resident and staff interviews the facility failed provide the grievance investigation and resolution in writing to 2 of 3 sampled resident (Resident #1 and #2). The findings included: 1a. Resident #1 was admitted to the facility on 08/04/18 and discharged on 08/09/17. Resident #1's diagnoses included: diabetes mellitus, anemia, tremors, hypertension, and chronic kidney disease. No minimum data set (MDS) was available for Resident #1. Review of a Grievance Form dated 08/07/17 indicated the grievance was filed by Resident #1. The summary of the grievance read in part, the resident stated that he has not received his medication for his tremors as of yet and he had told several nurses since being admitted to the facility. The Steps Taken to investigate read in part, social worker spoke with Resident #1's nurse about which medications he was on for tremors. The Nurse stated that she would have to check to see if Resident #1 was on any medication for his tremors. The summary of pertinent findings/conclusion read in part, Resident #1's tremors address to the physician with a new order being obtained for Primidone	F 166	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Based on observations, record review, family, resident and staff interviews the facility failed to provide the grievance investigation and resolution in writing to 2 of 3 sampled residents. F166 " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; o Resident #1 issued a written grievance resolution for grievance dated 8/7/17 on 8/28/17. o Resident #2 issued a written grievance resolution for grievance dated 8/2/17 on 8/28/17. o The grievance official identified during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 3 (medication used to treat tremors). The investigation was completed and signed off on by the Director of Nursing (DON). The grievance form indicated that the DON had provide resolution to Resident #1's family on 08/09/17. A telephone interview was conducted with Resident #1's family on 08/17/17 at 8:31 AM. The family member stated that Resident #1 had a right hand tremor that he took Primidone for at home. The family member stated she was not sure why but the Primidone was never given in the facility and Resident #1 had trouble feeding himself without the medication due to the tremors. The family member stated that Resident #1 had filed a grievance at the facility and the DON had called and spoke to her but there was no resolution to the issue that Resident #1 had not received the medication he was supposed to have had. The family member confirmed that she or Resident #1 had not received any written response to the grievance that was filed. An interview was conducted with the Social Worker (SW) on 08/17/17 at 2:50 PM. The SW confirmed that she was responsible for the grievance process in the facility. The SW stated that anytime a grievance was filed it was wrote up by the staff member taking the grievance and then given to her for tracking and assignment to the individual that would be investigating the grievance. She added that they discussed any new grievances in morning meeting and then she would give them to the appropriate staff to investigate and then return to her when finished. The SW stated that if the resident or family requested written follow up then she would be responsible for completing that and getting it to the resident or family. The SW confirmed that she	F 166	the survey as not providing the written grievance decision received a one-on-one in-service by the Assistant Administrator on providing written grievance decisions to the residents on 8/28/17. o Completion (8/28/17) " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; o Patients and residents who voiced grievances with facility resolutions as of 8/28/17 will be provided a written grievance decision to include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issue. (8/28/17) o Assistant Administrator will in-service grievance official, social workers, department managers and nursing supervisors regarding these practices. (8/30/17) o Completion (8/30/17) " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible for implementing the acceptable plan of correction. Dates	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 4 had not provided any written follow up to Resident #1 or his family because they had not requested it. The SW explained that her Administrator had attended the recent training and informed her of the changes in the grievance process, she was advised to only provide written follow up if requested. An interview was conducted with the Administrator on 08/17/17 at 3:00 PM. The Administrator confirmed that she had attended the recent training but was "under a different understanding" of how grievances should be handled. She added that the facility was a part of large hospital chain and recently they had started the process of integrating the hospital system for grievances into the long term care facility. The system included a template for written response and was computerized so the staff can easily track the grievances and the written follow up. 2. Resident #2 admitted to the facility on 02/28/17 with diagnoses that included: anemia, hypertension, diabetes mellitus, anxiety, depression, and others. Review of the most recent quarterly minimum data set (MDS) dated 08/02/17 revealed that Resident #2 was cognitively intact. Review of a Grievance Form dated 08/02/17 indicated that Resident #2 had filed the grievance. The Summary of the grievance read in part, Resident #2 stated she had not received a shower for over a week and her scheduled shower days were Tuesday and Friday. The steps taken to investigate read in part, reviewed the nursing staff bath sheet and it stated that Resident #2 refused on 07/25/17 and received a	F 166	when corrective action will be completed. The corrective action dates must be acceptable to the State. o Grievance official or Social Worker designee will complete and provide to resident a written grievance decision within 5 business days upon facility resolution of grievance decision. o Administrator or Assistant Administrator will co-sign with Grievance official or Social Worker designee written grievance decisions provided to resident. o Copies of written grievance decisions provided to the resident will be maintained for a period of no less than 3 years from the issuance of the grievance decision. o Facility grievance log to be updated to include date of written grievance decision to the resident. o Administrator, Assistant Administrator or designee will audit facility grievances for written grievance decisions provided to resident, 35% of grievances x 1 month, then 20% of grievances x 1 month, then 10% of grievances x 1 month and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. o Any issues identified will be corrected immediately and will also be taken to morning stand up meeting held daily Monday - Friday and QAPI. o Completion (8/30/17)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 5	F 166		

shower on 07/28/17. Spoke to the nursing assistant. Summary of pertinent findings read in part, shower was not given because Resident #2 had fallen and had leg pain and she was offered a bed bath. Explained to Resident #2 why she did not receive her shower and she was very understanding and appreciative. The form was signed off on the Director of Nursing (DON).

An interview was conducted with Resident #2 on 08/17/17 at 10:11 AM. Resident #2 confirmed that she had filed the grievance on 08/02/17 about her showers. She indicated that she "must have forgotten that she refused." Resident #2 stated that her shower days were Tuesday and Friday and that for the most part she received them as scheduled. Resident #2 confirmed that she had not received any written follow up from the staff about the grievance she filed.

An interview was conducted with the Social Worker (SW) on 08/17/17 at 2:50 PM. The SW confirmed that she was responsible for the grievance process in the facility. The SW stated that anytime a grievance was filed it was wrote up by the staff member taking the grievance and then given to her for tracking and assignment to the individual that would be investigating the grievance. She added that they discussed any new grievances in morning meeting and then she would give them to the appropriate staff to investigate and then return to her when finished. The SW stated that if the resident or family requested written follow up then she would be responsible for completing that and getting it to the resident or family. The SW confirmed that she had not provided any written follow up to Resident #2 or her family because they had not requested it. The SW explained that her Administrator had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 6 attended the recent training and informed her of the changes in the grievance process, she was advised to only provide written follow up if requested. An interview was conducted with the Administrator on 08/17/17 at 3:00 PM. The Administrator confirmed that she had attended the recent training but was "under a different understanding" of how grievances should be handled. She added that the facility was a part of large hospital chain and recently they had started the process of integrating the hospital system for grievances into the long term care facility. The system included a template for written response and was computerized so the staff can easily track the grievances and the written follow up.	F 166		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, family, and physician interviews the facility failed to clarify a medication order from a discharge summary that resulted in the resident not receiving the medication during his stay at the facility for 1 of 3 sampled residents (Resident #1). The findings included:	F 281	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	9/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 7 Resident #1 admitted to the facility on 08/04/17 and discharged from the facility on 08/09/17. Resident #1's diagnoses included essential tremors. No minimum data set (MDS) information was available for Resident #1. Review of a discharge summary from a local hospital dated 08/04/17 read in part that Resident #1's discharge medications included Primidone (mediation used to decrease tremors), daily dose at bedtime, dose was unknown. The discharge summary had been reviewed and initialed by Resident #1's physician at the facility on 08/04/17. Review of the medication administration record (MAR) dated 08/04/17 through 08/31/17 revealed the following, Primidone 1 tab at bedtime (clarify strength 08/04/17). There were no initials beside the medication indicating that the medication had not been administered to Resident #1 during his stay at the facility. Review of a physician order dated 08/07/17 read, clarification order Primidone 50 milligrams (mg) take 2 tabs at bedtime. A telephone interview was conducted with Resident #1's family on 08/17/17 at 8:31 AM. The family member stated that Resident #1 had a right hand tremor that he took Primidone for at home. The family member stated she was not sure why but the Primidone was never given in the facility and Resident #1 had trouble feeding himself without the medication due to the tremors. A telephone interview was conducted with Nursing Supervisor (NS) #1 on 08/17/17 at 1:05 PM. NS #1 stated that she was the nurse that	F 281	Based on record reviews, staff, family and physician interviews the facility failed to clarify a medication order from a discharge summary that resulted in the resident not receiving the medication during his stay at the facility for 1 of 3 sampled residents (Resident #1). F281 " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; o At the time of survey, Resident #1 had discharged from the facility to the hospital on 8/9/17 and has not returned. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; o 100% audit will be conducted on medication administration records in last 30 days by Director of Nursing/Assistant Director of Nursing/Designee. Those residents identified will have medication orders corrected immediately. (Completion 9/1/17) o Licensed Nursing staff will receive education related to proper medication administration record verification/transcribing medication from Discharge Summary. Education will include two licensed nurses signatures when transcribing medication orders, two licensed nurses signatures when transcribing medication order on MAR. A 24-hour chart check to verify completion of new orders to be completed by the 3rd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 8 transcribed Resident #1's medications from the discharge summary after the physician had verified the medications on the facility's MAR. She stated she noticed that there was not a strength next to the Primidone medication so she had asked Nurse #1 to ask Resident #1's family what dose he was taking so the order could be obtained from the physician. NS #1 stated when she returned to work on Monday 08/07/17 she realized that no one clarified the dose with Resident #1's family so she asked Nurse #2 to please contact Resident #1's family to verify what dose he was taking at home. NS #1 stated that Nurse #2 had called the family and gotten no answer but left a message and when Resident #1's family returned the call to the facility NS #1 stated she had spoken to the family and obtained the dose of Primidone that Resident #1 was on at home. NS #1 stated that after she spoke to his family she called the on-call provider and obtained the order for Primidone. An interview was conducted with the Physician on 08/17/17 at 1:48 PM. The Physician confirmed that he had reviewed and verified Resident #1's medications from the discharge summary. The Physician stated that the Primidone dose needed to be verified with Resident #1 or his family when the resident arrived at the facility. The physician stated that when the nurse saw that there was no dose for the Primidone she should have immediately contacted the on-call provider. The physician added that he would not have stopped this medication for Resident #1 and there were no adverse reactions to Resident #1 except "the annoying tremors." A telephone interview was conducted with Nurse #1 on 08/17/17 at 2:16 PM. Nurse #1 verified that	F 281	shift nurse with nurse□s signature. Duplicate yellow new orders will be brought to the clinical startup meeting Monday through Friday. RN Designee will review duplicate yellow new orders on Saturday and Sunday. Discrepancies noted will be brought to the attention of the Director of Nursing/Assistant Director of Nursing/ Administrator/Assistant Administrator for proper disciplinary action. For any nurse who does not complete the required in-service training, he/she will not be allowed to work a shift until the education is completed. Education related to proper medication administration record verification/transcribing medication from Discharge Summary will be included in new hire orientation for newly hired nurses. (Completion 8/28/17) " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible for implementing the acceptable plan of correction. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. o Director of Nursing or RN Designee will audit 35% of residents weekly per unit x one month to ensure new orders are complete with clarification then, 20% of residents weekly per unit x one month, then 10% of residents weekly per unit x one month. Results of audits will be reviewed in clinical startup Monday	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 9 she was the medication nurse for Resident #1 on 08/04/17 and confirmed that she had not administered the Primidone to Resident #1 because there was no dose on the MAR and the order needed to be clarified. Nurse #1 stated NS #1 had not asked her to clarify the order with the family and stated that "if there was no dosage on the order then it should have been clarified before being put on the MAR." Nurse #1 stated that she had not contacted the physician for clarification, she added that NS #1 should have gotten the clarification when she was transcribing the orders. A telephone interview was conducted with Nurse #2 on 08/17/17 at 2:35 PM. Nurse #2 stated that she was working on 08/07/17 when NS #1 had asked her to contact Resident #1's family and clarify the dosage that Resident #1 was taking at home. Nurse #2 stated that she called the family and got no answer but when they returned the call to the facility NS #1 spoke to the family and got what she needed and then contacted the on-call physician and obtained the order. Nurse #2 confirmed that she had not administered any Primidone to Resident #1 during stay at the facility. An interview was conducted with the Director of Nursing (DON) on 08/17/17 at 3:25 PM. The DON stated that anytime an order was received and processed in the facility it must be a complete order that includes the dosage. If any order is not complete then she expected the staff to immediately contact the medical provider for clarification.	F 281	through Friday and RN Designee will complete and review audits on Saturday and Sunday. o Director of Nursing will notify Medical Director/Nurse Practitioner with any discrepancies. o Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. (Completion 9/1/17) o Facility will convert to an electronic medical record in October 2017 with hard stops built in requiring the patient's name, date, name of the drug, dose, route, frequency of administration, any special instructions to be input prior to completing.	
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		9/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 10 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, and physician interview the facility failed to administer a medication ordered to treat tremors on 5 of 5 days of admission for 1 of 3 sampled residents (Resident #1.) This altered the resident's ability to feed himself. The findings included: Resident #1 admitted to the facility on 08/04/17 and discharged from the facility on 08/09/17. Resident #1's diagnoses included essential tremors. No minimum data set (MDS) information was available for Resident #1. Review of a discharge summary from a local hospital dated 08/04/17 read in part that Resident #1's discharge medications included Primidone (medication used to decrease tremors), daily dose at bedtime, dose unknown. The discharge summary had been reviewed and initialed by Resident #1's physician at the facility on 08/04/17. Review of the medication administration record (MAR) dated 08/04/17 through 08/31/17 revealed the following: Primidone 1 tab at bedtime (clarify strength 08/04/17). There were no initials in place on the MAR to indicate the medication had been administered to Resident #1 during his stay at the facility.	F 333	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Based on record reviews, staff, family and physician interviews the facility failed to administer a medication ordered to treat tremors on 5 of 5 days of admission for 1 of 3 sampled residents (Resident #1). This altered the resident's ability to feed himself. F333 " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; o At the time of survey, Resident #1 had discharged from the facility to the hospital on 8/9/17 and has not returned. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 11 Review of a physician order dated 08/07/17 read, clarification order Primidone 50 milligrams (mg) take 2 tabs at bedtime. A telephone interview was conducted with Resident #1's family on 08/17/17 at 8:31 AM. The family member stated that Resident #1 had a right hand tremor that he took Primidone for at home. The family member stated she was not sure why but the Primidone was never given in the facility and Resident #1 had trouble feeding himself without the medication due to the tremors. The family member stated that she had visited the resident on 08/05/17 at the facility at approximately 10:30 AM and he had food items from breakfast all over him. She added that Resident #1 was able to feed himself even with the hand tremor as long as he had the Primidone and without it he "clearly made a mess of himself." An interview with Nursing Assistant (NA) #2 was conducted on 08/17/17 at 11:47 AM. NA #2 stated that she worked on the unit Resident #1 was on and would at times assist him. NA #2 stated that Resident #1 needed some assistance with feeding due to "his shakes." NA #2 stated that she never fed him but did pick up his tray and at times he "was messy with his food." A telephone interview was conducted with NA #1 on 08/17/17 at 12:34 PM. NA #1 stated that she had cared for Resident #1 on 08/05/17 and had set him up for breakfast. She added that Resident #1 was able to feed himself but when she returned to pick up the tray she noticed "he did make a mess of his food." NA #1 stated that she had heard Resident #1 hand tremors but she did	F 333	o Licensed Nursing staff will receive education related to proper documentation of medication administration and the process of addressing omission of medication administration related to incomplete orders/orders not clarified/medication not available/documentation of refusals/accessing Pyxis and back up pharmacy to obtain medication and MD/NP notification. Education will include properly filling out the Pharmacy Medication Request Form and faxing the Pharmacy Medication Form Sheet along with Face Sheet to Pharmacy. Licensed nurse will call pharmacy after hours to verify appropriate forms are received. Licensed Nurse to verify by signing Medication Request Form with another Licensed Nurse. Licensed Nurse will put faxed copy of Medication Request Form and Face Sheet along with transmission form verifying time faxed copies sent in Clinical Supervisor box. Discrepancies noted will be brought to the attention of the Director of Nursing/Assistant Director of Nursing/Administrator/Assistant Administrator for proper disciplinary action. For any nurse who does not complete the required in-service training, he/she will not be allowed to work a shift until the education is completed. Education related to proper documentation of medication administration and the process of addressing omission of medication administration related to incomplete orders/orders not clarified/medication not available/documentation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 12	F 333		

had not noticed them.

A telephone interview was conducted with Nursing Supervisor (NS) #1 on 08/17/17 at 1:05 PM. NS #1 stated that she was the nurse that transcribed Resident #1's medications from the discharge summary after the physician had verified the medications on the facility's MAR. She stated she noticed that there was not a strength next to the Primidone medication so she had asked Nurse #1 to ask Resident #1's family what dose he was taking so the order could be obtained from the physician. NS #1 stated when she returned to work on Monday 08/07/17 she realized that no one clarified the dose with Resident #1's family so she asked Nurse #2 to please contact Resident #1's family to verify what dose he was taking at home. NS #1 stated that Nurse #2 had called the family and gotten no answer but left a message and when Resident #1's family returned the call to the facility NS #1 stated she had spoken to the family and obtained the dose of Primidone that Resident #1 was on at home. NS #1 stated that after she spoke to his family she called the on-call provider and obtained the order for Primidone but for some reason did not place the dose on the MAR.

An interview was conducted with the Physical Therapy Assistant (PTA) on 08/17/17 at 1:24 PM. The PTA stated that she had worked with Resident #1 on 08/05/17 and had noticed his hand tremor. She stated that it was not a consistent tremor, it was "almost stress induced."

An interview was conducted with the Physician on 08/17/17 at 1:48 PM. The Physician confirmed that he had reviewed and verified Resident #1's medications from the discharge summary. The

refusals/accessing Pyxis and back up pharmacy to obtain medication and MD/NP notification will be included in new hire orientation for newly hired nurses. (Completion 9/3/17)

" The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible for implementing the acceptable plan of correction. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State.
o Facility will convert to an electronic medication administration record in October 2017, which will change the process for the plan of correction described below. Auditing and monitoring will remain in place as outlined, adhering to the timeframe and guidelines.
o Director of Nursing or RN Designee will audit 35% of residents weekly per unit x one month to ensure proper documentation of medication administration and the process of addressing omission of medication administration related to incomplete orders/orders not clarified/medication not available/documentation of refusals/accessing Pyxis and back up pharmacy to obtain medication and MD/NP notification then, 20% of residents weekly per unit x one month then, 10% of residents weekly per unit x one month. Results of audits will be reviewed in clinical startup Monday through Friday and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 13 Physician stated that the Primidone dose needed to be verified with Resident #1 or his family when the resident arrived at the facility. The physician stated that when the nurse saw that there was no dose for the Primidone she should have immediately contacted the on-call provider for further instructions. The physician added that he would not have stopped this medication for Resident #1 and there were no adverse reactions to Resident #1 except "the annoying tremors." A telephone interview was conducted with Nurse #1 on 08/17/17 at 2:16 PM. Nurse #1 verified that she was the medication nurse for Resident #1 on 08/04/17 and confirmed that she had not administered the Primidone to Resident #1 because there was no dose on the MAR and the order needed to be clarified. Nurse #1 stated that "if there was no dosage on the order then it should have been clarified before being put on the MAR." Nurse #1 stated that she had not contacted the physician for clarification. A telephone interview was conducted with Nurse #2 on 08/17/17 at 2:35 PM. Nurse #2 stated that she was working on 08/07/17 when Nurse Supervisor (NS) #1 had asked her to contact Resident #1's family and clarify the dosage that Resident #1 was taking at home. Nurse #2 stated that she called the family and got no answer but when they returned the call to the facility NS #1 spoke to the family and got what she needed and then contacted the on-call physician and obtained the order. Nurse #2 confirmed that she had not administered any Primidone to Resident #1 during stay at the facility. An interview was conducted with the Director of Nursing (DON) on 08/17/17 at 3:25 PM. The DON	F 333	RN Designee will complete and review audits on Saturday and Sunday. o Director of Nursing will notify Medical Director/Nurse Practitioner with medication omissions. o Pharmacy Consultant to conduct medication pass observation of 2 licensed nurses per month x 90 days to ensure medications are administered as ordered and/or documented refusals. o Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. (Completion 9/3/17)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 14 acknowledged that the medication had not been clarified or administered while Resident #1 was present in the facility. She stated that anytime an order was received and processed in the facility it must be a complete order that included the dosage. If any order was not complete then she expected the staff to immediately contact the medical provider for clarification so that the ordered medication could be administered as ordered	F 333		