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 10/05/2017

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 224 SS=G	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record reviews and physician and staff interviews the facility neglected to assess a surgical incision on a resident's lower back or provide daily dressing changes according to physician's orders who had to be readmitted to the hospital for an incision drainage and revision of the incision due to a wound infection of their lower back (Resident #2) for 1 of 1 resident sampled with a surgical incision. Findings included: Resident #2 was admitted to the facility on 08/26/17 with diagnoses which included in part low back pain, degenerative deformity	F 224	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. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " Resident #2 identified during the survey	10/24/17

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

Electronically Signed | 10/24/2017

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 10/05/2017

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 224	Continued From page 1 (deterioration) of the spine and spinal surgery. A review of the 5 Day Admission Minimum Data Set (MDS) dated 09/02/17 indicated Resident #2 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #2 required extensive assistance by staff for bed mobility, transfers, dressing, toileting, bathing and was occasionally incontinent of bladder and always continent of bowel. A review of hospital discharge instructions dated 08/26/17 indicated to continue with daily dressing changes and follow up with surgeon in 2 weeks for suture removal. A review of an interim care plan dated 08/27/17 labeled skin integrity indicated to check surgical site every day. A review of nurse's progress notes dated 08/27/17 indicated the dressing on Resident #2's back was changed per order but there was no documentation regarding the appearance of the incision. A review of a physician's order dated 08/28/17 indicated to keep dry dressing on incision for 1 week and change every day per discharge instructions. A review of a MAR dated from 08/29/17 through 09/01/17 revealed nurse's initials were documented for daily dressing changes to Resident #2's back but there were no nurse's progress notes regarding an assessment or appearance of the surgical incision. A review of a MAR dated 09/02/17 through	F 224	discharged from the facility on 9/7/17. " The 3 nurses identified during the survey as not completing the dressing change and assessing the surgical wound received a one-on-one in-service or will receive one prior to 10/17/17 by RN Nurse Educator or RN designee on completing surgical dressing changes per MD orders, dating and initialing the dressing, and signing the MAR upon completion. 1 nurse is no longer employed by the facility. The two remaining nurses received disciplinary action for failure to assess the surgical incision and provide daily dressing changes. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " All patients and residents with surgical dressing orders were identified. An audit was completed by the DON or RN designee to determine whether the physician order was being followed to change the dressing for these patients and residents. " Surgical dressing changes will be completed per MD orders to include the dressings being dated for the date they were changed with the initials of the nurse completing the dressing change. Additionally, the nurse will document on the Electronic Medication Administration Record (EMAR) that he or she completed the dressing change per MD order. Daily the surgical dressing will be checked by the licensed nurse and documented on the EMAR to ensure that dressing is dry	

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 10/05/2017

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 224	Continued From page 2 09/03/17 revealed there were no nurse's initials documented for daily dressing change to Resident #2's back and there were no nurse's progress notes regarding assessment or appearance of the incision. Further review of Resident #2's medical record revealed there were no progress notes or assessment of Resident #2's back incision on 09/04/17. A review of a change in condition form titled Situation, Background, Assessment/Appearance and Recommendations (SBAR) dated 09/05/17 and signed by Nurse #3 indicated a wound to Resident #2's back had a foul smell. The section labeled assessment/appearance indicated vital signs but there was no documentation of the appearance or assessment of Resident #2's surgical incision. A section on the back of the document labeled additional notes was blank. A review of a physician's progress note dated 09/06/17 indicated in part a surgical incision bandage was removed from Resident #2's back with soiled dressing and foul odor. A section labeled plan indicated to change dressings daily to absorb any serosanguineous fluid for 5 additional days and follow up with surgeon as outpatient. A review of a hospital history and physical dated 09/07/17 indicated Resident #2 returned to the surgeon's office for a 2 week follow up appointment after back surgery and her incision was draining large amounts of serosanguineous fluid (thin, watery, pink or red drainage). A section labeled physical exam revealed Resident #2's back incision had visible eschar (dry, dark	F 224	and intact and assessment of the surgical wound. RN Nurse Educator or RN designee will in-service all nurses regarding these practices. 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. " The facility will convert to an electronic medical record in October 2017, which will change the process for the documentation of surgical dressing changes and assessment of the surgical wounds. Auditing and monitoring will remain in place as outlined, adhering to the timeframe and guidelines. " DON or RN designee will audit 100% of residents with surgical incision dressing changes (to include frequency), date/initialing of Surgical dressings, documenting of completion in the EMAR once a dressing change is completed. " An in-service will be completed for licensed nurses by the RN Nurse Educator or RN designee to include following MD orders for Surgical dressing changes (to include frequency), date/initialing of Surgical dressings, signing the EMAR once a dressing change is completed and daily the surgical dressing will be checked by the licensed nurse and documented on the	

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 10/05/2017

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 224	Continued From page 3 scab of dead tissue) and what appeared to be the beginning of a dehiscence mid incision (rupturing of the incision). The notes further revealed the tissue did not appear to be healthy with large amounts of serosanguineous drainage with applied pressure and was foul smelling. A section labeled assessment and plan revealed Resident #2 would be admitted to the hospital for wound irrigation, debridement, wound revision, obtain cultures and consult infectious disease for antibiotics. During an interview on 10/03/17 at 2:57 PM, the Director of Nursing (DON) explained the wound nurse was not available for interview because she was away for 2 weeks but they had a part-time wound nurse (Nurse #2) who did wound treatments when the wound nurse was not available. She further explained the nurse assigned to the resident was also responsible for doing wound treatments when a wound nurse was not working in the facility. During an interview on 10/03/17 at 3:16 PM, Nurse #2 stated she provided wound treatments when the wound nurse was not working at the facility but did not recall dressing changes or assessments of Resident #2's surgical incision on her back. She explained documentation of wounds was supposed to be done on the MAR and assessments of wounds were usually written in the nurse's progress notes. During a follow up interview on 10/03/17 at 3:33 PM the DON confirmed Resident #2 was ordered by her surgeon to have a dry dressing daily to her lower back incision for 1 week. She stated it was her expectation for nursing staff to assess surgical incisions and should document their	F 224	EMAR to ensure that dressing is dry and intact and assessment of the surgical wound is completed. Any nurse who is unable to attend the mandatory in-service by 10/17/17 will receive the in-service prior to working a shift. " Surgical dressings will be checked daily by licensed nurse and documented on the EMAR to ensure that dressing remains intact and is changed per MD orders and assessment of the surgical wound is completed. " Clinical supervisor or licensed nurse designee will report any new surgical wounds in morning stand up meeting daily (Monday □ Friday) and/or to the weekend RN in charge along with the MD orders to change the dressing. " Any issues identified will be corrected immediately and will also be taken to daily clinical start-up meeting (Monday □ Friday) and/or reported to the weekend RN in charge and QAPI. " DON or RN designee will audit daily x 1 month, then weekly x 2 months surgical incision dressing changes (to include frequency), date/initialing of Surgical dressings, documenting in the EMAR once a dressing change is completed and assessment of the surgical wound to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and/or 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. " QAPI committee will only consider	

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 10/05/2017

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 224	Continued From page 4 assessments. During an interview on 10/03/17 at 3:53 PM, Physician #1 who was also the facility Medical Director explained he did not examine Resident #2 but recalled Physician #2 had examined her because of wound drainage. He stated it was his expectation for nursing staff to follow physician's orders and if instructions were for dressings to be changed daily they should do so because dressings saturated with drainage were a culture medium for bacterial growth. He further stated if an incision was foul smelling or had more drainage than what the resident came to the facility with nursing staff should call the surgeon to see what they wanted them to do. During a telephone interview on 10/04/17 at 9:19 AM, Nurse #3 who had signed the SBAR on 09/05/17 stated she recalled Resident #2 but did not recall anything about the surgical incision, odor or drainage. She explained she did not recall filling out the SBAR and explained if she had done an assessment of the incision she would have documented it on the SBAR or in the nurse's progress notes. During an interview on 10/04/17 at 10:25 AM, Physician #2 confirmed she had examined Resident #2 on 09/06/17 because a nurse had completed an SBAR which indicated Resident #2 had a wound with a foul smell. She explained she examined Resident #2 who had recently had spinal surgery and the bandage on her incision was soiled with serosanguineous drainage. She stated she called the wound nurse to the room and instructed her to clean it. She further stated she expected to see the dressing dated and signed but it was not signed or dated so she was	F 224	discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. " (Completion 10/24/17)	

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 10/05/2017

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 224	Continued From page 5	F 224		

not sure how long it had been since the dressing had been changed. She explained it was her understanding Resident #2 went for a follow up appointment on 09/07/17 and from there was sent to the hospital and had not returned to the facility.

During an interview on 10/04/17 at 12:00 PM the DON verified there was no nursing documentation after 08/28/17 regarding assessments or appearance of the surgical incision. She confirmed there were no staff initials on the MAR for dressing changes on 09/02/17 or 09/03/17 and she felt the dressing had not been changed on those days.

During an interview on 10/04/17 at 12:30 PM with the Administrator and DON, the Administrator verified after review of the SBAR dated 09/05/17 there was documentation of Resident #2's vital signs but there was no documentation of an assessment of Resident #2's surgical incision and there was no assessment of the surgical incision documented in the nurse's progress notes on 09/05/17. The DON stated she would have expected to see nurse's progress notes and assessments to describe the length of the incision, any redness, what the drainage looked like and a description of the odor. The DON explained the nurse who should have done the dressing changes on 09/02/17 and 09/03/17 no longer worked at the facility.

On 10/05/17 at 3:05 PM a telephone call was received from Resident #2's Orthopedic Surgeon. He stated Resident #2 came to his office on 09/07/17 for what was supposed to be a routine 2 week follow up visit for suture removal after spinal surgery. He explained Resident #2's surgical

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 10/05/2017

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 224	Continued From page 6 incision on her lower back had a foul odor and there was wound dehiscence and it was not well healed as he had expected. He stated he had to take Resident #2 to surgery that night to wash and clean it out and he cultured the wound and it was infected with bacteria from urine. He explained Resident #2 was elderly and deconditioned and had not mobilized quickly which put her at greater risk for wound contamination. He further explained Resident #2's family had told him Resident #2 wore a brief at the facility and he felt the dressing had been saturated or soiled with urine which then contaminated the wound. He stated it was his expectation for attention to have been given to the wound and it should have been kept clean and dressed according to his orders to prevent infection.	F 224		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect,	F 225		10/17/17

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 10/05/2017

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 225	Continued From page 7	F 225		

exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated

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 10/05/2017

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 225	Continued From page 8 representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to notify the State Survey Agency within the required 24 hour initial report timeframe for an allegation of abuse for 1 of 7 residents (Resident #5) and failed to notify the State Survey Agency within the required 5 working day timeframe of allegation of abuse investigations for 2 of 7 residents with abuse investigations (Resident #5 and #2). Findings included: 1. Resident #5 was admitted to the facility on 05/11/17 but was no longer a resident in the facility. A review of an Admission Minimum Data Set dated 05/18/17 indicated Resident #5 was cognitively intact for daily decision making. A review of the facilities abuse investigations revealed on 05/31/17 at 3:00 PM Resident #5 reported an allegation of abuse. The 24 Hour Initial Report with a facsimile (fax) confirmation date of 06/02/17 at 12:46 PM which was after the required 24 hours revealed "during care by 2 nurses, resident stated she was being molested by 2 lesbians." A review of a 5 Working Day Report with a fax confirmation date of 06/09/17 at 3:25 PM revealed the facility faxed the completed	F 225	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. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " Facility failed to complete 24-hour initial report after the required 24 hours for resident #5. " The facility failed to complete the 5 working day report within 5 working days of incident for Residents #2 and #5. " The 2 nurses identified during the survey as not completing the investigation 24-hour initial report and the 5 working day report within days of the incident received a one-on-one in-service or will receive one prior to working a shift by the Nursing Home Administrator on ensuring that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	

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 10/05/2017

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 225	Continued From page 9 investigation to the Health Care Personnel Investigations 7 working days after the allegation was made. During an interview on 10/03/17 at 3:35 PM the Director of Nursing (DON) explained she was responsible for investigating an allegation of abuse. She stated she was aware of the timeframe for submitting the 24 hour initial report but was not sure why Resident #5's report had been sent in late. She reported her usual practice was to start the 5-day investigation after notifying the Health Care Personnel Investigations within 24 hours of the allegation. The DON stated she thought the 5 days to complete the investigation started after the first 24 hours. During an interview on 10/03/17 at 5:25 PM the Administrator stated he expected the DON to follow the federal regulations. The Administrator stated he understood that an abuse investigation was considered 5 working days from the time of the allegation was received. 2. Resident #2 was admitted to the facility on 01/13/17. Review of the facility's abuse allegations revealed on 06/27/17 at 4:45 PM Resident #2 reported an allegation of abuse. The 24-hour report dated 06/27/17 specified Resident #2 alleged she had been "mistreated" by a nurse that was rude and had "shoved" pills in her mouth while she was in pain. A document titled "5 day Working Report" dated 07/06/17 revealed the facility faxed the completed investigation to the Health Care Personnel	F 225	hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Have evidence that all alleged violations are thoroughly investigated. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " An in-service will be completed for all staff by the RN Nurse Educator or RN designee to ensuring that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	

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 10/05/2017

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 225	Continued From page 10 Investigations 6 working days after the allegation was made. On 10/03/17 at 3:27 PM an attempt to interview Resident #2 was made but the resident stated she was in too much pain and wanted the nurse. On 10/03/17 at 3:35 PM the Director of Nursing (DON) was interviewed and explained that she was responsible for investigating an allegation of abuse. She reported her usual practice was to start the 5-day investigation after notifying the Health Care Personnel Investigations within 24 hours of the allegation. The DON stated she thought the 5 days to complete the investigation started after the first 24 hours. On 10/03/17 at 5:25 PM the Administrator was interviewed and reported that he expected the DON to follow the federal regulations. The Administrator stated he understood that an abuse investigation was considered 5 working days from the time of the allegation was received.	F 225	hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Have evidence that all alleged violations are thoroughly investigated. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Any staff who is unable to attend the mandatory in-service by 10/17/17 will receive the in-service prior to working a shift. " Any issues identified will be corrected immediately and will also be taken to daily clinical start-up meeting (Monday □ Friday) and/or reported to the weekend RN in charge and QAPI. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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 10/05/2017

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 225	Continued From page 11	F 225	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. " Nursing home administrator or designee will audit 100% of abuse investigations to ensure reporting results of all investigations of abuse to the administrator or his or her designated representative and to other officials in accordance with state law, including to the state survey agency, within 24 hours of initial notification and 5 working day report is complete within 5 working days of initial notification of the incident, and if the alleged violation is verified appropriate corrective action must be taken x 3 months to ensure compliance. Any identified issues will be corrected at that time and disciplinary action provided to the staff member. Results of the monitoring will be shared with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 309		10/24/17

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 10/05/2017

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 309	Continued From page 12 well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews and physician and staff interviews the facility failed to assess a surgical incision on a resident's lower back or provide daily dressing changes according to physician's orders who had to be readmitted to the hospital for an incision and drainage and revision of the incision due to a wound infection of their lower back (Resident #2) for 1 of 1 resident sampled with a surgical incision.	F 309	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.	

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 10/05/2017

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 309	Continued From page 13 Findings included: Resident #2 was admitted to the facility on 08/26/17 with diagnoses which included in part low back pain, degenerative deformity (deterioration) of the spine and spinal surgery. A review of the 5 Day Admission Minimum Data Set (MDS) dated 09/02/17 indicated Resident #2 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #2 required extensive assistance by staff for bed mobility, transfers, dressing, toileting and bathing and was occasionally incontinent of bladder and always continent of bowel. A review of hospital discharge instructions dated 08/26/17 indicated to continue with daily dressing changes and follow up with surgeon in 2 weeks for suture removal. A review of a monthly Medication Administration Record (MAR) dated 08/26/17 through 08/31/17 indicated handwritten notes for dry dressing (low back) for 1 week and change every day until the last day 09/01/17. A review of nurse's progress notes dated 08/26/17 indicated Resident #2 was admitted to the facility and had a dressing to her back with no drainage noted. A review of an interim care plan dated 08/27/17 indicated in a section labeled skin integrity and check surgical site every day. A review of nurse's progress notes dated 08/27/17 indicated the dressing on Resident #2's back was changed per order but there was no	F 309	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " Resident #2 identified during the survey discharged from the facility on 9/7/17. " The 3 nurses identified during the survey as not completing the dressing change and assessing the surgical wound received a one-on-one in-service or will receive one prior to 10/17/17 by RN Nurse Educator or RN designee on completing surgical dressing changes per MD orders, dating and initialing the dressing, and signing the MAR upon completion. 1 nurse is no longer employed by the facility. The two remaining nurses received disciplinary action for failure to assess the surgical incision and provide daily dressing changes. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " All patients and residents with surgical dressing orders were identified. An audit was completed by the DON or RN designee to determine whether the physician order was being followed to change the dressing for these patients and residents. " Surgical dressing changes will be completed per MD orders to include the dressings being dated for the date they were changed with the initials of the nurse completing the dressing change. Additionally, the nurse will document on the Electronic Medication Administration	

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 10/05/2017

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 309	Continued From page 14 documentation regarding the appearance of the incision. A review of a physician's order dated 08/28/17 indicated to keep dry dressing on incision for 1 week and change every day per discharge instructions. A review of nurse's progress notes dated 08/28/17 indicated the dressing was changed on Resident #2's back per order and there were no signs or symptoms of infection. A review of a MAR dated from 08/29/17 through 08/31/17 revealed nurse's initials were documented for daily dressing changes to Resident #2's back but there were no nurse's progress notes regarding an assessment or appearance of the surgical incision. A review of a MAR dated 09/01/17 revealed nurse's initials were documented for a daily dressing change to Resident #2's back but there were no nurse's progress notes regarding assessment or appearance of the incision. Further review of a MAR dated 09/01/17 indicated dry dressing to surgical incision on Resident #2's back until 09/03/17. A review of a MAR dated 09/02/17 revealed there were no nurse's initials documented for daily dressing change to Resident #2's back and there were no nurse's progress notes regarding assessment or appearance of the incision. A review of a MAR dated 09/03/17 revealed there were no nurse's initials documented for daily dressing change to Resident #2's back and there	F 309	Record (EMAR) that he or she completed the dressing change per MD order. Daily the surgical dressing will be checked by the licensed nurse and documented on the EMAR to ensure that dressing is dry and intact and assessment of the surgical wound. RN Nurse Educator or RN designee will in-service all nurses regarding these practices. 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. " The facility will convert to an electronic medical record in October 2017, which will change the process for the documentation of surgical dressing changes and assessment of the surgical wounds. Auditing and monitoring will remain in place as outlined, adhering to the timeframe and guidelines. " DON or RN designee will audit 100% of residents with surgical incision dressing changes (to include frequency), date/initialing of Surgical dressings, documenting of completion in the EMAR once a dressing change is completed. " An in-service will be completed for licensed nurses by the RN Nurse Educator or RN designee to include following MD orders for Surgical dressing changes (to include frequency),	

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 10/05/2017

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 309	Continued From page 15 were no nurse's progress notes regarding assessment or appearance of the incision. Further review of nurse's progress notes revealed there were no progress notes or assessment of Resident #2's back incision on 09/04/17. A review of a change in condition form titled Situation, Background, Assessment/Appearance and Recommendations (SBAR) dated 09/05/17 and signed by Nurse #3 indicated a wound to Resident #2's back had a foul smell. The section labeled assessment/appearance indicated vital signs were blood pressure 102/71, pulse 83, respirations 16, temperature 98 degrees Fahrenheit and pulse oximetry was 96 percent but there was no documentation of the appearance or assessment of Resident #2's surgical incision. A section on the back of the document labeled additional notes was blank. A review of a physician's progress note dated 09/06/17 indicated in part a surgical incision bandage was removed from Resident #2's back with soiled dressing and foul odor. A section labeled plan indicated to change dressings daily to absorb any serosanguineous fluid for 5 additional days and follow up with surgeon as outpatient. A review of a hospital history and physical dated 09/07/17 indicated Resident #2 returned to the surgeon's office for a 2 week follow up appointment after back surgery and her incision was draining large amounts of serosanguineous fluid (thin, watery, pink or red drainage). A section labeled physical exam revealed Resident #2's back incision had visible eschar (dry, dark scab of dead tissue) and what appeared to be the	F 309	date/initialing of Surgical dressings, signing the EMAR once a dressing change is completed and daily the surgical dressing will be checked by the licensed nurse and documented on the EMAR to ensure that dressing is dry and intact and assessment of the surgical wound is completed. Any nurse who is unable to attend the mandatory in-service by 10/17/17 will receive the in-service prior to working a shift. " Surgical dressings will be checked daily by licensed nurse and documented on the EMAR to ensure that dressing remains intact and is changed per MD orders and assessment of the surgical wound is completed. " Clinical supervisor or licensed nurse designee will report any new surgical wounds in morning stand up meeting daily (Monday □ Friday) and/or to the weekend RN in charge along with the MD orders to change the dressing. " Any issues identified will be corrected immediately and will also be taken to daily clinical start-up meeting (Monday □ Friday) and/or reported to the weekend RN in charge and QAPI. " DON or RN designee will audit daily x 1 month, then weekly x 2 months surgical incision dressing changes (to include frequency), date/initialing of Surgical dressings, documenting in the EMAR once a dressing change is completed and assessment of the surgical wound to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and/or Director of Nursing	

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 10/05/2017

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 309	Continued From page 16 beginning of a dehiscence mid incision (rupturing of the incision). The notes further revealed the tissue did not appear to be healthy with large amounts of serosangineous drainage with applied pressure and was foul smelling. A section labeled assessment and plan revealed Resident #2 would be admitted to the hospital for wound irrigation and debridement and wound revision and obtain cultures and consult infectious disease for antibiotics. A review of a hospital discharge summary dated 09/14/17 indicated Resident #2 went for a 2 week follow up appointment on 09/07/17 and her incision had opened and was grossly infected. The summary revealed Resident #2 was admitted to the hospital for irrigation and debridement and wound revision the same day and a wound vacuum was placed over the incision to assist with healing, a urinary catheter was kept in place to prevent wound contamination due to wound cultures revealed urine bacteria was present in the incision and caused the wound infection and antibiotics were given through a peripherally inserted central catheter (PICC line) to continue for at least 6 weeks until the infection resolved. During an interview on 10/03/17 at 2:57 PM, the Director of Nursing (DON) confirmed the facility had a full-time wound nurse who worked during the week from 7:30 AM-3:30 PM. She explained the wound nurse was not available for interview because she was away for 2 weeks but they had a part-time nurse (Nurse #2) who was trained by the wound nurse and did wound treatments when the wound nurse was not available. She further explained the nurse assigned to the resident was also responsible for doing wound treatments when a wound nurse was not working in the	F 309	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. " QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. " (Completion 10/24/17)	

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 10/05/2017

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 309	Continued From page 17	F 309		

facility.

During an interview on 10/03/17 at 3:16 PM, Nurse #2 stated she provided wound treatments when the wound nurse was not working at the facility. She explained if a resident had a surgical wound, the treatment was ordered by the surgeon and if a wound did not look good she would call and let the physician or surgeon know. She stated she did not recall dressing changes or assessments of Resident #2's surgical incision on her back.

During a follow up interview on 10/03/17 at 3:33 PM the DON confirmed Resident #2 was ordered by her surgeon to have a dry dressing daily to her lower back incision for 1 week. She stated it was her expectation for nursing staff to assess surgical incisions and should document their assessments.

During an interview on 10/03/17 at 3:53 PM, Physician #1 who was also the facility Medical Director explained he did not examine Resident #2 but recalled Physician #2 had examined her because of wound drainage. He stated it was his expectation for nursing staff to follow physician's orders and if instructions were for dressings to be changed daily they should do so because dressings saturated with drainage were a culture medium for bacterial growth. He further stated if a wound or incision was foul smelling or had more drainage than what the resident came to the facility with nursing staff should call the surgeon to see what they wanted them to do.

During a telephone interview on 10/04/17 at 9:19 AM, Nurse #3 who had signed the SBAR on 09/05/17 stated she recalled Resident #2 but did

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 10/05/2017

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 309	Continued From page 18	F 309		

not recall anything about the surgical incision, odor or drainage. She explained she did not recall filling out the SBAR and explained if she had done an assessment of the incision she would have documented it on the SBAR or in the nurse's progress notes. She further stated she usually wrote a note in the nurse's progress notes if she did an assessment of a wound or a surgical incision.

During an interview on 10/04/17 at 10:25 AM, Physician #2 confirmed she had examined Resident #2 on 09/06/17 because a nurse had completed an SBAR because Resident #2 had a wound with a foul smell. She explained she examined Resident #2 who had recently had spinal surgery and the bandage on her incision was soiled with serosanguineous drainage. She stated she called the wound nurse to the room and instructed her to clean it. She further stated she could not identify when the dressing had last been changed because it was not signed or dated so she was not sure how long it had been since the dressing had been changed. She explained she wrote orders for dressing changes to continue for 5 more days because she was trying to prevent soiling of Resident #2's clothing. She stated it was her understanding Resident #2 went for a follow up appointment on 09/07/17 and from there was sent to the hospital and had not returned to the facility.

During an interview on 10/04/17 at 12:00 PM the DON verified Resident #2 had an interim care plan which indicated to check surgical site every day but there was no documentation after 08/28/17 regarding assessments or appearance of the surgical incision. She confirmed there was no documentation of dressing changes on

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 10/05/2017

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 309	Continued From page 19	F 309		

09/02/17 or 09/03/17 because there were no initials on the MAR and because there were no initials she felt the dressing had not been changed.

During an interview on 10/04/17 at 12:30 PM with the Administrator and DON, the Administrator stated an assessment was supposed to be completed as part of the SBAR but after review of the SBAR dated 09/05/17 he verified there was only documentation of Resident #2's vital signs. He confirmed there was no additional documentation of the surgical incision and no assessment of the surgical incision in the nurse's progress notes on 09/05/17. The DON stated she would have expected to see nurse's progress notes and assessments to describe the length of the incision, any redness, what the drainage looked like and a description of the odor. She verified the back of the S-Bar was available for the nurse to use for additional nurse's notes and should have been used to describe the appearance of the surgical incision. The DON explained the nurse who should have done the dressing changes on 09/02/17 and 09/03/17 no longer worked at the facility.

On 10/05/17 at 3:05 PM a telephone call was received from Resident #2's Orthopedic Surgeon. He stated Resident #2 came to his office on 09/07/17 for what was supposed to be a routine 2 week follow up visit for suture removal after spinal surgery. He explained Resident #2's surgical incision on her lower back had a foul odor and there was wound dehiscence and it was not well healed as he had expected. He stated he had to take Resident #2 to surgery that night to wash and clean it out and he cultured the wound and it was infected with bacteria from urine. He

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 10/05/2017

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 309	Continued From page 20 explained Resident #2 was elderly and deconditioned and had not mobilized quickly which put her at greater risk for wound contamination. He further explained Resident #2's family had told him Resident #2 wore a brief at the facility and he felt the dressing had been saturated or soiled with urine which then contaminated the wound. He stated it was his expectation for attention to have been given to the wound and it should have been kept clean and dressed according to his orders to prevent infection.	F 309		
F 520 SS=G	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are	F 520		10/24/17

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 10/05/2017

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 520	Continued From page 21 necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the recertification survey of 10/06/16. This was for one recited deficiency which was originally cited in October 2016 and was subsequently recited on the current follow up and complaint survey of 10/05/17. The repeat deficiency was in the area to provide care to maintain well-being. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 309: Provide Care to Maintain Well Being:	F 520	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. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " Resident #2 identified during the survey discharged from the facility on 9/7/17. " The 3 nurses identified during the survey as not completing the dressing change and assessing the surgical wound received a one-on-one in-service or will receive one prior to 10/17/17 by RN Nurse	

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 10/05/2017

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 520	Continued From page 22 Based on record reviews and physician and staff interviews the facility failed to assess a surgical incision on a resident's lower back or provide daily dressing changes according to physician's orders who had to be readmitted to the hospital for an incision and drainage and revision of the incision due to a wound infection of their lower back (Resident #2) for 1 of 1 resident with a surgical incision. During the recertification survey of October 6, 2016 the facility was cited at F 309 for failure to follow a physician order to change a peripherally inserted central catheter (PICC) line dressing weekly for 1 of 1 sampled resident. During an interview on 10/04/17 at 1:21 PM, the Administrator explained the facility conducted monthly Quality Assessment and Assurance meetings and the Administrator, Director of Nursing, Medical Director, Pharmacist and various department managers attended the meetings. He confirmed plans of correction were ongoing topics at the meetings. He stated for past deficiencies they maintained some sort of auditing either on a monthly basis or for some period of time in order to try and avoid repeat deficiencies.	F 520	Educator or RN designee on completing surgical dressing changes per MD orders, dating and initialing the dressing, and signing the MAR upon completion. 1 nurse is no longer employed by the facility. The two remaining nurses received disciplinary action for failure to assess the surgical incision and provide daily dressing changes. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " All patients and residents with surgical dressing orders were identified. An audit was completed by the DON or RN designee to determine whether the physician order was being followed to change the dressing for these patients and residents. " Surgical dressing changes will be completed per MD orders to include the dressings being dated for the date they were changed with the initials of the nurse completing the dressing change. Additionally, the nurse will document on the Electronic Medication Administration Record (EMAR) that he or she completed the dressing change per MD order. Daily the surgical dressing will be checked by the licensed nurse and documented on the EMAR to ensure that dressing is dry and intact and assessment of the surgical wound. RN Nurse Educator or RN designee will in-service all nurses regarding these practices. The monitoring procedure to ensure that	

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 10/05/2017

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 520	Continued From page 23	F 520	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. " The facility will convert to an electronic medical record in October 2017, which will change the process for the documentation of surgical dressing changes and assessment of the surgical wounds. Auditing and monitoring will remain in place as outlined, adhering to the timeframe and guidelines. " DON or RN designee will audit 100% of residents with surgical incision dressing changes (to include frequency), date/initialing of Surgical dressings, documenting of completion in the EMAR once a dressing change is completed. " An in-service will be completed for licensed nurses by the RN Nurse Educator or RN designee to include following MD orders for Surgical dressing changes (to include frequency), date/initialing of Surgical dressings, signing the EMAR once a dressing change is completed and daily the surgical dressing will be checked by the licensed nurse and documented on the EMAR to ensure that dressing is dry and intact and assessment of the surgical wound is completed. Any nurse who is unable to attend the mandatory in-service by 10/17/17 will receive the in-service prior to working a shift.	

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 10/05/2017

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 520	Continued From page 24	F 520	" Surgical dressings will be checked daily by licensed nurse and documented on the EMAR to ensure that dressing remains intact and is changed per MD orders and assessment of the surgical wound is completed. " Clinical supervisor or licensed nurse designee will report any new surgical wounds in morning stand up meeting daily (Monday □ Friday) and/or to the weekend RN in charge along with the MD orders to change the dressing. " Any issues identified will be corrected immediately and will also be taken to daily clinical start-up meeting (Monday □ Friday) and/or reported to the weekend RN in charge and QAPI. " DON or RN designee will audit daily x 1 month, then weekly x 2 months surgical incision dressing changes (to include frequency), date/initialing of Surgical dressings, documenting in the EMAR once a dressing change is completed and assessment of the surgical wound to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and/or 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. " QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. " (Completion 10/24/17)	