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	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntersville Oaks	12019 Verhoeff Drive Huntersville, NC 28078

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on record review, resident, and staff interview the facility failed to treat a resident in a dignified manner by not adequately preparing her for an outside medical appointment for 1 of 3 residents reviewed for dignity (Resident #18). This made Resident #18 feel forgotten and unimportant. The findings included: Resident #18 was admitted to the facility on [DATE] with diagnoses that included seizure, history of a cerebrovascular accident (stroke), and dysphagia as late effect of a stroke. A review of Resident #18's annual Minimum Data Set assessment dated [DATE] revealed her to be cognitively intact with no psychosis, behaviors, or rejection of care. Resident #18 had indicated is was very important to choose what clothes she wore daily. Resident #18 was also coded as requiring extensive assistance with dressing and bathing and required limited assistance with toilet use and personal hygiene. During an interview with Resident #18 on 11/13/23 at 12:18 PM, she reported she had been scheduled for a follow-up appointment on 11/09/23 but she had to cancel it because she was not dressed and adequately prepared to go out when transportation showed up to take her to the appointment. Resident #18 reported when transportation arrived to take her to the appointment she was still in her pajamas and had not yet had time to get herself put together. Resident #18 reported it was very important to her to be dressed and ready to go to her appointments outside of the facility and that the incident made her feel forgotten and unimportant. A review of Resident #18's electronic progress notes revealed a note dated 11/09/23 that read: Patient states she was upset about a mix-up today pertaining to the schedule and an appointment that she missed. Patient states she was scheduled to go out, but no one informed her .Patient states she likes to be aware of her schedule . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Social Worker on 11/16/23 at 11:33 AM revealed she was responsible for scheduling follow-up appointments and transportation. She reported she was aware of the incident where Resident #18 was not gotten up and dressed before her appointment and stated because the appointment was early in the morning, the Nurse Aide (NA) that was assigned to Resident #18 on 3rd shift the night before, should have gotten Resident #18 up and assisted her in getting dressed and ready for her appointment. She stated she did not know why the NA did not get Resident #18 up and dressed and indicated that she knew Resident #18 was upset about the situation. An interview by telephone was attempted on 11/16/23 at 1:02 PM with third shift NA #4 who was the NA assigned to Resident #18 the morning of her appointment and would have been responsible for ensuring Resident #18 was up, dressed, and prepared for her appointment by 8:00 AM. Unfortunately, that interview was unsuccessful. During an interview with the Director of Nursing (DON) on 11/16/23 at 2:49 PM, her reported he was aware of the incident regarding Resident #18 not being adequately prepared to go to her appointment. He also stated that he was aware that Resident #18 was very particular and that it took some time to get her up, dressed, and ready to go to outside appointments. He stated he did not know why she was not adequately prepared to go to her appointment and that she should have been given ample and sufficient time to get up, get dressed, and prepare herself to go to her appointment. An interview with the Administrator on 11/16/23 at 2:56 PM revealed she was aware of the incident regarding Resident #18 and she reported Resident #18 should have been gotten up and dressed before her appointments. She further stated she expected all residents to be sufficiently prepared for appointments.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, and staff interviews the facility neglected to feed a dependent resident (Resident #15) her lunch meal for 1 of 2 residents reviewed for neglect. The findings included: Resident #15 was admitted to the facility on [DATE] with diagnosis that included vascular dementia with severe anxiety. Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed that Resident #15 was severely cognitively impaired and required total assistance with eating. The MDS further revealed no behaviors or rejection of care and indicated that Resident #15 received Hospice services during the look back period. An observation of Resident #15 was made on 11/13/23 at 4:19 PM. Resident #15 was resting in bed with head of bed elevated and was resting on her left side. Resident #15's lunch tray sat on her sink counter. The silverware on the tray had not been unrolled or taken out of the sealed plastic bag, the lids of the drink and dessert had not been removed. Once the tray lid was lifted the three scoops of puree food were undisturbed. An interview was conducted with Nurse Aide (NA) #1 on 11/13/23 at 4:20 PM who confirmed that she was one of two NAs that were working on the unit where Resident #15 resided. She stated that she had fed Resident #15 her breakfast tray and she had eaten about 33% of the meal and drank most of her supplement but stated she had not fed Resident #15 her lunch tray. She also was not aware of who had fed Resident #15 her lunch tray. An interview was conducted with NA #2 on 11/13/23 at 4:22 PM who confirmed that she was the second NA that was working on the unit where Resident #15 resided. She stated that she had not fed Resident #15 her lunch and was not sure who had fed Resident #15. NA #2 stated that maybe someone from the office fed her. Nurse #1 was interviewed on 11/13/23 at 4:24 PM who confirmed that she was the nurse on the unit where Resident #15 resided. She was asked to observe Resident #15 in her room and also her lunch tray that remained untouched on her sink counter. Nurse #1 stated she had not fed Resident #15, and she was not sure who had but she would find out who had fed her. She indicated it would have either been NA #1 or NA #2 as they were the assigned NAs to that unit. Nurse #1 also stated that Unit Manager (UM) #1 may have fed Resident #15 her lunch tray. UM #1 was interviewed on 11/13/23 at 4:37 PM who stated that she had not fed Resident #15 her lunch tray but observed the lunch tray sitting untouched on her sink counter. She stated she would find out what happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview was conducted with UM #1 on 11/13/23 at 4:54 PM who stated that she had spoken to the two NAs on the unit where Resident #15 resided as well as the two NAs on the other unit and it was a breakdown in communication and it got missed and no one had fed Resident #15 her lunch tray. UM #1 stated that she ordered Resident #15 an early dinner tray and was going to feed her. An observation of Resident #15 was made on 11/13/23 at 5:12 PM. Resident #15 was in bed with her head of bed elevated. UM #1 was seated next to her bed and was feeding her dinner meal. Resident #15 appeared calm and did not appear to be grabbing at the food tray but was accepting of each bite of food offered to her. UM #1 was again interviewed on 11/16/23 at 11:06 AM. UM #1 stated that Patient Safety Attendant (PSA)#1 had taken the lunch tray into Resident #15's room on 11/13/23 but she was unable to assist residents with their meals. She explained that the meal tray should not have been delivered to Resident #15's room until the staff were ready to assist her with the meal. UM #1 stated she fed Resident #15 her early dinner tray on 11/13/23 and she had eaten 25% of the meal and drank 300 milliliters (ml) of fluid. PSA #1 was interviewed on 11/16/23 at 3:27 PM who confirmed that she worked on 11/13/23 on the other unit. She stated she did not recall if she delivered Resident #15's lunch tray to her or not. She explained that she generally only delivered the trays of independent residents and just could not recall if she had accidentally delivered Resident #15's tray or not. The Administrator and Director of Nursing (DON) were interviewed on 11/16/23 at 2:41 PM. The DON stated that the staff had told him that there was a miscommunication on who was going to feed Resident #15 on 11/13/23. He further explained that they immediately got Resident #15 a tray and fed her. The Administrator stated that the meal tray should not have been taken into Resident #15's room until someone was ready to assist her with the meal.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35789 Based on observations, record review, and staff interviews the facility failed to remove expired medications from 1 of 2 medications carts reviewed (Pine Bluff medication cart). The findings included: An observation of the Pine Bluff Medication cart was conducted on 11/15/23 at 10:38 AM along with Nurse #2 revealed the following expired medications that were on the cart and available for use: -Open bottle of Multivitamin 220 tablets that expired on 06/22. -Open bottle of Vitamin B complex 60 tablets that expired September 2022 Nurse #2 was interviewed on 11/15/23 at 10:42 AM who stated that she was a resource nurse and floated to wherever she was needed. She stated she had not been to the facility in months and was not familiar with their procedures. Nurse #2 explained the Pine Bluff Medication cart was generally assigned to the supervisor and it would their responsibility to go through the cart and look for any expired medications, but she did not know how often they did that. Nurse #2 confirmed that she had not gone through the medication cart before her shift started to check for expired medications. The Pharmacist was interviewed on 11/16/23 at 1:50 PM who stated that she did monthly inspections of each medication room and each medication cart and removed any expired medications and to ensure proper storage of each medication. The Pharmacist explained when an expired medication was found it would be pulled off the medication cart and placed in a bin to return to the pharmacy. She stated if there was no bin in the facility the medication would remain on the cart but separate from the active medications until a bin was available for return to the pharmacy. She added that she had completed her monthly review of the Pine Bluff Medication cart on 11/02/23 and again on 11/13/23 and found no expired medications. The Pharmacist explained maybe the medications were placed on the medication cart while waiting on a bin from the pharmacy to return them or they were waiting to be returned to a family member, but she was not sure who or when the medications were placed on the medication cart. The Director of Nursing (DON) was interviewed on 11/16/23 at 2:45 PM who stated the expired medication should not have been on the medication cart. If they needed to be returned to the family or to the pharmacy, it should have been pulled off the medication cart and secured in the medication room.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on observations, record review, and staff and resident interviews, the facility failed to ensure routine dental care for 1 of 2 residents reviewed for dental services (Resident #52). The findings included: Resident #52 was admitted to the facility on [DATE] with diagnoses that included history of hemorrhagic stroke with residual hemiplegia, A review of Resident #52's significant change Minimum Data Set assessment dated [DATE] revealed she was cognitively intact with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #52 was coded as needing limited assistance with personal hygiene and was independent with oral hygiene. Resident #52 was coded with no noted dental issues which included no obvious or likely cavities or broken natural teeth. A review of Resident #52's care plan revealed a care plan for [Resident #52] has her own teeth, requires supervision with oral care and hygiene. Interventions included [Resident #52] will comply with oral care and hygiene and there would be no avoidable complications through the review date. An observation which included an interview with Resident #52 on 11/14/23 at 2:42 PM revealed possible poor oral dentition with presence of plaque on her teeth. Resident #52 was able to eat, was not in pain, and had not lost any unintended weight. Resident #52 reported at that time she had not seen a dentist in a while and that she was aware that a dentist came into the facility and saw residents but reported she had not been seen. Resident #52 added she had seen the facility dentist before and did not know why she had not been seen for a while. Resident #52 also indicated she would like to be seen by the facility's dentist for routine cleanings. A review of Resident #52's electronic medical record revealed the last time resident was seen by a dentist was on 12/22/21 for tooth extractions. Additional review of Resident #52's medical record revealed a note dated 04/22/22 indicating Resident #52 was discharged per Social Worker #1. During an interview with the Administrator on 11/15/23 at 3:09 PM, she verified Resident #52 had not been seen by a dentist since 2021. She reported she was unsure why Resident #52 had not been seen by a dentist since then and reported she would see if there were any notes from the contracted dental company. An interview with Social Worker #1 on 11/16/23 at 11:17 AM revealed she was the social worker in the facility from October 2019 until October 2022. She verified while she was at the facility, she was responsible for scheduling dental appointments for residents. She also stated she did not remember requesting that Resident #52 be discharged from the dental practice and stated it must have been a misunderstanding. Social Worker #1 reported Resident #52 was in and out of the hospital around that time and she most likely called to let them know Resident #52 had been discharged to the hospital. She also reported she left the facility prior to when Resident #52 would have been scheduled to be seen again. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview with the Administrator on 11/16/23 at 2:56 PM, she reported the facility has a dental consult binder that was maintained by the Social Worker. She indicated if Resident #52 was discharged from the dental services provider she would not be in the binder. She also reported any residents who complain about dental issues or if nursing staff report possible dental concerns, the resident's name would be placed in the binder and, to her knowledge, Resident #52 had not voiced any complaints. The Administrator stated she was unsure how Resident #52 had been overlooked for so long and that every resident should be seen by the facility's dentist or dentist of the resident's choice at least annually.