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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345096 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/14/2025 |
| NAME OF PROVIDER OR SUPPLIER Huntersville Oaks | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366</p> <p>Based on observations, record review, and resident and staff interviews, the facility failed to maintain a resident's dignity by continuously utilizing a video and audio monitoring device in his room for 1 of 3 sampled residents reviewed for dignity (Resident #49). Resident #49 stated the video and audio device in his room did not make him feel good at all and he had to watch what he said around it because it was always watching him.</p> <p>Findings included:</p> <p>Resident #49 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, hypertension, and peripheral vascular disease.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #49 was cognitively intact and needed substantial assistance with transfers and walking. Resident #49 was not coded for any falls.</p> <p>Resident #49's care plan revised 1/30/25, indicated a problem area for falls and an intervention was the use of a video and audio monitoring device.</p> <p>A physician's order for the video and audio and monitoring device was written on 1/30/25 due to Resident #49's confusion and multiple falls.</p> <p>An observation on 3/10/25 at 3:55 PM revealed Resident #49 did not have a roommate and a video and audio monitoring device was visualized on a metal stand in Resident #49's room facing the bed.</p> <p>An interview with Resident #49 on 3/11/25 at 8:45 AM revealed he was aware of the video and audio monitoring device in his room but did not give written consent for its use.</p> <p>An interview with Resident #49 on 3/13/25 at 12:37 PM revealed he had the video and audio monitoring device in his room to watch him, so he didn't stand up and fall in his room. He explained the device will come on and speak to him and remind him to sit down and call for help. Resident #49 stated the device did not make him feel good at all and he couldn't even stand up before it started making loud noises. He stated that the video and audio monitoring device bothered him when it was first used but noted he had gotten used to dropping his pants and picking his nose in front of it. Resident #49 said he had to watch what he said in front of the device because it was always watching him.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A second observation and second interview with Resident #49 was conducted on 3/13/25 at 4:12 PM. The surveyor asked the video and audio monitoring device for privacy and the computer screen read Privacy Mode. The monitoring technician audibly explained through system speaker to wave at the device to turn off privacy mode. Resident #49 stated one day the staff rolled in the device and it had been in his room since. He did not know who the people were monitoring the device but explained he had talked to them before through the device. Resident #49 noted he was not aware he could ask for the system to be put in privacy mode and said only staff were able to ask for that. Resident #49 stated he felt he needed to watch what he said around the device because it had ears.</p> <p>A review of the video and audio monitoring device's instructions found attached to Resident #49's device was conducted. The device included a camera with pan, tilt, and zoom capabilities, a monitor that enabled two-way video, and a speaker that provided two-way audio between the resident's room and viewing station.</p> <p>An interview with Nurse Aide (NA) #2 on 3/14/25 at 9:36 AM revealed the video and audio monitoring devices had been used about two years at the facility. She explained staff could ask for privacy mode when providing care for residents who had the devices in their room. NA #2 stated she was unsure when staff asked for Privacy mode in front of the device, if the resident and staff were actually receiving privacy, as she was unsure of what was visible on the other end of the camera. She stated family members and residents with the video and audio monitoring devices wouldn't know if there is a way to mute the device, so they are being watched in the room. NA #2 revealed she knew the monitoring technician could hear what was going on in the resident's room.</p> <p>An interview with Nurse #1 on 3/14/25 at 10:03 AM revealed Resident #49 had the video and audio monitoring device because he needed staff assistance, and he would often forget to call for assistance. She stated all of Resident #49's personal care was given in the bathroom, out of sight of the device.</p> <p>An interview with Nurse #2 on 3/14/25 at 11:13 AM revealed she managed the video and audio monitoring device unit offsite for the company. She stated she was an employee of the larger company and did not work on site at the facility. Her staff was comprised of many video and audio monitoring technicians who also worked for the company and were not on site at the facility. Nurse # 2 stated each device used in the facility had a plan for the corresponding resident and each monitoring technician would watch 10-12 video and audio feeds simultaneously at an offsite location. She stated the facility staff could ask for privacy and the device would go into Privacy Mode that lasted for 10 minutes. The video screen is blurred to the attendant during that time and staff is asked to wave to the device and the attendant would visualize the hand motion. Nurse #2 explained that the audio never turns off, but the device does not record and multiple feeds are viewed at once, so it would be hard to focus on a conversation. She stated the device used artificial intelligence to learn the movements of the resident and the video and audio monitoring technician would get an alert on their screen if a resident moved in a problematic way. Nurse #2 stated the technician would talk through the camera to the resident and if the resident was not redirected from the behavior, an alarm would sound from the device to alert staff in the facility.</p> <p>(continued on next page)</p> | | |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview with the Director of Nursing (DON) and Administrator on 3/14/25 at 2:34 PM revealed the video and audio monitoring device in Resident #49's room was continuously on for fall prevention, but the device did not record the feed. The DON stated she was not aware who was monitoring the devices but knew they were employees of the larger company, and they had background checks completed for their employment. The Administrator stated she was unaware Resident #49 was uncomfortable with the device in his room.</p> | | |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366</p> <p>Based on observations, record review, and resident and staff interviews, the facility failed to maintain privacy and obtain written consent for the use of a video and audio monitoring device in a resident's rooms for 1 of 3 sampled residents reviewed for privacy (Resident #49). A reasonable person would expect privacy in their living area and not be monitored continuously by a monitoring technician at an offsite location.</p> <p>Findings included:</p> <p>A review of the facility's policy entitled Assignment and Use of Virtual Patient Observation (VPO) Greater [NAME] Market dated 4/12/23 revealed the administrative supervisor or designee would bring the monitoring device to the unit as needed and would contact the VPO monitoring center to enroll the resident. The nurse and/or administrative supervisor would review the virtual sitter process with the resident, family, or caregiver present.</p> <p>Resident #49 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, hypertension, and peripheral vascular disease.</p> <p>The admission MDS dated [DATE] revealed Resident #49 was cognitively intact and needed substantial assistance with transfers and walking. Resident #49 was not coded for any falls.</p> <p>Resident #49's care plan revised 1/30/25, indicated a problem area for falls and an intervention was the use of a video and audio monitoring device.</p> <p>A physician's order for the video and audio and monitoring device was written on 1/30/25 due to Resident #49's confusion and multiple falls.</p> <p>A review of Resident #49's medical record revealed that no written consent for video or audio monitoring was obtained.</p> <p>An observation on 3/10/25 at 3:55 PM revealed Resident #49 did not have a roommate and a video and audio monitoring device was visualized on a metal stand in Resident #49's room facing the bed.</p> <p>An interview with Resident #49 on 3/11/25 at 8:45 AM revealed he was aware of the video and audio monitoring device in his room but did not give written consent for its use. He stated when he was admitted to the facility, his spouse signed all admissions paperwork and stated he was unsure if she gave written consent.</p> <p>Multiple attempts were made to contact Resident #49's spouse and were unsuccessful.</p> <p>A second interview with Resident #49 on 3/13/25 at 12:37 PM revealed he had the video and audio monitoring device in his room to watch him, so he didn't stand up and fall in his room. He explained the device will come on and speak to him and remind him to sit down and call for help. Resident #49 noted that the device also made a loud alarm noise to alert staff before he could stand up.</p> <p>(continued on next page)</p> | | |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A second observation and third interview with Resident #49 was conducted on 3/13/25 at 4:12 PM. The surveyor asked the video and audio monitoring device for privacy and the computer screen read Privacy Mode. The monitoring technician audibly explained through system speaker to wave at the device to turn off privacy mode. Resident #49 stated one day the staff rolled in the device and it had been in his room since. He did not know who the people were monitoring the device but explained he had talked to them before through the device. Resident #49 stated he was not aware he could ask for the system to be put in privacy mode and said only staff were able to ask for that. Resident #49 stated he felt he needed to watch what he said around the device because it had ears.</p> <p>A review of the video and audio monitoring device's instructions found attached to Resident #49's device was conducted. The device included a camera with pan, tilt, and zoom capabilities, a monitor that enabled two-way video, and a speaker that provided two-way audio between the resident's room and viewing station.</p> <p>An interview with Nurse Aide (NA) #2 on 3/14/25 at 9:36 AM revealed the video and audio monitoring devices had been used about two years at the facility. She explained staff could ask for privacy mode when providing care for residents who had the devices in their room. She stated the device would have privacy mode on the screen when they used the word privacy and sometimes the monitoring attendant would speak over the device. She stated privacy mode usually lasted about 10 minutes and if care was completed before the end of 10 minutes, she would wave and speak to the device and privacy mode would be turned off. NA #2 noted the device would alarm loudly if a resident was not responding to the person monitoring the device. She explained she was unaware of who was monitoring the devices but knew it was not someone at the facility as staff was told the monitoring technicians were at an offsite location.</p> <p>An interview with Nurse #1 on 3/14/25 at 10:03 AM revealed Resident #49 had the video and audio monitoring device because he needed staff assistance, and he would often forget to call for assistance. Nurse #1 stated the device would alarm loudly if Resident #49 moved without calling for assistance. She explained the staff would often get a phone call from the monitoring service at the nurse's desk after each alarm incident. She stated she did not ask for Privacy mode when working with Resident #49 as it did not include any personal care. She stated all of Resident #49's personal care was given in the bathroom, out of sight of the device. Nurse #1 stated she did not recall receive any formal training on the device.</p> <p>(continued on next page)</p> | | |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview with Nurse #2 on 3/14/25 at 11:13 AM revealed she managed the video and audio monitoring device unit offsite for the company. She stated she was an employee of the larger company and did not work on site at the facility. Her staff was comprised of many video and audio monitoring technicians who also worked for the company and were not on site at the facility. Nurse # 2 stated each device used in the facility had a plan for the corresponding resident and each monitoring technician would watch 10-12 video and audio feeds simultaneously at an offsite location. She stated the facility staff could ask for privacy and the device would go into Privacy Mode that lasted for 10 minutes. The video screen is blurred to the attendant during that time and staff is asked to wave to the device and the attendant would visualize the hand motion. Nurse #2 explained that the audio never turns off, but the device does not record and multiple feeds are viewed at once, so it would be hard to focus on a conversation. She stated the device used artificial intelligence to learn the movements of the resident and the video and audio monitoring technician would get an alert on their screen if a resident moved in a problematic way. Nurse #2 stated the technician would talk through the camera to the resident and if the resident was not redirected from the behavior, an alarm would sound from the device to alert staff in the facility.</p> <p>An interview with the Director of Nursing (DON) and Administrator on 3/14/25 at 2:34 PM revealed the facility did not use written consents for the video and audio monitoring devices used in resident's rooms as the facility did not require consent. The DON explained the staff would ask for Privacy Mode when care was given near the device. She stated she was not aware who was monitoring the devices but knew they were employees of the larger company, and they had background checks completed for their employment. The Administrator explained each time one of the devices was used, an order was written and a plan for the device was put in place. She stated if any resident or responsible party refused the device, another plan would be put in place for the resident.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>40476</p> <p>Based on observations, record review, and staff, Nurse Practitioner, and Medical Director interviews, the facility staff failed to follow the manufacturer's instructions for cleaning and disinfecting of a shared glucometer between resident usage for 2 of 2 residents whose blood sugar levels were checked (Resident #58, Resident #1). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood borne infections. There were two residents with a bloodborne pathogen in the facility at the time of the investigation.</p> <p>Immediate Jeopardy began on 03/12/25 when Nurse Aide #1 was observed performing blood glucose checks on residents using a shared glucometer without disinfecting per manufacturer's instructions. Immediate jeopardy was removed on 03/14/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place.</p> <p>Findings included:</p> <p>The undated glucometer manufacturer's instructions for cleaning and disinfecting indicated that the blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. Additional instructions were to use a purple top wipe or an orange top bleach wipe if the resident was on enteric precautions.</p> <p>Review of the facility policy Glucometer Disinfection revised in September 2021 read, in part, to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The procedure for disinfecting glucometers included:</p> <p>The manufacturer's guidelines are as follows: put on clean gloves, clean the glucometer as below with Germicidal Disposable Wipes ([purple top] for all non-contact enteric isolation) or Bleach Germicidal Wipes ([orange wipes] if resident on contact enteric isolation)</p> <ul style="list-style-type: none"> - Place the meter on a level surface and ensure meter has been powered off - Obtain appropriate wipe and squeeze excess liquid from wipe - Wipe the meter to clean by gently wiping the outside of the meter and carefully wipe around the test strip port area, making sure that no liquid enters the test strip port - Dry the meter thoroughly with a dry cloth or gauze. Visually verify that no solution is seen anywhere on the meter at the completion of cleaning <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <ul style="list-style-type: none"> - Use a fresh wipe to disinfect by gently wiping the outside of the meter three times horizontally and three times vertically and carefully wipe around the test strip port area, making sure that no liquid enters the test strip port. - Allow the surface of the meter to remain damp with the recommended contact time (two minutes for purple-top, 4 minutes for orange-top) - Dry the meter thoroughly with a dry cloth or gauze. Visually verify that no solution is seen anywhere on the meter at the completion of cleaning and disinfecting. - If further testing is not needed, return the meter to the base unit to charge the battery. <p>The purple top wipes container which was located at the nurse's station read in part to disinfect nonfood contact surfaces to thoroughly wet surface, allow treated surface to remain wet for two minutes and let air dry. These wipes were an EPA-registered germicidal wipe and approved for bloodborne pathogen use.</p> <p>A continuous observation of Nurse Aide (NA) #1 was conducted from 03/12/25 at 11:46 AM through 12:00 PM and revealed the following:</p> <p>On 03/12/25 at 11:46 AM Nurse Aide #1 was observed in Resident #58's room. She stated she needed to go to the medication cart and gather necessary supplies. When she returned to Resident #58's room she was observed with a glucometer in her hand, alcohol swabs, and a lancet (used to stick the resident's finger). While in the room a second glucometer was observed on Resident #58's bedside table, NA #1 stated the first glucometer on Resident #58's table would not scan his barcode (on the resident identification bracelet), so that was why she had to obtain the second glucometer from the medication cart. NA #1 obtained Resident #58's blood sugar with a reading of 135 at 11:48 AM. She then stacked the two identical glucometers on top of one another and threw away her trash, exiting the room with both glucometers in hand at 11:50 AM. Nurse Aide #1 went over to Resident #1 with both glucometers still in her hand and pushed the resident to her room. She told Resident #1 she was going to check her blood sugar and would be right back. Nurse Aide #1 then went to the medication cart and obtained alcohol swabs, a lancet, test strip and placed one of the glucometers onto the medication cart. NA #1 kept the other glucometer in her hand and scanned Resident #1's barcode. NA #1 was not observed disinfecting the glucometer and no disinfecting wipes were observed on the medication cart.</p> <p>At 11:54 AM Nurse Aide #1 entered Resident #1's room with one of the two glucometers that were in Resident #58's room. NA #1 began to obtain Resident #1's blood sugar, the surveyor stopped NA #1 and asked if the glucometer was the same glucometer used on Resident #58. NA #1 stated, No, I am using the glucometer that was laying on his table, not the glucometer I used to get his blood sugar. NA #1 obtained Resident #1's blood sugar which was 244 at 11:57 AM and exited the room at 11:58 AM.</p> <p>At 12:00 PM the surveyor asked to see the glucometer history for the machine used to obtain Resident #1's blood sugar. The glucometer history revealed on 03/12/25 at 11:48 AM a blood sugar reading of 135 was obtained and at 11:57 AM a blood sugar reading of 244 was obtained. NA #1 was observed taking the glucometer to the nurse's station and obtaining a purple top wipe. She wiped the glucometer front and back quickly and immediately placed it onto the docking station to charge.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>An interview occurred with Nurse Aide #1 on 03/12/25 at 12:00 PM. NA #1 stated she had taken one glucometer into Resident #58's room and sat it on his bedside table, however it would not scan so she had to go to the medication cart and obtain another glucometer. Once in Resident #58's room she had two glucometers and used one of them to obtain his blood sugar. She stated she placed both glucometers on top of one another and thought she had placed the one she used to obtain Resident #58's blood sugar on the medication cart however made a mistake and took it into Resident #1's room and also obtained Resident #1's blood sugar using the same machine without cleaning it in between residents. NA #1 stated she knew she was supposed to clean the glucometer in between residents and had been educated on it but just made a mistake. She also stated she knew there was a wet time for the cleaning of the glucometer and thought she had cleaned the glucometer for two minutes but did not time it. NA #1 stated she thought she could just let the glucometer air dry on the docking station.</p> <p>An interview on 03/12/25 at 12:53 PM with the Infection Preventionist (IP)/ Director of Nursing revealed each resident household had 2 glucometers to use because not all residents admitted into the facility had their own glucometer. She stated the facility was very strict on disinfecting glucometers in between use of each resident and had just provided education on glucometer cleaning and disinfecting in January 2025. The IP stated the nurses and nurse aides should be using the disinfectant wipes after each use of the glucometer with a wet contact time of 2 minutes using two wipes and wiping the entire surface of the glucometer. After that, the nurses and nurse aide were to lay the glucometer on a towel and let it dry for a duration of 2 minutes. She stated NA #1 should have known the policy on cleaning and disinfecting the glucometers and followed it. The IP stated the negative outcome that could have occurred from not disinfecting the glucometer between resident use included the spread of bloodborne pathogens. She stated there were two current residents in the facility with a bloodborne pathogen and they were located in the same neighborhood of Resident #58 and Resident #1. The IP stated the facility did not have dedicated glucometers for each individual resident because the staff had been provided with education and training on how to disinfect the glucometers per manufacturer's instructions.</p> <p>An interview conducted on 03/13/25 at 2:34 PM with the Nurse Practitioner (NP) revealed all nursing staff should be disinfecting the glucometers in between each resident and according to manufacturer's instructions. The NP stated there was a risk of spreading bloodborne pathogens by using the same glucometer on both residents without cleaning it per manufacturer instructions. She stated bloodborne pathogens could be spread by blood or bodily fluid if the nursing staff were not following standard precautions by cleaning the glucometer in between residents. She stated the risk of cross contamination could be high.</p> <p>An interview conducted on 03/13/25 at 3:03 PM with the Medical Director (MD) revealed he felt using the same glucometer on multiple residents was an issue Administration needed to look into, including why it happened and preventative measures. The MD stated the staff could not use the same test strip for the glucometer on more than one resident. The interview revealed he felt using a test strip on multiple residents was the only likely way a bloodborne pathogen could be spread. The MD stated the nursing staff should be disinfecting the glucometer as directed by the facility.</p> <p>An interview on 03/12/25 at 1:00 PM with the Administrator revealed that glucometers should be disinfected according to the manufacturer's instructions.</p> <p>The Administrator was notified of the immediate jeopardy on 03/12/25 at 3:30 PM.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345096 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/14/2025 |
| NAME OF PROVIDER OR SUPPLIER Huntersville Oaks | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>The facility provided the following credible allegation of immediate jeopardy removal.</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance;</p> <p>During an observation on 3/12/25 at 11:46 AM, the Nursing Assistant failed to follow the manufacturer's guidelines for cleaning and disinfection of one blood glucose meter used for Resident #58 and Resident #1. Following the observation, this glucometer was cleaned and disinfected based on manufacturer's guidelines by the Director of Nursing. This failure provides the high likelihood for the spread of blood borne pathogens in the facility.</p> <p>On 3/12/25, the Nursing Assistant was reeducated by the facility's Nurse Educator on the manufacturer's guidelines for cleaning and disinfecting blood glucose meters to include competency validation. On 3/12/25, the Nursing Assistant was provided competency validation by the Nurse Educator.</p> <p>On 3/12/25, 100% of the blood glucose meters were cleaned and disinfected based on manufacturer's guidelines by the Director of Nursing. The manufacturer's guidelines are as follows: put on clean gloves, clean the glucometer as below with Germicidal Disposable Wipes ([purple top] for all non-contact enteric isolation) or Bleach Germicidal Wipes ([orange wipes] if resident on contact enteric isolation)</p> <ul style="list-style-type: none"> - Place the meter on a level surface and ensure meter has been powered off - Obtain appropriate wipe and squeeze excess liquid from wipe - Wipe the meter to clean by gently wiping the outside of the meter and carefully wipe around the test strip port area, making sure that no liquid enters the test strip port - Dry the meter thoroughly with a dry cloth or gauze. Visually verify that no solution is seen anywhere on the meter at the completion of cleaning - Use a fresh wipe to disinfect by gently wiping the outside of the meter three times horizontally and three times vertically and carefully wipe around the test strip port area, making sure that no liquid enters the test strip port. - Allow the surface of the meter to remain damp with the recommended contact time (two minutes for purple-top, 4 minutes for orange-top) - Dry the meter thoroughly with a dry cloth or gauze. Visually verify that no solution is seen anywhere on the meter at the completion of cleaning and disinfecting. - If further testing is not needed, return the meter to the base unit to charge the battery. <p>On 3/13/25, Resident #58 and Resident #1 were evaluated by the Medical Director. On 3/13/25, the Resident #58 and Resident #1's responsible parties were notified of the infection control breach and provided information regarding the Medical Director's evaluation.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 3/13/25 the facility's Pharmacy Consultant conducted a 100% audit of all residents who require blood sugar checks and identified that thirty residents in the facility have the potential to be affected by the deficient practice.</p> <p>In addition, it was determined that two residents in the facility have a diagnosis of bloodborne pathogen. It was determined that both residents who have bloodborne pathogens do not have any blood sugar checks ordered and would not have any teammate use a blood glucose monitor to obtain any blood.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>On 3/12/25 facility took immediate action by having the Nurse Educator review the manufacture's guidelines and facility's cleaning grid for cleaning and disinfecting blood glucose meters to ensure that the guidelines were accurate and did not require changes.</p> <p>The Nurse Educator provided education to all current nursing staff (Nursing Assistants and Nurses) to follow the manufacturer's guidelines for cleaning and disinfection of blood glucose meters, for staff competency. Any current nursing staff who do not receive education by 3/13/25 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. All nursing staff hired after 3/13/25 will be required to complete this training and education upon hire. The education will be required annually.</p> <p>Beginning 3/12/25, the facility's Nursing Leadership team (Nurse Educator, Director of Nursing, Licensed Practical Nurse Unit Coordinators and Clinical Supervisors) will complete competency validation to monitor for compliance of all nurses and nurse aides following the manufacturer's guidelines for cleaning and disinfecting blood glucose meters. All currently employed nurses and nurse aides will have the competency validation completed by 03/13/25. Any employed nurses and nurse aides who have not received competency validation by 03/13/25 will receive competency validation by prior to their next working shift. All nursing staff hired after 03/13/25 will be required to complete the competency validation upon hire.</p> <p>On 3/13/25, the facility Administrator notified the local Health Department regarding the infection control breach.</p> <p>Alleged IJ Removal Date: 3/14/25</p> <p>On 03/13/25, the credible allegation of immediate jeopardy removal was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff had received education on provided education to follow the manufacturer's guidelines for cleaning and disinfection of blood glucose meters. Nursing staff (Nurses and Nurse Aides) were asked by educators to provide demonstration of glucometer use and cleaning during the education. The facility's in-service log and training material was reviewed. Additional observations were conducted of nursing staff obtaining residents blood sugars and disinfecting the glucometer per manufactures instructions. The IJ removal date of 03/14/25 was validated.</p> | | |