STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntersville Health & Rehab Center	13835 Boren Street 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366 Based on record review, Responsible Party, Medical Director, and staff interviews, the facility failed to ensure a safe and orderly discharge when the facility failed to remove a midline catheter (a long peripheral intravenous catheter, typically 6-15 centimeters in length, that is inserted into a large vein in the upper arm or forearm) before discharging a resident home for 1 of 3 residents reviewed for discharge (Resident #229). The findings included: Resident #229 was admitted to the facility 11/11/24 with diagnoses that included dysphagia and hyponatremia. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #229 had moderate cognitive impairment. A review of Resident #229's physician orders revealed an order dated 12/10/24 that read in part; midline [catheter] to be placed one time a day for hydration. Resident #229 had a physician's order dated 12/11/24 for an intravenous solution of one liter of normal saline at 75 milliliters (ml) per hour given one time on 12/11/24 for hyponatremia. A review of Resident #229's discharge summary dated 12/20/24 and signed by Nurse #1 revealed no devices including a midline catheter were indicated. The discharge summary revealed that there were no orders that required a midline IV access upon discharge. A telephone interview with Resident #229's Responsible Party (RP) occurred on 5/7/25 at 9:37 AM. He stated on the day of Resident #229's discharge, he received medications from the nursing staff and took Resident #229 home. The RP could not remember what education he received before discharge from the nursing staff. He stated when Resident #229 arrived home, she (Resident #229) pointed to her right arm to the midline IV still in place. The RP stated he called the facility and made them aware of the IV that remained in Resident #229's arm. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with Unit Manager #1 on 5/7/25 at 12:02 PM revealed Resident #229 had a midline IV in place while she was at the facility. He stated he could not recall the specifics of Resident #229's discharge but stated generally when residents were discharged , an assessment would be completed beforehand and if there was no need for an IV after discharge, the midline catheter would be taken out. Unit Manager #1 also indicated all education was typically completed with residents and families before discharge. An interview with Nurse #1 on 5/7/25 at 2:21 PM indicated the discharge for Resident #229 was rushed due to her wanting to go home and could not recall what education had been given to Resident #229 and her RP. He did not recall if Resident #229 had an IV when he discharged her on 12/20/24. Nurse #1 stated he later found out that the Director of Nursing (DON) went to Resident #229's home after her discharge to remove the midline catheter that was left in place. An interview with the Therapy Director on 5/7/25 at 11:45 AM revealed he worked with Resident #229 after her admission to the facility and she experienced an acute decline which ended her rehabilitation stay and she wanted to return home. He stated he worked with the Discharge Planner on the needed durable medical equipment she needed to be successful at home. The Therapy Director explained all resident discharges were discussed at the interdisciplinary team (IDT) meetings each week. An interview with the Discharge Planner occurred on 5/7/25 at 3:00 PM. She started discussing discharge planning at the care plan meeting with each resident. The Discharge Planner stated when therapy is coming to an end, she discusses what type of equipment is needed for discharge or any other resources required after the resident's facility stay. She stated IDT meetings were held twice a week and upcoming discharge needs from therapy, nursing, and discharge planning were discussed then. An interview conducted with the Director of Nursing (DON) on 5/7/25 at 3:12 PM revealed Resident #229 had a midline catheter while at the facility. The DON stated nursing staff alerted her that Resident #229 was discharged home with the midline catheter in her arm. She could not recall which staff member informed her. The DON stated she went to Resident #229's home and removed the midline catheter later that day on 12/20/24. She stated the midline catheter should have been removed during an education session with Resident #229 and her RP before she discharged home because she no longer required the IV fluids for hyponatremia. An interview with the Medical Director on 5/7/25 10:35 AM revealed she did not recall Resident #229's discharge but stated if the midline catheter was in place, it should have been removed before she left the facility and was an oversight by nursing staff in this instance. An interview with the Administrator was conducted on 5/7/25 at 3:36 PM. He stated the midline catheter in Resident #229's arm should have been removed by nursing staff prior to discharge.