

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Huntersville Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160</p> <p>Based on record review and staff interviews the facility failed to complete a Preadmission Screening and Resident Review (PASRR) level II for a resident with a level II PASRR that expired prior to admission to the facility. This deficient practice occurred for 1 of 2 residents reviewed for PASRR (Resident #43).</p> <p>The findings included:</p> <p>Resident #43 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder.</p> <p>Review of the PASRR level II dated [DATE] revealed it expired on [DATE] prior to Resident #43's admission to the facility [DATE] and a level II PASRR had not been obtained since admission.</p> <p>An interview conducted with the Assistant Discharge Planner [DATE] at 11:24 AM revealed she had been working at the facility for approximately four months. She indicated when a resident was admitted to the facility the PASRR was completed by the hospital prior to admission. The Assistant Discharge Planner stated she used the Medicaid Uniform Screening Tool (MUST) to access the completed PASSR and then entered it into the resident's electronic medical record (EMR). The Assistant Discharge Planner revealed she was unaware Resident #43 had a level II PASRR that expired, she thought it was a PASRR level I, and did not obtain a new PASRR level II for Resident #43.</p> <p>An interview with the Discharge Planner on [DATE] at 10:45 AM revealed she and the Assistant Discharge Planner were responsible for monitoring and completing all level II PASRRs. She stated the Assistant Discharge Planner reviewed Resident #43's PASRR when she was admitted but was unaware the PASRR was a level II that had expired. The Discharge Planner indicated a level II PASRR should have been obtained for Resident #43 but was overlooked.</p> <p>During an interview with the Administrator on [DATE] at 5:35 PM he revealed the Discharge Planner and Assistant Discharge Planner were responsible for monitoring and ensuring all level II PASRRs were obtained. He stated if a resident was admitted with a PASRR level II that was expired then a new level II PASRR should be obtained.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160</p> <p>Based on record review, resident and staff interviews, the facility failed to provide a bagged meal or snack for 1 of 1 resident reviewed for dialysis (Resident #83).</p> <p>The findings included:</p> <p>Resident #83 was admitted to the facility on [DATE] with diagnoses that included stage 5 chronic kidney disease.</p> <p>Resident #83's admission assessment dated [DATE] indicated she was cognitively intact and oriented to person, place, time and situation.</p> <p>The admission Minimum Data Set (MDS) was in progress and no information was available.</p> <p>A physician's order dated 5/01/25 revealed Resident #83's dialysis treatments were Mondays, Wednesdays, and Fridays at 12:25 PM.</p> <p>An interview conducted with Resident #83 on 5/06/25 at 12:30 PM revealed she was admitted to the facility from the hospital on 5/01/25 for short term rehabilitation. She stated during her hospital stay she started dialysis treatments and was continuing treatments at an outpatient dialysis center on Mondays, Wednesdays and Fridays. Resident #83 revealed the facility transported her to the dialysis center on 5/02/25 and 5/05/25, and she left the facility at 11:15 AM and returned around 5:00 PM. She indicated she had breakfast at 8:00 AM before she left for dialysis but was starving when she returned to the facility. Resident #83 revealed a bagged lunch was not provided and she was unsure if that was something the facility offered but it would be nice to have on the days she went to dialysis.</p> <p>During an interview with the Dietary Manager on 5/06/25 at 4:56 PM she indicated bagged lunches were prepared and kept in the kitchen for residents that went to dialysis. She stated nursing staff were responsible for getting a bagged lunch from the kitchen to send with the resident to dialysis. The Dietary Manager revealed she was unaware a bagged lunch was not sent with Resident #83 to dialysis and was unsure as to why because a bagged lunch was prepared and available in the kitchen on 5/02/25 and 5/05/25.</p> <p>An interview conducted with Nurse Aide #1 (NA) on 5/07/25 at 9:00 AM revealed she was assigned to Resident #83 on 5/02/25 and 5/05/25. NA #1 stated when one of her assigned residents was going to dialysis, she was responsible for getting a bagged lunch from the kitchen to send with the resident. NA #1 indicated on 5/02/25 and 5/05/25 Resident #83 went to dialysis without lunch because she forgot to get her bagged lunch from the kitchen.</p> <p>An interview conducted with the Medical Director on 5/07/25 at 9:50 AM indicated Resident #83 not having lunch when she went for dialysis was not ideal, however she would not have any adverse outcomes. The Medical Director stated a bagged lunch should be provided and sent with Resident #83 on the days she went for dialysis treatment.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted with the Administrator on 5/06/25 at 5:45 PM indicated bagged lunches were prepared and available for residents on the days they went to dialysis and should be sent with the resident.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>40476</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, record review, and staff interviews, the facility failed to follow their Hand Hygiene policy when the Treatment Nurse did not perform hand hygiene before each donning of clean gloves while providing wound care to Resident #53. This deficient practice occurred for 1 of 4 staff members observed for infection control practices (Treatment Nurse).</p> <p>The findings included:</p> <p>Review of the facility's policy and procedure entitled Hand Hygiene read in part:</p> <p>Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:</p> <ul style="list-style-type: none"> - When coming on duty. - Before and after assisting a patient with personal care (e.g., oral care, bathing). - Before and after changing a dressing. - After any contact with potentially contaminated materials (used wound/treatment dressings). <p>A wound observation was made on 05/07/25 at 9:54 AM on Resident #53 with the Treatment Nurse. The Treatment Nurse was observed cleaning the bedside table with disinfectant wipe and placed her wound supplies on the table after it dried. The Treatment Nurse washed her hands in Resident #53's bathroom using soap and water, then donned a clean gown and clean gloves. She then removed the old dressing from the residents left posterior thigh and placed the soiled dressing into the trash can. The Treatment Nurse went into Resident #53's bathroom and washed her hands. She then, donned a clean pair of gloves and proceeded to clean the area around the wound with a wound care solution. She applied skin prep to the outer portion of the wound, then doffed her gloves without sanitizing her hands, donned clean gloves and packed the wound with a wet to dry dressing packing the gauze into the residents wound with her finger and a Q-tip. She then doffed her gloves and without sanitizing her hands, donned clean gloves and moved to Resident #53's second wound located on the left thigh. She cleaned the wound with skin prep and applied Calcium Alginate to the area with a dry dressing. The Treatment Nurse then doffed her gloves and without sanitizing her hands, donned clean gloves to assist Resident #53 adjust her pants back up in the correct position and placed a wedge under the residents left side. She then doffed her gown, washed her hands with soap and water, collected her supplies and trash and wiped down the table and left the resident's room.</p> <p>An interview conducted on 05/07/25 at 10:20 AM with the Treatment Nurse revealed she was not aware that she had not sanitized her hands each time she had doffed her gloves. She stated she had to change gloves so much during the wound care that she must have forgotten to always sanitize her hands when she removed her gloves. The Treatment Nurse further stated she knew she was supposed to always sanitize her hands when she removed her gloves each time and before putting on clean gloves and typically had hand sanitizer with her in the room however she was just nervous.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted on 05/07/25 at 10:38 AM with the Infection Preventionist (IP) revealed she was not aware of the errors made by the Treatment Nurse during wound care. She stated her expectation was that she would sanitize her hands every time that she removed her gloves and before putting on clean gloves during wound care. The IP further stated staff received education on infection control annually and multiple times during the year.</p> <p>An interview on 05/07/25 at 1:03 PM with the Director of Nursing (DON) revealed she was aware of the Treatment Nurse's errors during wound care and said she had been provided with additional education regarding doffing and donning and sanitizing in between glove changes. The DON stated it was her expectation that the Treatment Nurse follow infection control best practices to avoid introducing microorganisms into the wounds. She further stated there was a lot of donning and doffing and she felt the Treatment Nurse had just become nervous during the observation.</p> <p>An interview on 05/07/25 at 3:35 PM with the Administrator revealed he would expect the Treatment Nurse to follow the Hand Hygiene policy for wound care.</p>		