DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		PLETED	
	345541		B. WING			C 03/10/2015		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
OLDE KN	OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG				13825 HUNTON LANE			
				ŀ	HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309 SS=D	HIGHEST WELL BEII Each resident must re	NG eceive and the facility must	F	309				
	or maintain the higher mental, and psychoso	y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment						
	by: Based on staff interv facility failed to condu at the time of a fall to transfer the resident a	is not met as evidenced iews and record review, the act a complete assessment determine if it was safe to and the resident had a left for 1 of 3 residents reviewed						
	fall with fracture, anxi others. The Minimum 12/04/14 specified the impaired cognition, re with activities of daily							
	a nurse's entry dated that she responded to for help around 9:15 F Resident #1 off the flo that it appeared Resid wheelchair and that h	1's medical record revealed 02/18/15 made by Nurse #1 o the Nurse Supervisor's call PM to assist with moving oor. Nurse #1 documented dent #1 fell out of her er left leg was twisted at the og was turned outward.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 03/16/2015

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.

			0/02 141 17				0.0938-039	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
			A. BUILDII	NG				
		345541	B. WING					
NAME OF PF	OVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
				13	3825 HUNTON LANE			
OLDE KNO	DX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		н	UNTERSVILLE, NC 28078			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 309	Continued From page	e 1	F3	309				
	Nurse #1's entry spec							
		move Resident #1 using a						
	•	sfer Resident #1 back to						
	bed. The entry adde							
	transferred back to be							
	were removed and a							
	was observed. Nurse Nurse Supervisor left							
	on-call physician and							
		he Emergency Department.						
	Further review of the							
	reveal any additional							
	Residnet #1's fall on	02/18/15.						
	On 03/10/15 at 10:25	AM the Nurse Supervisor						
		reported she was working						
		and heard Resident #1						
	yelling from inside the							
	-	sident #1 sounded like she						
		Nurse Supervisor opened						
		nd found the resident in the elp. She exaplined that she						
		r help and Nurse #1 entered						
	2	Supervisor reported that						
		ne floor and appeared to						
	have fallen out of the	wheelchair and that the						
		wisted and her leg left leg						
		The Nurse Supervisor						
		#1 was unable to report what						
	happended and was Supervisor stated that							
	-	ed a "quick" assessment, did						
		it's range of motion and						
		fe to move the resident using						
		the floor to the bed for so						
	-	m a complete assessment.						
	The Nurse Superviso nurse aide #1 and he	or explained that Nurse #1,						

Facility ID: 990623

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING	TRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
A. BUILDING		CONT LETED
		С
345541 B. WING		03/10/2015
	ADDRESS, CITY, STATE, ZIP CODE	
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	UNTON LANE RSVILLE, NC 28078	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 309 Continued From page 2 F 309 back to bed using the mechaincal lift. The Nurse Supervisor added that she removed Resident #1's clothing and observed a large raised area on the left thigh and the resident began complaining of pain. The Nurse Supervisor stated she then notified the on-call physician and obtained orders to send the resident to the Emergency Department. The Nurse Supervisor confirmed that she did not document the fall or the assessment in the medical record because she forgot. On 03/10/15 at 11:45 AM the Director of Nursing (DON) was interviewed and reported that she had investigated Resident #1's fall on 02/18/15. The DON stated that she expected the nurses to conduct an immediate head to toe assessment when a resident fell that would include range of motion, vital signs and evidence of an injury before moving a resident. On 03/10/15 at 2:10 PM the Physician was interviewed and stated that when a fall occurred he expected the nurse to perform a complete assessment to determine if it was safe to move a resident. The Physician added that a complete assessment would include range of motion. F 323 F 323 HAZARDS/SUPERVISION/DEVICES F 323 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. F 323		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDIN	IG			C
		345541	B. WING			03/	10/2015
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG					825 HUNTON LANE UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	2.3	F 3	23			
	by: Based on staff intervi facility failed to impler resident at risk for fall	is not met as evidenced lews and record review the ment fall precautions for a s that fell and sustained a of 3 sampled residents					
	The findings included	:					
	fall with fracture, anxie others. Resident #1's 11/11/14 specified the related to history of fa safety awareness due	itted to the facility on ses that included history of a ety, Alzheimer's disease and fall care plan updated on resident was at risk for falls Ils with a fracture and poor to dementia. The care intions to prevent a major					
	bed or wheelchair una	for attempts to get out of assisted arms in place to alert staff of					
	specified the resident cognition, required ex	et (MDS) dated 12/04/14 had severely impaired tensive assistance with g (ADL) including transfers, ce the last review.					
	A fall risk assessment the resident was a hig	ated 01/24/15 specified the risk for falls.					
	a nurse's entry dated that she responded to	1's medical record revealed 02/18/15 made by Nurse #1 o the Nurse Supervisor's call PM that Resident #1 fell.					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/16/2015 1 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345541	B. WING _			C 03/10/2015			
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CO	DE			
		/ILLAGES OF MECKLENBURG		1382	5 HUNTON LANE				
	OX COMMONS AT THE V	ALLAGES OF MECKLENBORG		HUN	ITERSVILLE, NC 28078				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD B		(X5) COMPLETION DATE	
F 323	 #1 fell out of her whe was twisted at the kn turned outward. The Resident #1's person at the time of the fall. Further review of Res revealed that on 02/1 the Emergency Depa left distal femur fractu- the facility. On 03/10/15 at 10:10 interviewed and repo- care for Resident #1 that she did not routin was aware that the re- care, was at risk for fi- alarm at all times. NA- placed Resident #1's resident's wheelchain The NA could not rec- alarm was functioning 02/18/15 she attempt but the resident was that that she left the resid calm down and proce NA stated that she not leaving for break but Resident #1 was still assumed the other nu- her residents while sh 	d that it appeared Resident elchair and that her left leg ee and the lower leg was entry specified that al alarm was not sounding sident #1's medical record 8/15 she was transported to rtment and diagnosed with a ure as a result of the fall in 9 AM nurse aide (NA) #1 was rted she was assigned to on 02/18/15. She explained hely care for the resident but esident at times resisted alls and required a personal w#1 reported that she had personal alarm on the prior to the evening meal. all if she checked that the g. The NA explained that on red to put Resident #1 to bed combative. NA #1 added ent alone in her room to beded to go on break. The otified her peers that she was did not report to them that up. The NA added that she urse aides knew to monitor ne was on break. The NA she returned from break she	F 3	23					
	was interviewed and	AM the Nurse Supervisor reported she was working and heard Resident #1			/ ID: 990623			ant Page 5 of	

		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 03/16/201 ORM APPROVE NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345541		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		B. WING			C 03/10/2015				
	ROVIDER OR SUPPLIER	/ILLAGES OF MECKLENBURG		13825	T ADDRESS, CITY, STATE, ZIP CODE HUNTON LANE FERSVILLE, NC 28078	 ≣			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 323 F 514 SS=D	yelling from inside the Supervsior stated Re was in distress. The Resident #1's door an floor and called for he added that Resident is happended and was Supervisor reported t alarm was not sound did not investigate to was not sounding bea injured resident. The that Resident #1's do door to the resident's closed because the re and required frequen On 03/10/15 at 1:15 I interviewed and repo Resident #1 had bea was still up when the Nurse #1 added that aides to report incide combative and/or res 483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practic accurately document systematically organi The clinical record m information to identify	e room. The Nurse sident #1 sounded like she Nurse Supervisor opened hd found the resident in the elp. The Nurse Supervisor #1 was unable to report what crying. The Nurse hat Resident #1's personal ing. She explained that she determine why the alarm cause her priority was the * Nurse Supervisor added or was closed and that the room should not have been esident was at risk for falls t monitoring. PM Nurse #1 was rted that NA #1 did not report n combative with care and nurse aide left for break. she would expect nurse nts of residents being isting care. ETE/ACCURATE/ACCESSIB thain clinical records on each ces that are complete; ed; readily accessible; and zed. ust contain sufficient r the resident; a record of the nts; the plan of care and		514					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		NG _		COMPLETED		
		345541	B. WING				C 10/2015	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·		
OLDE KN	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 514		e 6 ing conducted by the State;	F	514				
	by: Based on staff intervi facility nurse that disc floor failed to docume floor and failed to doc	is not met as evidenced iews and record review, the covered a resident in the ent finding the resident in the cument that the resident was er the fall occurred for 1 of 3 or falls (Resident #1).						
	falls, anxiety, Alzheim The Minimum Data Se							
	that Nurse #1 made a she responded to the help to get Resident #	1's medical record revealed an entry dated 02/18/15 that Nurse Supervisor's call for #1 out of the floor. Nurse #1 opeared Resident #1 fell out						
		medical record did not documentation surrounding 02/18/15.						
	was interviewed and r #1 fell, she was respo the medical record the surrounding the fall in	AM the Nurse Supervisor reported that when Resident onsible for documenting in e circumstrnaces ncluding vital information her assessment of Resident						

Facility ID: 990623

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/16/2015 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUC A. BUILDING			(X3) DATE COMF	SURVEY PLETED
		345541	B. WING				C 1 0/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 514	 #1. The Nurse Super was working the night Resident #1 yelling from Nurse Supervsior add staff member to respon Resident #1's door ar floor. The Nurse Sup did not document the because she forgot. performed a "quick" at but also failed to documedical record. On 03/10/15 at 11:45 (DON) was interviewed expected nurses to do record. The DON station 	visor explained that she t of 02/18/15 and heard om inside the room. The led that she was the first ond to the yell, opened nd found the resident in the ervisor confirmed that she fall in the medical record She also stated that she issessment of the resident ument the assessment in the AM the Director of Nursing ed and reported that she boument falls in the medical ted that the Nurse ve documented Resident al record and her	F	514			

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