	-	ND HUMAN SERVICES				FOR	M APPROVED
		MEDICAID SERVICES					<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		E SURVEY PLETED
		345541	B. WING				C
	ROVIDER OR SUPPLIER	545541		5	REET ADDRESS, CITY, STATE, ZIP CODE	11	/08/2018
	ROVIDER OR SOFFLIER				1825 HUNTON LANE		
OLDE KN	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG			UNTERSVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000		3	FO	000			
		ation (Event ID #KRGX11) /4/18. Past-noncompliance					
	CFR 483.12 (a) (1) F CFR 483.12b at tag F						
	The tags F 600 and F Substandard Quality						
	-	began 10/16/18. The facility ance effective 10/25/18.					
	An extended survey	was completed on 11/8/18.					
F 600 SS=J		•	F 6	00			12/4/18
	Exploitation	m Abuse, Neglect, and					
	neglect, misappropria and exploitation as de includes but is not lin corporal punishment, any physical or chem	involuntary seclusion and ical restraint not required to					
	treat the resident's m §483.12(a) The facilit						
	§483.12(a)(1) Not us physical abuse, corport involuntary seclusion	e verbal, mental, sexual, or oral punishment, or					
	Based on record rev was determined that	iew and staff interviews it the facility failed to protect a free of physical abuse for 1			Past noncompliance: no plan of correction required.		
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
	ically Signed						12/04/2018
	J - U						

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.

STATE MENT OF DEFICIENCIES AND PLAN OF CORRECTION (M) DEVIDENCE (UNK) DESTIFICATION NUMBER 345541 (M) UNIT THE CONSTRUCTION A BUILING DEVIDENCE OR SUPPLIER 345541 (M) UNIT THE CONSTRUCTION A BUILING DUE KNOX COMMONS AT THE VILLAGES OF MECKLENEURG (M) UNIT THE CONSTRUCTION LAKE 1000 FROMUERS OR SUPPLIER DLDE KNOX COMMONS AT THE VILLAGES OF MECKLENEURG (M) UNIT THE VILLAGES OF MECKLENEURG (M) UNIT THE VILLAGES OF MECKLENEURG (M) UNIT PRESULT SUMMARY STATEMENT OF DEFICIENCIES MOD (M) UNIT THE VILLAGES OF MECKLENEURG (M) UNIT THE VILLE, NO 28078 (M) UNIT THE VILLE, NO 28078 (P) III DEVIDENCY OF LIS CENTRIFTING INFORMATION MOD (M) UNIT THE VILLAGES OF MECKLENEURG (M) UNIT THE VILLE, NO 28078 (M) UNIT THE VILLE, NO 28078 (P) III DEVIDENCY OF LIS CENTRIFTING INFORMATION MOD (M) UNIT THE VILLAGES OF MECKLENEURG (M) THE VILLE, NO 28078 (M) UNIT THE VILLE, NO 28078 (P) III DEVIDENCY OF LIS CENTRIFTING INFORMATION MOD (M) UNIT THE VILLAGES OF MECKLENEURG (M) THE VILLE, NO 28078 (M) UNIT THE VILLE, NO 28078 (F) GOD Continued From page 1 of 1 (Resident #1) resident was assessed at the facility and found to have no physical injuries from being salpaped by a staff member. Findings including muscle weakness and anxiety disorders. Review of his 14 DAY Minimum Data Set (MD) Sassessment dated 362/19 revealed the resident's speech was unclear. He scored a 22 roo mite bind for lobeing with 2 persons assist. The resident was also dependent on staff for eating, dressing, batting and personal hygiene. He had no limits with range of molion per		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
345541 B. WING 11/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE 2/P CODE OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG INVECTION OF SUPPLIER STREET ADDRESS, CITY, STATE 2/P CODE OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG INVECTION OF SUPPLIER STREET ADDRESS, CITY, STATE 2/P CODE OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG INVECTION OF SUPPLIER COMPLET COMPLET OUDER NOX COMMONS AT THE VILLAGES OF MECKLENBURG INVECTION OF SUPPLIER COMPLET COMPLET OUDER NOX COMMONS AT THE VILLAGES OF MECKLENBURG INVECTION OF SUPPLIER COMPLET OUDER NOX COMMONS AT THE VILLAGES OF MECKLENBURG INVECTION OF SUPPLIER COMPLET CONTINUE OF DECISION OF NUMBER OF NUME COMPLET COMPLET OTH (Resident #1) residents reviewed for abuse. From being slapped by a nursing assistant during the provision of Care. Resident #1 was assessed at the facility and vectory (MOCS) assessment dated M20/18 revealed the resident was also dependent on staff for esting. dressing, bathing and personal hygiene. He had noor cognition and menoy. No beh	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /			COMPLETED	
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG 13235 HUNTON LANE HUNTERSVILLE, KO 28078 OWID PHETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDULTORY OR LISC (DENTFYING INFORMATION) ID PRECIX (EACH CORRECTS ACTION SHOULD BE CROSSREEPERENCED TO THE APPROPRIATE DEFICIENCY) DOINT (EACH CORRECTS ACTION SHOULD BE CROSSREEPERENCED TO THE ASSESS ACTION TO ACTION THE ASSESS ACTION TO ACTION THE ASSESS ACTION TO ACTION THE ASSESS ACTION THE MEDICAL CORRECTS ACTION THE ASSESS ACTION THE ASSESS ACTION THE ASSESS ACTION TO ACTION THE ASSESS ACTION THE ASSESS ACTION THE APPROPRIATE ACTION THE ASSESS ACTION			345541	B. WING				-
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG HUNTERSVILLE, NC 28078 (A)IJU TWO ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST ERECEDED BY FULL RECOLLITORY OR LSC IDENTIFYING INFORMATION) ID PREFIX FAC ID ROWDERS PLAN OF CORRECTION COULD BE (EACH DEFICIENCY WIST ERECEDED BY FULL RECOLLITORY OR LSC IDENTIFYING INFORMATION) ID PREFIX FAC ID ROWDERS PLAN OF CORRECTION COURSE (EACH DEFICIENCY WIST ERECEDED BY FULL RECOLLITORY OR LSC IDENTIFYING INFORMATION) ID PREFIX FAC ID ROWDERS PLAN OF CORRECTION COURSE (EACH DEFICIENCY) Comment and DEFICIENCY) F 600 Continued From page 1 of 1 (Resident #1) residents reviewed for abuse. Resident #1, a cognitively impaired resident was slapped by a nursing assistant during the provision of care. Resident #1 was admitted to the facility on B/I5/18 with diagnosis including muscle weakness and anxiety disorders. Review of his 14 Day Minimum Data Set (MDS) assessment dated 8/29/16 revealed the residents' speech was unclear. He scored a zero on the birl Interview of mental status indicating that he had poor cognition and memory. No behaviors were documented during the assessment. Review of the medical record revealed a general net dated 10/16/18 6:49 AM which stated, "Res (Resident) was very combative while doing care, he punched CNA (certified nursing assistant) in the jaw and kicked her, was combative during tee entire care." Review of the medical record revealed a general net dated 10/16/18 10:37 PM written by Nurse #1 which stated "Resident combative during tee. This nurse called into roma assisted CNAs with changing Diref. CNAs stated that resident was	NAME OF PI	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
Principul Tag IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG ICACH CORRECTIVE ACTION SHOULD BE CROSS-METERENCED TO THE APPROPRIATE COMPLETION INTERPRECEDENCY F 600 Continued From page 1 of 1 (Resident #1) residents reviewed for abuse. Resident #1, a continued new physical injuries from being slapped by a nursing assistant during the provision of care. Resident #1 was assessed at the facility and found to have no physical injuries from being slapped by the staff member. Findings including muscle weakness and anxiety disorders. Review of his 14 Day Minimum Data Ste (MDS) assessment dated 8/29/18 revealed the residents' speech was unclear. He scored a zero on the brief interview of mental status indicating that he had poor cognition and memory. No behaviors were documented during the assessment period. He required extensive, two-person assistance for bed mobility and was tablaly dependent for toilering with 2 persons assist. The resident was also dependent on staff for eating, dressing, bathing and personal hygiene. He had no limits with range of motion per the assessment. Review of the medical record revealed a general note dated 10/18/18 643 AM which stated, "Res (Resident) was very combative while doing care. The punched CNA (certified nursing assistant) in the jaw and kicked her, was combative during the entire care." Review of the medical record revealed a general note dated 10/16/18 643 AM writen by Nurse #1 which stated "Resident combative during care. This nurse called into room assisted CNAs with changing brief. CNAs stated that resident was	OLDE KNO	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG					
of 1 (Resident #1) residents reviewed for abuse. Resident #1, a cognitively impaired resident was slapped by a nursing assistent during the provision of care. Resident #1 was assessed at the facility and found to have no physical injuries from being slapped by the staff member. Findings included: Resident #1 was admitted to the facility on 8/15/18 with diagnosis including muscle weakness and anxiety disorders. Review of his 14 Day Minimum Data Set (MDS) assessment dated 8/29/18 revealed the residents' speech was unclear. He scored a zero on the brief interview of mental status indicating that he had poor cognition and memory. No behaviors were documented during the assessment period. He required extensive, two-person assistance for bed mobility and was totally dependent for toileting with 2 persons assist. The resident was also dependent on staff for eating, dressing, bathing and personal hygiene. He had no limits with range of motion per the assessment. Review of the medical record revealed a general note dated 10/16/18 fi-49 AM which stated. "Res (Resident) was very combative during the entire care." Review of the medical record revealed a general note dated 10/16/18 10:37 PM written by Nurse #1 which stated "Resident combative during care. This nurse called into room assisted CNAs with changing brief. CNAs stated that resident was	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
Review of a Daily Skilled Nursing Evaluation	F 600	of 1 (Resident #1) res Resident #1, a cognit slapped by a nursing provision of care. Re the facility and found from being slapped by Findings included: Resident #1 was adm 8/15/18 with diagnosi weakness and anxiet 14 Day Minimum Data dated 8/29/18 reveale unclear. He scored a of mental status indic cognition and memor documented during the required extensive, twe mobility and was total with 2 persons assist dependent on staff for and personal hygiene range of motion per the Review of the medical note dated 10/16/18 of (Resident) was very of he punched CNA (cent the jaw and kicked he entire care." Review of the medical note dated 10/16/18 of the jaw and kicked he entire care."	sidents reviewed for abuse. ively impaired resident was assistant during the sident #1 was assessed at to have no physical injuries y the staff member. itted to the facility on s including muscle y disorders. Review of his a Set (MDS) assessment ed the residents' speech was a Set (MDS) assessment ed the residents' speech was a zero on the brief interview ating that he had poor y. No behaviors were he assessment period. He vo-person assistance for bed lly dependent for toileting . The resident was also r eating, dressing, bathing e. He had no limits with he assessment. I record revealed a general 5:49 AM which stated, "Res combative while doing care, rtified nursing assistant) in er, was combative during the I record revealed a general 10:37 PM written by Nurse ident combative during care. room assisted CNAs with a stated that resident was	F	600			

						0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SI COMPLE	
			/		с	
		345541	B. WING		11/08	8/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	OX COMMONS AT THE	/ILLAGES OF MECKLENBURG		3825 HUNTON LANE HUNTERSVILLE, 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 2	F 600			
	dated 10/16/18 (untir	ned) stated, alert not				
		blem, unclear speech,				
		ands. Behavior hitting er, behaviors unchanged.				
	others, grabbing othe	n, benaviors unchanged.				
	Review of the Facility	Investigation Time Line of				
		ved Resident #1 being				
		ssistant (NA) #1 on 10/16/18 le Administrator 10/22/18				
		g: At approximately 7:15PM-				
	NA #1 went to superv	visor and floor nurse and				
	informed them that re	•				
	combative by way of	hitting, kicking, and ding personal care (changing				
		Floor nurse then went into				
		ith personal care until task				
		ervisor requested staff				
		sident being combative from the room. Statements				
	were turned into the					
	•••	PM while CNAs were				
		ving the statement, it was				
		ement from NA #1, she ent became very violent and				
		NA (NA#2) and herself in the				
	chest and slapped N					
		r off guard "I slapped him				
		h to leave a mark". After t in, she left the facility.				
		gation-employee statement				
	-	e signed 10/16/18 7:00PM ht in Room # with (NA #1) to				
		on (Resident #1) in room #.				
		to put the brief on he started				
		unching both of us. I tried to				
	hold his hands and fe	ot but was unable to And		1		
		I him because he hit her and				

Facility ID: 990623

If continuation sheet Page 3 of 26

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/18/2018 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345541	B. WING				C / 08/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			13825 HUNTON LANE 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 APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 600	she did." During interview on 17 #2 she stated that NA help (with Resident #7 while we changed him was trying to hold his us. He punched me in us and kicking us. He She was on the side of had already put the pareded help to get the stated she then let go to go get the nurse. N Resident #1 hit NA #1 She slapped him oper left side. He didn't sa trying to fight us. She a reflex. NA #2 stated that NA #1 hit the resi him again. That one wo one. NA #2 reported another NA (NA #3), w Assistant Director of N came and talked to he and told her to slip a r could not talk about it received abuse training incident. Review of an Investig date signed 10/16/18 stated, "At 7 PM after and dressed him for b allow me to put his bri from another CNA (Ce	her to go get the nurse and 1/4/18 at 3:20 PM with NA #1 needed someone to 1), someone to hold him b. She was changing him, I hands, so he wouldn't hit in my breast. He was hitting e slapped her in the face. closest to the window. She ad underneath him, but she e diaper on him. NA #2 of his hand and told NA #1 NA #1 went to get the nurse. before the nurse came in. in handed on the face on the y anything, he was still thit him hard, it was more of d they got the brief on and dent twice. She slapped was not as bad as the first that she went out and told who told her to tell the Nurses (ADON). The ADON er (NA#2) after the incident note under the door if she . NA #2 stated that she ng after the date of the ation-Employee Statement 9:00PM written by NA #1 I had cleaned the resident ted. The resident wouldn't ief on so I went to get help ertified Nursing Assistant)	F	600			
	from another CNA (Ce NA #2 and when we the	ertified Nursing Assistant)					

Facility ID: 990623

If continuation sheet Page 4 of 26

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	1 ° <i>î</i>			MPLETED
						С
		345541	B. WING		1	1/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
OLDE KN	OX COMMONS AT THE	VILLAGES OF MECKLENBURG		13825 HUNTON LANE		
	1			HUNTERSVILLE, 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 CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 4	F 60	0		
1 000		c - i chest, and slapped me in	F 00	6		
	the face, because it of					
		ot hard enough to leave a				
		ely contacted the nurse and				
	informed her of what	happened."				
		ing assistant #1 (NA) at				
		revealed that it was a				
	-	s not told that the resident medication. The resident				
		ent and she entered the				
		b. She stated that she got				
	-	er because the resident was				
		e no English, he weighed				
	200 pounds and was	a 2 person assist. The NA				
	-	dent was agitated, and they				
	-	hen he started fighting and				
		the other NA in the chest.				
		ped providing care and went				
		or who told her to get her me into the room and was				
		nd the other NA were holding				
		to clean him up. "I turned my				
		me, I mean slapped the fire				
	out of me. I slapped	his hand on instinct. I told				
		I hit him, and I apologized."				
	-	probably did slap his face, but				
		s a pop like don't hit me.				
	-	e only hit Resident #1 once. Jid not hurt him. He had no				
		did not intend to hurt him.				
		esident was calm when the				
		him and she told them to go				
		up. He snapped again so				
		NAs) to leave him alone. NA				
		d worked with the resident				
		as calm when he was on				
	medication.					

Facility ID: 990623

If continuation sheet Page 5 of 26

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	√G		COMP	PLETED
		245544	B. WING				С
	ROVIDER OR SUPPLIER	345541	B. WING _		TREET ADDRESS, CITY, STATE, ZIP CODE	11/	08/2018
					3825 HUNTON LANE		
	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		Н	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	written by Nurse #1 d 9:00PM stated, "I was #1) told me that resid and hitting them and " went into the room. F the bed on his side. I told him to let them cl together at first but di Did not try to hit or kid Telephone interview w 11/4/18 revealed that because Resident #1 they needed help. Sh hands and talked to h The resident let them said she wanted then "At the end of the shift witness statements a NA #1 did leave early she was upset. This resident was combati The resident was obs laid back in his wheel ground. During interview with Clinical Nurse Consu reported completing a	pation-employee statement lated and signed 10/16/18 at is called into the room. (NA ent was being combative they couldn't change him. I Res. (Resident) was laying in I held resident's hands and hange him. Res. Held legs d let them change his brief. ck." with Nurse #1 at 2:23 PM on the NA #1 came and got her was being combative, and he stated that she held his him and he was calm for her. I change him. Supervisor in to do a witness statement. ft I was going over the nd saw what was written. If that day. She looked like was not the first time the ve when being changed." Served at 4:39 PM on 11/4/18 Ichair with his feet off the the Administrator and Itant on 11/4/18; they a plan of correction. the the following corrective pleted as of 10/25/18:	F	600			
	and hitting them and went into the room. If the bed on his side. If told him to let them of together at first but di Did not try to hit or kid Telephone interview v 11/4/18 revealed that because Resident #1 they needed help. Sh hands and talked to h The resident let them said she wanted then "At the end of the shift witness statements a NA #1 did leave early she was upset. This resident was combati The resident was obs laid back in his wheel ground. During interview with Clinical Nurse Consu reported completing a The Administrator sta action had been com	they couldn't change him. I Res. (Resident) was laying in I held resident's hands and hange him. Res. Held legs id let them change his brief. ck." with Nurse #1 at 2:23 PM on the NA #1 came and got her was being combative, and he stated that she held his him and he was calm for her. change him. Supervisor in to do a witness statement. ft I was going over the nd saw what was written. that day. She looked like was not the first time the ve when being changed." Served at 4:39 PM on 11/4/18 Ichair with his feet off the the Administrator and Itant on 11/4/18; they a plan of correction. thed the following corrective pleted as of 10/25/18:					

If continuation sheet Page 6 of 26

		D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345541	B. WING				C 08/2018
NAME OF PI	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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	FREEDOM FROM AE EXPLOITATION Resident has the righ neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemi- treat the resident's me Address How Correct Accomplished For Th Have Been Affected E Immediately after lear following interventions Administrator and Dir 1. The employee who resident was suspend and then terminated of completed. 2. On October 17, 20 thorough skin assess resident and there we bruising, discoloration The resident did not a or emotional distress he mentally appeared did not show any non distress such as cryin care givers. 3. The Assistant Dire Development conduct	BUSE, NEGLECT, AND to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. ive Action (S) Will Be ose Residents Found To By The Deficient Practice: ming of the incident the swere put into place by the ector of Nursing: o admitted to abusing the led pending the investigation once the investigation was 118 the ADON completed a ment on the ere no noted areas of a, scratches and or injury. appear to have any mental as a result of the incident as 1 to be at his baseline and verbal signs of mental g out or being scared of ctor of Nursing/Staff ted In-services with all ginning on 10/17/2018 and 2018 on the following;	F	600			

If continuation sheet Page 7 of 26

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345541	B. WING				C 108/2018
NAME OF P	ROVIDER OR SUPPLIER		•		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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	 d. How to react to coresidents; how to providents; how to providents; how to providents to residents; how to providents; how to providents; how to providents; how to provide care to his history of combain and provide care to his history of combained for the practice; Immediately after least following interventions; were put into place by Director of Nursing for potential to be affected practice; 1. Following the incident and the practice; 1. Following the incident reports for the determine if there were unknown origin as a stresident abuse. The review of the incident reports for the determine if there were unknown origin for 2. On October 25, 20 resident were intervied director concerning reviolation of any resident reports for the discussion of resident resident rights took place to president reports for the resident rights took place to president rights took place to president president rights took place to president president reports for the resident rights took place to president rights took place to president president rights took place to president presid	 mbative behavior from vide care and services to to prevent abuse to the care giver; 2018 an intervention of two NA and one nurse) are to ogether for this resident due tative behavior. tive Action Will Be ose Residents Having ted By The Same Deficient rring of the incident the s and corrective actions y the Administrator and r residents having the ed by the alleged deficient ent on October 16, 2018, the ector of Nursing reviewed all e past three (3) months to re any bruises or injuries of sign of a systemic issue with dent reports completed on eveal any injuries or bruises any resident. 018 alert and oriented ewed by the facility activity esident abuse as well as 	F	600			

Facility ID: 990623

If continuation sheet Page 8 of 26

DEPARTI	MENT OF HEALTH AN	ND HUMAN SERVICES					ED: 12/18/2018 RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				E SURVEY IPLETED
		345541	B. WING _			1'	C 1/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				1382	25 HUNTON LANE		
	DX COMMONS AT THE	VILLAGES OF MECKLENBURG		HUN	NTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	2	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	Continued From page	e 8	F 6	00			
1 000			FO	00			
	resident rights.	ent abuse or violation of					
	3. Between the date	s of 10/17/2018 and					
		lit was completed on all					
		A's and given to the Staff					
	Nurses who in turn re	eviewed for any signs or					
		, impairment of skin or signs					
		origin. There were no injuries					
	of unknown origin de	tected.					
	Addross What Moas	ures Will Be Put Into Place					
		s Made To Ensure That The					
	Deficient Practice Wi						
	1. For any resident v	with combative behaviors,					
		been employed by the					
		an three (3) months and have					
		ility to work with combative					
		ate the behaviors and					
	-	nner and way that protects use will be assigned to these					
	residents. The decisi						
		e on October 17, 2018 by the					
	-	ho then educated the					
	supervisory nurses, (
		this procedure . The CNA's					
		re then educated on this					
	•	17, 2018 by the DON.					
		nd supervisory nurses were					
		ent and instructed to be pservation of CNAs to ensure					
		r and to report immediately					
		behaviors to the Director of					
	Nursing. The decisio						
	÷	on October 17, 2018 by the					
	-	ho then educated the					
	supervisory nurses, (who make the CNA					
		this procedure. The CNA's					
	and Staff Nurses wer	re then educated on this					

Facility ID: 990623

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CENTERS FOR MEDICARE & MEDIC STATEMENT OF DEFICIENCIES (X1) PR	ROVIDER/SUPPLIER/CLIA			OMB NO	D. 0938-0391
· · · · · · · · · · · · · · · · · · ·	ENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G	(X3) DATE COMF	E SURVEY PLETED
	345541	B. WING			C /08/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
OLDE KNOX COMMONS AT THE VILLAGE	ES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
 F 600 Continued From page 9 protocol on October 17, 201. 3. Administrative Staff, follor rounded on the resident care the first week (entering room where care was being provid times the following week to a delivery was being conducted preserved the resident's priv freedom from abuse. These at four (4) per week (includin the 11-7 shift for the next six two (2) per week for the follor to ensure that the deficient preoccur. The Administrative October 17, 2018 by the Administrative Sustained. The Facility Pla Performance To Make Sure Sustained. The Facility Must Ensuring That Correction Is Sustained: 1. The QA Committee, QAP Medical Director have been and commit their support to with achieving and sustainin this alleged citation. The QA notified on 10/18/2018. 2. The resident care unit root presented at weekly QA meet the QAPI Committee for eva if the system is adequate an re-implement a system to er deficient practice does not o 3. Incident Reports will be re through Friday in morning munusual incident to include b 	wing the incident, e units six (6) times as and showers ded) and four (4) ensure that care ed in a way that racy, dignity and rounds will continue ag at least one (1) on t (6) months and then owing six (6) months practice does not Staff were notified ministrator who ans To Monitor It's That Solutions Are t Develop A Plan For Achieved And PI Committee and the apprised of this plan assisting the facility g compliance with PI Committee was unds will be etings and monthly to luation to determine d if not to devise and nsure that the alleged ccur again.	F 60			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/18/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345541	B. WING				08/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KNO	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page injuries of unknown of investigation will be st unknown origin, skin t any other incident or i any occurrence that is reported immediately Department and the N Personnel Registry. 4. The incident repor electronically by the s supervisors are respon report(s) for their unit and are responsible to meeting. In the event absent the responsibi- reports is assigned to DON. 5. All incident reports the QAPI Committee skin tears and injury of investigations of incid determine if any patter may be considered at practices are noted, th begin an immediate in solutions are put into action is achieved and Date of Compliance: To Validation Information Administrator and Dim at 4:14 PM revealed to staff to follow the facil	e 10 rigin. An immediate tarted for all bruises or tears of unknown origin or injury of unknown origin and a suspected abuse will be to the Huntersville Police North Carolina Health Care ts are completed staff nurses and the nurse onsible to print the incident before the morning meeting o bring them to the morning the nursing supervisor is lity of printing the incident the ADON and then to the swill be reviewed monthly at Meeting for any bruises, of unknown origin and lents of unknown origin to erns or practices exist that buse. If any patterns or he QAPI Committee will hvestigation to ensure that place to ensure corrective d sustained. 10-25-2018 A: An interview with the ector of Nursing on 11/8/18 they expected the nursing lity's abuse policy and to		600			
	with abuse. The Admi	administration any concerns inistrator stated the following been completed as of					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/18/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345541	B. WING		11/08/2018
	ROVIDER OR SUPPLIER	/ILLAGES OF MECKLENBURG	138	REET ADDRESS, CITY, STATE, ZIP COL 25 HUNTON LANE NTERSVILLE, 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 600	Quality Assurance Per (QAPI) Committee m All staff were in-servi reporting abuse; any not work until they we trained nurse aides e would be assigned to identified with aggres Body audits were cor residents, residents w abuse and a Resider to discuss any conce residents had Resident care plans w regarding residents w Incident reports for the reviewed to identify a injuries of unknown of Administrative staff m interactions during nu- currently monitoring a ensure staff/residents procedure for reportin was not occurring Staff reviewed orienta contained up-to-date identifying/reporting a The facility continued compliance The facility provided a all staff regarding abu body audits, revised of Resident Council, res- monitoring for correct the time of the survey observed to receive m concerns related to a	erformance Improvement et and developed a plan ced on identifying and prn (as needed) staff could ere re-educated and only mployed at least 3 months work with residents sive behaviors. mpleted on 100% of the vere interviewed regarding it Council meeting was held rns related to abuse that were audited/updated vith aggressive behaviors re prior 3 months were ny concerns related to rigin nonitored resident: staff ursing care and were 4 residents each week to s were aware of the ng abuse, and that abuse ation packets to make sure it information regarding abuse to monitor/audit for ongoing	F 600		

Facility ID: 990623

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/18/2018 M APPROVED D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED	
		345541	B. WING		11/08/2018		
	ROVIDER OR SUPPLIER	/ILLAGES OF MECKLENBURG	13	IREET ADDRESS, CITY, STATE, ZIP CODE 8825 HUNTON LANE UNTERSVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 607 SS=J	aware of the facility's for preventing/reportin of compliance was va Develop/Implement A CFR(s): 483.12(b)(1) §483.12(b) The faciliti implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establi to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on record revi facility to implement t the areas of reporting immediately reporting administration for 1 of reviewed for abuse. immediately report sta 1 cognitively impaired who was slapped by a Findings included: Review of the facility Procedures Reporting abuse, neglect or mis property is to be report	 with staff revealed they were revised policy/procedures on abuse. The facility's date alidated as 10/25/18. buse/Neglect Policies -(3) y must develop and licies and procedures that: it and prevent abuse, sion of residents and esident property, sh policies and procedures challegations, and e training as required at is not met as evidenced iew and staff interviews the heir policy and procedure in and protection by not g staff to resident abuse to f 1 Residents (Resident #1) Facility staff failed to aff to resident abuse for 1 of d residents (Resident #1) a nursing assistant. 	F 607	Past noncompliance: no plan of correction required.		12/4/18	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		SURVEY PLETED
		345541	B. WING				08/2018
	ROVIDER OR SUPPLIER	ILLAGES OF MECKLENBURG		13	TREET ADDRESS, CITY, STATE, ZIP CODE 3825 HUNTON LANE UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 607	"(Facility) will review a possible, the cause of may have been inflict through follow up will cause of all injuries. 3 will be conducted with foremost concern in of from future harm. 3) suspected, the individ neglecting the resider suspension pending t investigation." Resident #1 was adm 8/15/18 with diagnosi- weakness and anxiety 14 day Minimum Data dated 8/29/18 reveale unclear. He scored a of mental status indic cognition and memory documented during the required extensive, two mobility and was total with 2 persons assist. dependent on staff for and personal hygiene range of motion per the Review of the medica note dated 10/16/18 a "Resident combative called into room assis assistants) with change resident was hitting an	Protection Policy stated, all incidents to determine, if f the incident and injury that ed. 1) a complete and be conducted to identify the 2) Needed investigations in the resident's safety as the order to protect the resident If abuse or neglect is lual suspected of abusing or it will be placed on he outcome of the itted to the facility on s including muscle y disorders. Review of his a Set Assessment (MDS) ed the residents' speech was zero on the brief interview ating that he had poor y. No behaviors were he assessment period. He vo-person assistance for bed lly dependent for toileting . The resident was also r eating, dressing, bathing a. He had no limits with he assessment. I record revealed a general at 10:37 PM which stated during care. This nurse sted CNAs (certified nursing ging brief. CNAs stated that	F	607			

						10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BOILDING			С
		345541	B. WING		1	1/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				13825 HUNTON LANE		
	OX COMMONS AT THE	/ILLAGES OF MECKLENBURG		HUNTERSVILLE, 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 607	Continued From page	e 14	F 60	7		
1 007	signed 10/16/18 at 7:00 PM stated, "I (NA					
		(NA #1) to help her put the				
) in room #. While we were				
a s k I		on he started kicking, hitting				
		us. I tried to hold his hands				
		ble to. And then (NA #1)				
		e he hit her and he started				
		r so she slapped him again. Jet the nurse and she did."				
	During interview on 1	1/4/18 at 3:20 PM with NA				
	#2 she stated that NA	A #1 needed someone to				
		I), someone to hold him				
		m. She was changing him, I				
		hands, so he wouldn't hit in my breast. He was hitting				
		e slapped her in the face.				
		closest to the window. She				
		ad underneath him, but she				
		e diaper on him. NA #2				
	•	o of his hand and told NA #1				
		NA #1 went to get the nurse. 1 before the nurse came in.				
		in hand on the face on the				
		ay anything, he was still				
		e hit him hard, it was more of				
		d they got the brief on and				
		ident twice. She slapped				
	-	was not as bad as the first that she went out and told				
		who told her to tell the				
		Nurses (ADON). The ADON				
	came and talked to h	er (NA#2) to her after the				
	incident and told her if she could not talk a	to slip a note under the door bout it.				
	Interview with the AD					
		M revealed that she was				
	present in the facility	on 11/16/18. She told NA #2				

Facility ID: 990623

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/18/2018 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY PLETED
		345541	B. WING			C / 08/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP C	ODE	
			1	3825 HUNTON LANE		
		ILLAGES OF MECKLENBURG	н	IUNTERSVILLE, 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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 607	Continued From page	e 15	F 607			
	to put a note under he visibly upset and cryin	er door because NA#2 was ng.				
	dated and signed 10/ NA #1 stated, "At 7 P resident and dressed wouldn't allow me to p get help from another Assistant) NA #2 and care, (Resident #1) b punched (NA#2) and	ation-Employee Statement 16/18 at 9:00 PM written by M after I had cleaned the him for bed. The resident out his brief on so I went to CNA (Certified Nursing d when we tried to continue became very violent he myself in chest, and the because it caught me off				
	guard I slapped him b leave a mark, but I im	pack, not hard enough to mediately contacted the er of what happened."				
	revealed that it was a told that the resident medication. The resid and she entered the r stated that she got an because the resident	at 12:43 PM on 11/4/18 normal day. She was not was taken off of all his dent had a bowel movement room to clean him up. She nother NA to help her was a tall man, who spoke ed 200 pounds and was a 2				
	person assist. The N was agitated, and the he started fighting and other NA in the chest. providing care and was who told her to get he into the room and was other NA were holding clean him up. "I turne me, I mean slapped th his hand on instinct. I hit him, and I apologiz probably did slap his	A reported that the resident by tried talking to him when d kicking he hit her and the . She stated they stopped ent to the nurse supervisor er nurse. The nurse came s talking to him, she and the g him down still trying to ed my head and he socked he fire out of me. I slapped told the nurse supervisor I zed." She stated that she face, but it wasn't a slap e don't hit me. She reported				

Facility ID: 990623

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>			(X3) DATE COMP	
		345541	B. WING				08/2018
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 .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	that she only hit Resi that she did not hurt h that she did not inten- that the resident was talking to him and she clean him up. He "sn again so the nurse to alone. NA #1 stated resident previously an was on medication. If followed protocol to th Review of an Investig written by Nurse #1 d 9:00 PM stated, "I wa #1) told me that resid and hitting them and went into the room. F the bed on his side. It told him to let them ch together at first but di Did not try to hit or kid Telephone interview v 11/4/18 revealed that because Resident #1 they needed help. Sh hands and talked to F The resident let them said she wanted then At the end of the shift witness statements a NA#1 did leave early she was upset. This resident was combati Review of the Facility	dent #1 once. She stated him. He had no bruises and d to hurt him. She stated calm when the nurse was e told them to go ahead and apped" (became combative) ld them (NAs) to leave him that she had worked with the nd he was calm when he NA #1 stated that she he letter. lation-employee statement ated and signed 10/16/18 at s called into the room. (NA ent was being combative they couldn't change him. I Res. (Resident) was laying in I held resident's hands and hange him. Res. Held legs d let them change his brief. ck." with Nurse #1 at 2:23 PM on the NA came and got her was being combative, and e stated that she held his him and he was calm for her. change him. "Supervisor in to do a witness statement.	F	607			

Facility ID: 990623

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TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTR	UCTION	(X3) DA	NO. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		CO	MPLETED
		345541	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COI		DRESS, CITY, STATE, ZIP CODE	11/08/2018	
		/ILLAGES OF MECKLENBURG		13825 HUN	ITON LANE		
				HUNTERS	SVILLE, 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 607	Continued From page	e 17	F 6	07			
		nately 7:15PM- NA #1 went					
		or nurse and informed them					
	that resident #1 was	being combative by way of					
		unching while providing					
		ing brief and peri-care).					
		t into room and assisted with					
	personal care until ta	•					
		d staff statements on the					
	resident being comba	Statements were turned into					
	•	pproximately 10:45 PM while					
	CNAs were leaving.						
	-	ed that in the statement from					
		at the resident became very					
		the other CNA (NA#2) and					
	-	nd slapped NA #1 in the					
		caught her off guard "I					
		ot hard enough to leave a					
	mark". After turning l facility.	her statement in, she left the					
		"Received call back from					
		ne), questioned her in					
		on the previous evening.					
	PM in regards to the	vas informed around 8:00					
	•	NA (NA#1) responding to the					
		Supervisor stated that she					
		b let their charge nurse					
		ut what happened and to					
	. ,	is writer then spoke to Nurse					
		as informed that she did not					
		pping of the resident until					
		s the CNA was leaving and					
		ent. It was confirmed by					
	-	that from time of incident to					
	Resident #1; the floor	NA #1, did not attend to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345541	B. WING				C 08/2018
					TREET ADDRESS, CITY, STATE, ZIP CODE 3825 HUNTON LANE	•	
	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG		Н	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	 4:01 PM on 11/4/18 resupervisor on duty tol that Resident #1 was had responded with a the day of the inciden said she did not make busy. The Clinical Nu and facility managem with the nurse supervher in person. The resident was obs laid back in his wheel be in distress. During interview with (DON) during the every stated that she was in following day by the C She stated we all (refificant out that mornin aggressive, and staff DON reported that the written and that intervision further stated that per duty she was in the mergency and that's incident immediately. were properly in-servitive regarding immediate she would have expension. 	hical Nurse Consultant at evealed that the nurse d her that she was informed combative, and that NA #1 a slap back around 8 PM on t. The nurse supervisor e a report because she was urse Consultant stated she ent had a phone interview isor (10/17/18) and met with erved at 4:39 PM on 11/4/18 chair He did not appear to the Director of Nurses ning of 11/4/18, the DON formed of the incident the Clinical Nurse Consultant. erring to management) g that the resident was slapped the resident. The e statements were already riews were continued. She the nurse supervisor on hiddle of handling another why she did not report the The DON stated the staff	F	607			
	•	at 4:14 PM revealed they staff to follow the facility's					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/18/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>			(X3) DATE	
		345541	B. WING				C 108/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	 abuse policy and to ir administration any co administrator stated th action had been comp CORRECTIVE ACTIO Facility must develop policies and procedur abuse, neglect and ex- misappropriation of re policies and procedur allegations, and Inclu- Address How Correct Accomplished For Th Have Been Affected E 1. For Resident MR# committed the abuse investigation and ther 2. All staff was in-ser Development on the f exploitation and misa procedures and proto zero tolerance of abus dementia residents, a neglect, exploitation a IMMEDIATELY to the and Administrator. Th 10-24-2018. 3. For Resident MR# been updated on 10/1 to reflect how to appre- care and services to r to gain his cooperatio 	nmediately report to incerns with abuse. The he following corrective pleted as of 10/25/18: DN PLAN F- 607 and implement written res that; Prohibit and prevent xploitations of residents and esident property, Establish res to investigate any such de training as required. tive Action (S) Will Be ose Residents Found To By The Deficient Practice: 4 2129 the CNA having was suspended during the in terminated. rviced by the ADON/Staff facilities abuse, neglect,	F	607			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED			
		345541	B. WING				C 108/2018			
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE					
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 607	spoke English, Germa onset of Alzheimer's I respond to either of th wife/partner) and to s combative and to re-a become calm and coord 4. For Resident MR# been with the facility f months and have der care to combative res responses to their cord and soothe combative to him. The Director of supervisory nurses, (n assignments,)about h implemented it on Oc and Staff Nurses were protocol on October 1 5. For Resident MR# was completed and a North Carolina Health and the Police Depar hour report filed on 10 the police departmer Corporate Complianc 6. On October 17, 20 thorough skin assess there were no noted a discoloration, scratch resident did not appea- emotional distress as he mentally appeared	ing to be done to the ag care (Resident #2129 an and Dutch before his Disease but now does not he languages, even to his top care if resident becomes approach after he has operative to finish care. 2129, only CNAs that have for greater than three (3) nonstrated ability to provide idents with appropriate mbativeness (how to calm e residents) will be assigned of Nursing educated the who make the CNA is procedure and tober 17, 2018. The CNA's e then educated on this 7, 2018 by the DON. 2129 a full investigation report was made to the Care Personnel Registry tment on 10-17-2018. (24 D/17/2018 by DON and 5 /22/2018 by DON) and to it on 10/17/2018 by e Nurse.	F	607						

Facility ID: 990623

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CAID SERVICES					ORM APPROVED NO. 0938-0391
ROVIDER/SUPPLIER/CLIA	. ,			(X3) D	ATE SURVEY OMPLETED
345541	B. WING _				C 11/08/2018
		STREET ADDR	RESS, CITY, STATE, ZIP CODE		
ES OF MECKLENBURG					
BE PRECEDED BY FULL	ID PREFIX TAG		EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
tion Will Be esidents Having The Same Deficient developed and s and procedures that neglect and nd misappropriation of ty also has occdures to investigate include training as screened upon of abuse, neglect, ad misappropriation of des criminal ng previous e licensing boards and /17/2018 and completed on all given to the Staff d for any signs or rment of skin or signs There were no injuries ident that occurred by to readily admitted that at the resident after esident. The ot following the abuse visory staff did not /A from all care giving ng the investigation.	F	007			
	CAID SERVICES ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER: 345541 ES OF MECKLENBURG IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) or being scared of tion Will Be esidents Having The Same Deficient developed and s and procedures that neglect and nd misappropriation of ty also has ocedures to investigate aclude training as screened upon of abuse, neglect, ad misappropriation of ides criminal ng previous e licensing boards and /17/2018 and completed on all given to the Staff d for any signs or rment of skin or signs There were no injuries cident that occurred by to readily admitted that at the resident after resident. The ot following the abuse visory staff did not IA from all care giving ing the investi	ROVIDER/SUPPLIER/CLIA (X2) MULT A. BUILDIN 345541 B. WING_ ES OF MECKLENBURG ID TT OF DEFICIENCIES ID BE PRECEDED BY FULL PREFIX NTIFYING INFORMATION) TAG F 6 or being scared of tion Will Be esidents Having The Same Deficient developed and s and procedures that neglect and neglect and nd misappropriation of ty also has screened upon of abuse, neglect, nd misappropriation of nd misappropriation of ides criminal ng previous e licensing boards and /17/2018 and completed on all given to the Staff d for any signs or rment of skin or signs There were no injuries cident that occurred by no readily admitted that at the resident after resident after resident. The to following the abuse visory staff did not IA from all care giving ing the investigation. did not immediately	ROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC A. BUILDING	ROVIDERSUPPLIERICLIA ENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A. BUILDING 345541 B. WING ES OF MECKLENBURG STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078 IT OF DEFICIENCIES BE PRECEDED BY FUL DIFFING INFORMATION) PROVIDER'S PLAN OF COD (EACH CORRECTIVE ACTION TAG Or being scared of PROVIDER'S PLAN OF COD (EACH CORRECTIVE ACTION TAG Or being scared of PROVIDER'S PLAN OF COD (EACH CORRECTIVE ACTION TAG Or being scared of PROVIDER'S PLAN OF COD (EACH CORRECTIVE ACTION TAG Or being scared of PROVIDER'S PLAN OF COD (EACH CORRECTIVE ACTION TAG developed and s and procedures that neglect and nd misappropriation of ty also has screened upon of abuse, neglect, and misappropriation of dues criminal ng previous a licensing boards and /17/2018 and completed on all given to the Staff d for any signs or There were no injuries sident that occurred by to readily admitted that at the resident after esident. The t following the abuse visory staff did not IA form all care giving ing the investigation. did not immediately	CAID SERVICES OMB ROVIDERSUPPLIERCIAL ENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) D A BUILDING 345541 E. WING

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	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345541	B. WING		1	C 1/08/2018
	ROVIDER OR SUPPLIER	/ILLAGES OF MECKLENBURG	13	REET ADDRESS, CITY, STATE, ZIP CODE 825 HUNTON LANE JNTERSVILLE, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 607	22-2018. The CNA at abuse that occurred of they failed to report th Administrator and Dir 5. The facility has all to provide supervision policies and procedur Immediately after lea following intervention Administrator and Dir A. The employee who resident was suspend and then terminated of completed. She was the Health Care Pers Huntersville Police Di B. The staff involved report the incident to and/or Administrator Abuse, Proper Repor report and prevention	ing the abuse was -2018 and terminated on 10- nd the Nurses aware of the were disciplined because he abuse immediately to the rector of Nursing. ways provided and continues n of staff to assure that its res are followed. rning of the incident the s were put into place by the rector of Nursing: to admitted to abusing the ded pending the investigation once the investigation was reported on 10-17-2018 to onnel Registry and the epartment. in the incident who did not the Director of Nursing timely were re-educated on ting to include timing of the h. They also received y the Director of Nursing. on October 17, 2018.	F 607			

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	MENT OF HEALTH AN					FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345541	B. WING				C 08/2018
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			13825 HUNTON LANE HUNTERSVILLE, 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 607	Or Systemic Changes Deficient Practice Wil 1. All abuse policies, protocols were review 24, 2018 to ensure th abuse, neglect and ex- misappropriation of th 2. Administrative Sta care units six (6) time the incident entering r resident care is being times a week for the r (2) times a week for the r (2) times a week for the mith at least one (1) r the 11-7 shift to ensur provided in a way tha abuse. The Administr 10/17/2018 by the Ad assignments. Indicate How The Fac Performance To Make Sustained. The Facilit Ensuring That Correct Sustained: 1. Administrative Rot QAPI Committee mor that solutions are ach prevent reoccurrence 2. All incident reports QAPI Committee mor patterns or practices of indicative of abuse or patterns or practices of Committee will immed	s Made To Ensure That The I Not Recur: practices, procedures and ved with all staff by October at residents are free from exploitations or leir property. If will round on the resident s a week the week following rooms and showers were provided, then four (4) next six (6) months and two he following six (6) months ound per week occurring on re that care is being t protects residents from ative Staff were notified ministrator who makes the cility Plans To Monitor It's e Sure That Solutions Are ty Must Develop A Plan For tion Is Achieved And unds will be presented to the nothly to review and evaluate ieved and sustained to	F	607			

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DEPART	FORM APPROVED OMB NO. 0938-0391						
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345541	B. WING				C 108/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG					3825 HUNTON LANE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	 issue and to ensure thand sustained to prev 3. All policies, proced practices pertaining to quarterly by the QAPI quarters and annually appropriateness in prin the facilities policie 4. The QA Committee Medical Director were and corrective action commit their support achieving and sustain Date of Compliance: Validation Information Administrator and Dir at 4:14 PM revealed the staff to follow the facili immediately report to with abuse. The admit corrective action had 10/25/18. Quality Assurance Per (QAPI) Committee med All staff were in-service reporting abuse; any not work until they we trained nurse aides en would be assigned to identified with aggress Body audits were commendation. 	hat solutions are achieved vent reoccurrence. dures, protocols and o abuse will be reviewed I Committee for the next two v thereafter for eventing abuse as outlined s. e, QAPI Committee and the e apprised of the problem plan on 10-18-2018 and to assisting the facility with hing compliance. 10-25-2018 at: An interview with the ector of Nursing on 11/8/18 they expected the nursing lity's abuse policy and to administration any concerns inistrator stated the following been completed as of erformance Improvement et and developed a plan ced on identifying and prn (as needed) staff could ere re-educated and only mployed at least 3 months work with residents	F	507			

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S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES						D: 12/18/2018 APPROVED D: 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				(X3) DATE SURVEY COMPLETED	
	345541	B. WING					C 08/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT	E, ZIP CODE		
OX COMMONS AT THE V	ILLAGES OF MECKLENBURG				78		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				<i>,</i>			(X5)
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTI CROSS-REFERENC	IVE ACTION SHOULD BE ED TO THE APPROPRIA		COMPLETION DATE
 REGULATORY OR LSC IDENTIFYING INFORMATION) 7 Continued From page 25 residents had Resident care plans were audited/updated regarding residents with aggressive behaviors Incident reports for the prior 3 months were reviewed to identify any concerns related to injuries of unknown origin Administrative staff monitored resident: staff interactions during nursing care and were currently monitoring 4 residents each week to ensure staff/residents were aware of the procedure for reporting abuse, and that abuse was not occurring Staff reviewed orientation packets to make sure it contained up-to-date information regarding identifying/reporting abuse The facility continued to monitor/audit for ongoing compliance The facility provided documentation of training for all staff regarding abuse, documentation of all body audits, revised care plans, minutes from Resident Council, resident interviews and QAPI monitoring for corrective action as of 10/25/18. At the time of the survey, sampled residents were observed to receive nursing care without concerns related to abuse. Interviews with alert/oriented residents revealed they were they 		F 607		7			
felt safe. Interviews w aware of the facility's for preventing/reportir	ith staff revealed they were revised policy/procedures ng abuse. The facility's date						
	Continued From page residents had Resident care plans v regarding residents w Incident reports for th reviewed to identify a injuries of unknown ou Administrative staff m interactions during nu currently monitoring 4 ensure staff/residents procedure for reportin was not occurring Staff reviewed orienta contained up-to-date identifying/reporting a The facility continued compliance The facility provided of all staff regarding abu body audits, revised of Resident Council, res monitoring for correct the time of the survey observed to receive n concerns related to al alert/oriented resident felt safe. Interviews w aware of the facility's for preventing/reporting	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA CORRECTION 345541 A 345541 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 residents had Resident care plans were audited/updated regarding residents with aggressive behaviors Incident reports for the prior 3 months were reviewed to identify any concerns related to injuries of unknown origin Administrative staff monitored resident: staff interactions during nursing care and were currently monitoring 4 residents each week to ensure staff/residents were aware of the procedure for reporting abuse, and that abuse was not occurring Staff reviewed orientation packets to make sure it contained up-to-date information regarding identifying/reporting abuse The facility continued to monitor/audit for ongoing compliance The facility provided documentation of training for all staff regarding abuse, documentation of all body audits, revised care plans, minutes from Resident Council, resident interviews and QAPI monitoring for corrective action as of 10/25/18. At the time of the survey, sampled residents were observed to receive nursing care without concerns related to abuse. Interviews with	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL CORRECTION IDENTIFICATION NUMBER: (X2) MUL A BUILD 345541 B. WING ROVIDER OR SUPPLIER OX COMMONS AT THE VILLAGES OF MECKLENBURG ID (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 F residents had Resident care plans were audited/updated regret to identify any concerns related to injuries of unknown origin Administrative staff monitored resident: staff interactions during nursing care and were currently monitoring 4 residents each week to ensume staff/residents were aware of the procedure for reporting abuse, and that abuse was not occurring Staff reviewed orientation packets to make sure it contained up-to-date information regarding identifying/reporting abuse, documentation of all body audits, revised care plans, minutes from Resident Council, resid	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL FORMECTION 345541 B. WING ROVIDER OR SUPPLIER 345541 B. WING OX COMMONS AT THE VILLAGES OF MECKLENBURG ID PREFIX Continued From page 25 ID PREFIX residents had Resident care plans were audited/updated PREFIX Resident care plans were audited/updated reviewed to identify any concerns related to injuries of unknown origin Administrative staff monitored resident: staff interactions during nursing care and were currently monitoring 4 residents each week to ensure staff/residents were aware of the procedure for reporting abuse, and that abuse was not occurring Staff reviewed orientation packets to make sure it contained up-to-date information regarding identifying/reporting abuse, documentation of all body audits, revised care plans, minutes from Resident Council, resident interviews and QAPI monitoring for corrective action as of 10/25/18. At the time of the survey, sampled residents were observed to receive nursing care without concerns related to abuse. Interviews with alert/oriented residents were aware of the facility's revised policy/procedures for preventing/reporting abuse. The facility's date	OP DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER. (X2) MULTIPLE CONSTRUCTION A BUILDING AS5541 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAT 13825 HUNTON LANE HUNTERSVILLE, NC 2807 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS (EACH CORRECT CROSS-REFERENCE DE Continued From page 25 residents had Resident care plans were audited/updated regarding residents with aggressive behaviors Incident reports for the prior 3 months were reviewed to identify any concerns related to injuries of unknown origin Administrative staff monitored resident: staff interactions during nursing care and were currently monitoring 4 residents each week to ensure staff/residents were aware of the procedure for reporting abuse, and that abuse was not occurring Staff reviewed orientation packets to make sure it contained up-to-date information regarding identifying/reporting abuse The facility continued to monitor/audit for ongoing compliance The facility provided documentation of training for all staff regarding abuse, documentation of all body audits, revised care plans, minutes from Resident Council, resident interviews and QAPI monitoring for corrective action as of 10/25/18. At the time of the survey, sampled residents were observed to receive nursing care without concerns related to abuse. Interviews with alert/oriented residents revealed they were aware of the facility's revised policy/procedures for preventing/reporting abuse. The facility's date	DEFICIENCIES CORRECTION (M1) PROVIDERISUPPLIENCLIA IDENTIFICATION NUMBER: (M2) MULTIPLE CONSTRUCTION A BUILDING ARDIDING 345541 STREET ADDRESS, CITY, STATE, ZIP CODE CORRECTION 345541 STREET ADDRESS, CITY, STATE, ZIP CODE CONMONS AT THE VILLAGES OF MECKLENBURG STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EXCHAPPICIESNY WINTE BE PRECIDENDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX PROVIDERSTON SHOLD BY (EACH CORRECTION ATTON) SOULD BY (EACH CORRECTION CONSISTING THE PRECIDEND BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX PROVIDERSTON SHOLD BY (EACH CORRECTION CONSISTING THE PRECIDEND BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 residents had Resident care plans were audited/updated regarding residents with aggressive behaviors Incident reports for the prior 3 months were reviewed to identify any concerns related to injuries of unknown origin Administrative staff monitored resident: staff interactions during nursing care and were currently monitoring 4 residents were aware of the procedure for reporting abuse, and that abuse was not occurring Staff reviewed orientation packets to make sure it contained up-to-date information regarding identifying/reporting abuse. 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Facility ID: 990623

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