PRINTED: 08/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345541	B. WING			С		
NAME OF B	20/1050 00 01/00/155	343041	D. WING				08/2013	
NAME OF PI	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE			
OLDE KNO	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE			
500 CO				ŀ	HUNTERSVILLE, NC 28078			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EA		(X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE	S-	COMPLETION DATE	
ino		or in the contract of the cont	170		DEFICIENCY)			
					OLDE KNOX COMMONS RESPONSE	TO		
F 000	INITIAL COMMENTS			000	THIS REPORT OF SURVEY DOES NO	Т		
1 000	INTIAL COMMENTS		F	UUU	DENOTE AGREEMENT WITH THE			
					STATEMENT OF DEFICIENCIES; NOR			
	No defiencies were c				IT CONSTITUTE AN ADMISSION THAT			
	complaint investigatio				STATED DEFICIENCY IS ACCURATE.	WE		
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F:	225	ARE FILING THE POC BECAUSE IT IS	i		
SS=D	INVESTIGATE/REPO				REQUIRED BY LAW.			
	ALLEGATIONS/INDIV	/IDUALS			• F225			
					ADDRESS HOW CORRECTIVE ACTIO	N (S)	09-05-13	
		mploy individuals who have			WILL BE ACCOMPLISHED FOR THOS			
	been found guilty of al				RESIDENTS FOUND TO HAVE BEEN			
		by a court of law; or have			AFFECTED BY THE DEFICIENT PRAT	ICE:		
		into the State nurse aide						
	registry concerning ab	ouse, neglect, mistreatment			A system was put into place on 08-19-13			
		propriation of their property;			resident, a body audit to be completed b			
		edge it has of actions by a			shift by Nurse. Each Nurse is directed to			
		n employee, which would			document on Body Audit Form. A syster			
		service as a nurse aide or			put into place for this; all ADL's assistant			
		e State nurse aide registry			provided by CNA's to be supervised by a			
	or licensing authorities	5.			for 30 days to ensure CNA's provide app	ropriate		
	The feelite would are	as Host all alless soluted at			approach while providing care. The Nurs	е		
32		re that all alleged violations			supervising ADL care is to also provide			
	involving mistreatment including injuries of un				observation and documentation of reside	nt's		
		sident property are reported			behaviors that could result in unintention	al self-		
		ministrator of the facility and			inflicted injury as a direct result of those			
		cordance with State law			behaviors and not a suspicious injury of			
		ocedures (including to the			unknown origin. At the end of 30 days, the	nen		
	State survey and certif				every other day for two (2) weeks, then the	nree (3)		
	otato ourvoy and conti	indutori agency).			times a week for two (2) weeks, then wee	ekly for		
	The facility must have	evidence that all alleged			two (2) weeks. At this time the need to			
		nly investigated, and must			supervise the residents will be re-evaluat	ed by		
	prevent further potenti				the Administrator and DON. In-service tr	aining		
	investigation is in prog				by the ADON/DON, on incident reporting	, proper		
	, ,				identification of potential injury of unknow	n origin		
	The results of all inves	stigations must be reported		- 1	and appropriate reporting to the			
	to the administrator or				Administrator/DON to determine the nece	essity of		
		other officials in accordance			24 hour report completion and submissio			
	with State law (includir	ng to the State survey and			NC State Personnel Registry will be com			
	certification agency) w	ithin 5 working days of the		- 1	on all Nurse's by 09-05-13.			
	-/1 W	5 -027			5 2 3 X X X X			
BORATORY	/ // // // //	UPPLIER REPRESENTATIVE'S SIGNATURE			A / TITLE / /	0	X6) DATE	
	11my D_ / JOHN	ne			Administration	7-1	6-13	

Any deficiency statement ending with an actorisk (*) 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 trese documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation SEP 1 9 2013

by: PAM

FORM CMS-2567(02-99) Previous Versions Versions

Event ID: KUG711

Facility ID: 990623

If continuation sheet Page 1 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
OOMILOTIC	JN	345541	B. WING	1100 3 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		C 08/08/2013		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRE	SS, CITY, STATE, ZIP CODE	001	00/2013	
OLDE KI	IOV COMMONO AT THE	VII. 1 4 0 5 0 5 1 1 5 0 1 1 5 1 5 1 5 1 5 1 5 1		13825 HUNTON	ILANE			
OLDE KI	NOX COMMONS AT THE	VILLAGES OF MECKLENBURG		HUNTERSVIL	LE, NC 28078			
(X4) ID PREFI X TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX CORRECTIVE ACTION SHOULD BE CROS			(X5) COMPLETION DATE	
F 225	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. F 225 WILL RES AFFI PRA		WILL BE A RESIDENT AFFECTED PRACTICE An education	– onal training tool has been dev	E_ BE_ - veloped			
	by: Based on record revi	dents (Resident #51)		unknown or process for will be inser orientation employees appropriate completion	I that defines what an injury of rigin is and the appropriate repall levels of staff. This training red into the new employee process to ensure all future are properly educated on the reporting process to include and submission of a 24 hour povides detailed instruction on:	porting g also		
	12/27/10 with diagnost Alzheimer's disease at A review of the most of Data Set (MDS) dated resident had short and impairment and sever for daily decision makindicated Resident #5 staff for transfers and exhibited physical behavior others 4-6 day. A review of an incident revealed Resident #5 bruise covering her let indicated an unidentificated an unidentificated an unidentificated to the bruise. The concluded the bruise withous transfer to stand lift straps to sit-to-stand lift straps to the straps of the straps to the straps of	ecent quarterly Minimum d 05/14/13 specified the d long term memory ely impaired cognitive skills ing. The MDS further 1 was totally dependent on activities of daily living and navioral symptoms directed s but less than daily. It report dated 06/07/13 If was noted to have a large fit side. The incident report ed nurse aide (NA) ring the 7:00 AM to 3:00 PM report noted Nurse #4 was caused from the used to transfer Resident cumentation on the report		po CN imi in- pre CN ob orc ski pai Sta a r Th imi inv api	entification and notification of stential injury of unknown origin NA Staff or non-nursing staff a mediately notify a Nurse or Nurse as soon as you observed as soon as you observed anything that is out of the dinary such as; bruising, reducing tear or any signs or symptonin. aff should never make an assumant injury has already been reported in the end of the e	re to urse — ve the o ne ess, ms of umption orted to vill all ess s, on of		

OF CORRECTION C C 345541 B. WING 08/08/	C 08/08/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	3/2013	
13825 HUNTON LANE		
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG HUNTERSVILLE, NC 28078		
PRE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE FIX TAG DEFICIENCY)	(X5) COMPLETION DATE	
Continued From page 2 A review of the nurse's note dated 08/07/13 7-3 PM revealed Resident #51 was combative with #51 left side measured 18cm x 5cm. Review of Weekly Skin Assessment of 06/07/13 revealed no new skin issues. The 06/14/13 assessment indicated a resolving bruise (no measurements noted) on the left side with no new skin issues. Interview with NA #3 on 08/08/13 at 8:17 AM revealed she worked with Resident #51 on 08/07/13 and observed a large dark colored bruise covering Resident #51 left side when she changed the resident's clothes that morning. NA #3 stated she reported the bruise to Nurse #4. NA #3 reported she was not interviewed by anyone about the cause of the bruise. NA #3 reported the norweight bearing mechanical lift had never been used to transfer Resident #51. She stated she incovered with the sit-to-stand lift, the resident would take her arms out of the sling and the NAs would sit her down, let her calm down and try the transfer again. NA #3 stated Resident #51 could be transferred without the sit-to-stand lift by 2 people when the resident wasn't being combative. NA #3 reported the non-weight bearing mechanical lift had never been used to transfer Resident #51. She stated she was unaware of how the resident sustained the bruise. She also explained that it wasn't 1 likely the bruise was caused by the sit-to-stand lift because the bruising was only on the resident's 1 left side and the resident had never exhibited bruising from the sit to stand lift in the past. **F 225 A review of Weekly Skin Assessment on deaded and skin injuries to report. Notice mails according to the solve what happened or did someone witness the cause of injury and provide witness documentation. Notified Nurse is to immediately notify the Nurse Banager. **Notifie President responsible party. Question your information, i.e.; can resident say double line. Notifier Nurse is to information, i.e.; can resident say double line. Notifier Nurse is to information. Notified Nurse is to information. Notified Nurse is		

STATEMENT OF DEFICIENCIES AND PLAN	(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
OF CORRECTION	96 8				С	
	345541	B. WING			08/08/2013	
NAME OF PROVIDER OR SUPPLIER OLDE KNOX COMMONS AT THE	E VILLAGES OF MECKLENBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078				
ID (EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EA PREFIX CORRECTIVE ACTION SHOULD BE CROS TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
Interview with Nurse # revealed she assesse Resident #51 left side straps on the sit-to-stabruise due to the bruise due to the bruise due to the sit-to-stand lift. She also repor combative with care a the sit-to-stand lift. Nu new to the facility and an incident report for a and to inform the char injury of unknown orig Nurse #4 stated she d from an injury of unknown inform the charge nurse further stated she did staff that worked with 06/07/13 to gather any make her determination bruise. An observation was make her determination bruise. An observation was make her determination bruise. An observation was make her determination bruise. Interview with the sit-to-star was very cooperative of straps on the sling of the positioned properly un no movement of the slinterview with NA #4 or revealed she observed side of Resident #51 of questioned by anyone occurred. NA #4 states bruise matched the stradue to the large size or	d on 08/08/13 at 9:15 AM d a large bruise on on 06/07/13 and felt the and lift had caused the se matching the straps of ted Resident #51 was nd would fight staff when in res #4 reported she was was instructed to complete all injuries and accidents ge nurse or DON of any in as soon as possible. id not feel the bruise was own origin so she did not se or the DON. Nurse #4 not interview any direct care Resident #51 on or around additional information to on for the cause of the during the transfer. The he sit-to-stand lift were der Resident #51 arms with ing during the transfer. on 08/08/13 at 2:15 PM d a large bruise on the left on 06/07/13 and was not on how the bruise	F2	225	 Identification and notification of potential injury of unknown origi CNA Staff or non-nursing staff a immediately notify a Nurse or Nin-charge as soon as you observe presence of an injury. CNA staff when providing care to observe anything that is out of the ordinary such as; bruising, reductions skin tear or any signs or sympto pain. Staff should never make an assisthat injury has already been reproduced and the injury has already been reproduced and injury has already been reproduced and investigation process obtaining applicable medical records, with statements, employee interviews MARS, body audit, and completing Quality Assurance Event Report ensure appropriate intervention place to meet the needs of residence. Notify Physicians Elder Care via line. Notify resident responsible party Question your information, i.e.; or resident state what happened or someone witness the cause of in and provide witness documental Notified Nurse is to immediately the Nurse Manager. Both the Nurse and Nurse Manager and provide witness documental Notified Nurse is to immediately the Nurse Manager. Both the Nurse and Nurse Manager and provide witness documental Notified Nurse is to immediately the Nurse and Nurse Manager and provide witness and Nurse Manager and provide witness and texts and appropriate and will not be utilized. Administrator/DON will make the determination whether the compand submission with fax confirmation whether the compand submission with fax confirmation whether the compand submission with fax confirmation is necessary. 	are to urse — ve the other ess, oms of umption orted to will all less s, ion of t. is in lent. It triage can or did njury tion. notify ager are to the ontinue ive e not ed. e letion	

DÉPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		OMB NO	0. 0938-0391		
STATEMEN DEFICIENC OF CORRE	CIES AND PLAN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345541	B. WING			C 08/08/2013	
NAME OF	PROVIDER OR SUPPLIER	5050.000.000.000.000.000.000.000.000.00	5566565555	-	TREET ADDRESS, CITY, STATE, ZIP CODE	001	00/2013
TVANIE OF	THOUBER OR GOFFEIER						
OLDE K	NOX COMMONS AT THE	VILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078		
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F 225		∮2 on 08/08/13 at 2:22 PM	F		This training will be completed with all No 09-05-13. INDICATE HOW THE FACILITY PLANS MONITOR IT'S PERFORMANCE TO MA	S TO	
	revealed she reviewed the incident report dated 06/07/13 for Resident #51 then sent the report to the DON. Nurse #2 reported she assessed Resident #51's bruise to the left side, she reported Resident #51 had a significant bruise				SURE THAT SOLUTIONS ARE SUSTA THE FACILITY MUST DEVELOP A PLA ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLA	INED. IN FOR	
	that covered the ribs beginning under the arm to the waist with an area not bruised around the waist and then bruise continued to the hip bone. Nurse #2 stated she did not think the bruise				MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED F EFFECTIVENESS. THE POC IS INTEGI INTO THE QUALITY ASSURANCE SYS	RATED	
	occurred from the sit-	o-stand lift straps due to bruise and only occurring on			OF THE FACILITY: Nurses are to turn in any Quality Assurar		
	Resident #51 tries to	get out of the bed by rolling I she felt that was how the			Event Reports to the Nurse Manager price end of their shift for review by the Nurse Manager. The Administrator/DON will be by the Nurse Manager regarding any inci	or to the	
65	2:40 PM revealed all i reviewed by her, she responsibility of the nu incident reports' to con	further stated it was the urse who completed the nduct an investigation of the			unknown origin upon receipt of the Qualit Assurance Event Report. The Administrator/DON will determine if an investigation is to be initiated along with r to NCHPR via 24 hour report. The	ty	
	origin have to be repo possible. If the DON a it is a true injury of unl	d all injuries of unknown rted to the DON as soon as nd Administrator conclude known origin an onducted and a 24 hour and			Administrator/DON will direct the Nurse Note initiate the investigation. In addition, Administrator/DON/ will review all Quality Assurance Event Reports daily Monday to the contract of the c	hrough	
		he DON stated an clude observations, , staff, resident, and family			Friday to ensure compliance is being ach and staff is appropriately following facility process and documentation. A log of the Assurance Event Reports will be maintain	Quality ned by	
	skin integrity.	review, and the residents		Ì	month to include the type of injury, the ca injury, and whether a 24 hour report to the HCPR was completed if necessary. The i log and the Quality Assurance Event Rep	e ncident	
	dated 06/07/13 for Re she assessed Resider	sident #51. She reported ht #51 bruise and described , very significant bruising			be reviewed by the Quality Assurance Committee to ensure the facility is in com with facility/state/federal policies,		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
OF CORRE		is Entitle Anisot Nomber.	A. BUILDI	NG _				
		345541	B. WING _	B. WING			C 08/08/2013	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	Control (who control the property form who about the first of the control of the		13825 HUNTON LANE		3825 HUNTON LANE			
OLDE F	NOX COMMONS AT THE	E VILLAGES OF MECKLENBURG		Н	IUNTERSVILLE, NC 28078			
(X4)		ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION (E			(X5) COMPLETION		
ID PRE		SC IDENTIFYING INFORMATION)	TAG	PREFIX CORRECTIVE ACTION SHOULD BE CRO TAG REFERENCED TO THE APPROPRIAT		5-	DATE	
FIX	THE REAL PROPERTY OF THE REAL PROPERTY OF THE			DEFICIENCY)				
TAG	Continued From page	5		guidelines and laws on reporting all inci				
_					injuries and/or unknown origin. The QA	CITIS OF		
F 225		eft side. The DON stated	F 2	225	Committee will be responsible to ensure	that		
225		e #4 that the bruise was			corrective action is achieved and sustain			
	caused by the strap o					ea. The		
		atched the strap on the			QA Committee will be responsible for			
		ON stated the strap could			implementing new policies and procedur	es		
	N 50 50	ound the residents' waist			and/or systems if current policies and			
		using the bruise to be on the			procedures and/or systems are identified			
		ver left side of the resident.			insufficient to maintain corrective action a	*********		
		e did not think the bruise			sustain solutions. The QA Committee me	ets		
was an injury of unknown origin so she did not make a 24 hour report for the incident and did not				weekly, monthly, and quarterly.	1			
	follow up with a 5 day investigative report to the					1		
	Health Care Personne						00 05 10	
	483.13(c) DEVELOP/		F 2	226	• F226		09-05-13	
	ABUSE/NEGLECT, E				ADDRESS HOW CORRECTIVE ACTION			
Е	ADOUL/NEOLLOT, L	TO TOLIOILO			WILL BE ACCOMLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	<u> -</u> 0		
F 226	The facility must deve	lop and implement written			AFFECTED BY THE DEFICIENT PRAC	TICE		
SS=	policies and procedure				ALL DE TOLENT TRACE	HOL.		
D		, and abuse of residents			A system was put into place on 08-19-13	for this		
_	and misappropriation				resident, a body audit to be completed by			
					shift by Nurse. Each Nurse is directed to			
					document on Body Audit Form. A system	n was		
					put into place for this; all ADL's assistanc	1100		
	This REQUIREMENT	is not met as evidenced			provided by CNA's to be supervised by a			
	by:				for 30 days to ensure CNA's provide app			
	Based on a record re	view and staff interviews,			approach while providing care. The Nurs			
	the facility failed to foll	low their abuse policy and		- 1	supervising ADL care is to also provide			
	procedures by not inve	estigating an injury of		- 1	observation and documentation of reside	nt's		
	unknown origin for 1 o	of 3 residents (Resident		- 4	behaviors that could result in unintention	B1012-045		
	#51).			- 1	inflicted injury as a direct result of those	ar och		
					behaviors and not a suspicious injury of			
	The findings are:				unknown origin. At the end of 30 days, th	nen		
	- 6 · · · ·				every other day for two (2) weeks, then the			
	The facility's undated			- 1	times a week for two (2) weeks, then we			
(9	Procedures read in pa	irt:			two (2) weeks. At this time the need to	illy ioi		
	THE PL STURET SHE AMERICA			- 1	supervise the residents will be re-evaluat	ed by		
		entify and investigate any		- 1	the Administrator and DON.	ou by		
	and all "cause unknow	wn" injuries to ensure		1	and Administrator and DON.			
					-			
				1			I	

CLIVILIA	OT ON WILDICANL &	WILDIGAID SERVICES				OINID INC	7. 0930-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		345541	B. WING _				C /08/2013
	PROVIDER OR SUPPLIER	E VILLAGES OF MECKLENBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078			00/2013
(X4) ID PRE FIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EAR CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	completed for each in abuse/neglect has no include the nature of the discovered, who discovered, who discovered, who discovered to the injury if known. The forwarded to the Direct follow up. All bruises, skin the reviewed to determined will be broad accidents that can determined will be broad accidents and accident accident and accident accident accident accident and accident ac	s not occurred. nce Event Report will be cident/accident to assure t occurred. The report will he injury, when it was overed it and the cause of the report will then be ctor of Nursing (DON) for the ears of unknown origin will nine the cause. Incidents in not be reasonably ought to the attention of the mitted to the facility on the se of hypertension, and dysphasia. the dos/14/13 specified the dos/14/13 spec	F2	2226	In-service training by the ADON/DON, or incident reporting, proper identification of potential injury of unknown origin and appropriate reporting to the Administrator to determine the necessity of 24 hour reporting to the NC St. Personnel Registry will be completed on Nurse's by 09-05-13. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO AFFECTED BY THE SAME DEFICIENT PRACTICE: An educational training tool has been deed by the DON that defines what an injury of unknown origin is and the appropriate reporting is and the appropriate reporting in the inserted into the new employee orientation process to ensure all future employees are properly educated on the appropriate reporting process to include completion and submission of a 24 hour Training provides detailed instruction on: Identification and notification of potential injury of unknown origing. CNA Staff or non-nursing staff as immediately notify a Nurse or Non-charge as soon as you observe anything that is out of the ordinary such as; bruising, reduction of the potential injury has already been reported in the providing care to a staff should never make an asson that injury has already been reported in the providing has already been reported in the providing that is out of the ordinary such as; bruising, reduction of the providing that is out of the providing that the providing t	f r/DON port port port port port port porting g also report. n. pre to pre to pre to pre the	

STATEMENT OF DEFICIENCIES AND PLAN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
OF CORRE	CTION		A. BOILDI	NG _		C	
		345541	B. WING			08/08/2013	
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE I	NOV COMMONO AT THE	E VII I AGEG OF MEGIZI ENDUDO		1	13825 HUNTON LANE		
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG				ŀ	HUNTERSVILLE, NC 28078		
(X4) ID PRE FIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PREFIX CORRECTIVE ACTION SHOULD BE CR			(X5) COMPLETION DATE
F 226	PM revealed Resident care, hitting, pushing skin injuries to report. Review of Weekly Skin revealed no new skin assessment indicated measurements noted skin issues. Review of nurse's not the bruise covering Remeasured 18cm x 5cm. Interview with NA #3 or revealed she worked to 6/07/13 and observe bruise covering Reside changed the resident #3 stated she reported #3 reported she was reabout the cause of the Resident #51 could be being transferred with resident would take het he NAs would sit her and try the transfer ag #51 could be transferred with the NAs would sit her and try the transfer ag #51 could be transferred with resident #51. She state how the resident sustate explained that it was no caused by the sit to state bruising was only on to the state of th	Is note dated 06/07/13 7-3 at #51 was combative with and slapping NAs. No new In Assessment of 06/07/13 issues. The 06/14/13 Is a resolving bruise (no of on the left side with no new In Assessment of 06/07/13 issues. The 06/14/13 Issues. The 06/14/14/13 Issues. The 06/14/14/13 Issues. The 06/14/14/13 Issues. The 06/14/14/13 Issues. The 06/14/14/14/14/14/14/14/14/14/14/14/14/14/	F		The Nurse receiving the report immediately initiate an internal	all ness vs, tion of rt. n is in dent. a triage y. can or did injury ation. v notify ager are live re not live re not led. e poletion nation of EPUT SENT veloped f porting g also	

STATEMENT OF (X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES AND PLAN IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
OF CORRE	CTION		A. BOILBING		С	
		345541	B. WING		08/08/2013	
AMERICAN SERVICES		E VILLAGES OF MECKLENBURG	1	STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078		
ID PRE FIX TAG	네	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	S- COMPLÉTION DATE	
	revealed she assessed Resident #51 left side straps on the sit to star bruise due to the bruist the lift. She also report combative with care at the sit to stand lift. Nurnew to the facility and an incident report for and to inform the char injury of unknown orig Nurse #4 stated she of from an injury of unkninform the charge nursurther stated she did staff that worked with 06/07/13 to gather any make her determinated bruise. An observation was meaning the state of the sit to star was very cooperative straps on the sling of the positioned properly un no movement of the sit to the nurse on the hemeasure it. The family meeting with the DON	the day of the second s	F 226	 Identification and notification on potential injury of unknown origi CNA Staff or non-nursing staff a immediately notify a Nurse or N in-charge as soon as you obser presence of an injury. CNA staff when providing care to observe anything that is out of tordinary such as; bruising, redn skin tear or any signs or symptopain. Staff should never make an ass that injury has already been repanurse, but must always report immediately initiate an internal investigation process obtaining applicable medical records, with statements, employee interview MARS, body audit, and complet Quality Assurance Event Report Quality Assurance Event Report Inne. Notify Physicians Elder Care via line. Notify Physicians Elder Care via line. Notify resident responsible party Question your information, i.e.; or resident state what happened on someone witness the cause of in and provide witness documentary. Notified Nurse is to immediately the Nurse Manager. Both the Nurse and Nurse Manager immediately start notification of the Administrator/DON and are to conto to make calls until they reach all person. Voice mails and texts an appropriate and will not be utilized. 	in. are to urse — ve the to the ess, oms of umption orted to . will all tess s, ion of t. is in lent. triage . can r did njury tion. notify ager are are to the ontinue ive e not	

PRINTED: 08/22/2013 FORM APPROVED OMB NO. 0938-0391

CLIVILLI	OT ON WILDICANE &	MEDICAID SERVICES			OMB NO. 0938-0391	
STATEMEN DEFICIENC OF CORRE	CIES AND PLAN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345541	B. WING _		08/08/2013	
\$250 A. S.	PROVIDER OR SUPPLIER	E VILLAGES OF MECKLENBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078		
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F 226	had not been informe happened or what typ conducted. Interview with NA #4 revealed she observe side of Resident #51 questioned by anyone occurred. NA #4 state matched the straps of the large size of the bunaware of how Reside bruise. Interview with Nurse # revealed she reviewed 06/07/13 for Resident #51's bruise reported Resident #51's bruise reported Resident #51's bruise reported Resident #51's that covered the ribs to the waist with an area waist and then bruise Nurse #2 stated she doccurred from the sit of positioning of the bruilleft side of the body. N #51 tries to get out of side rails and she felt occurred. Interview with the DOI 2:40 PM revealed all in reviewed by her, she fresponsibility of the nuincident report to conditions.	sue. The family stated they d of how the bruise re of investigation was on 08/08/13 at 2:15 PM d a large bruise on the left on 06/07/13 and was not re on how the bruise red she didn't think the bruise red she didn't think the bruise red she stated she was dent #51 sustained the #2 on 08/08/13 at 2:22 PM d the incident report dated reported she assessed to the left side, she red a significant bruise reginning under the arm to not bruised around the continued to the hip bone. The stand lift straps due to the se and only occurring on the durse #2 reported Resident the bed by rolling onto the that was how the bruise	F 2	Administrator/DON will make the determination whether the come and submission with fax confirms the 24 hour report is necessary INDICATE HOW THE FACILITY PLANS MONITOR IT'S PERFORMANCE TO M. SURE THAT SOLUTIONS ARE SUSTATHE FACILITY MUST DEVELOP A PLANS DEVELOP A PLANS DEVELOP AND SUSTAINED. THE POC IS INTEGURED INTO THE QUALITY ASSURANCE SYSTOF THE FACILITY: Nurses are to turn in any Quality Assurance Event Reports to the Nurse Manager price and of their shift for review by the Nurse Manager. The Administrator/DON will determine if an investigation is to be initiated along with to NCHPR via 24 hour report. The Administrator/DON will direct the Nurse Monday to to initiate the investigation. In addition, Administrator/DON will review all Quality Assurance Event Reports daily Monday to the investigation. In addition, Administrator/DON will review all Quality Assurance Event Reports will be maintain month to include the type of injury, the cainjury, and whether a 24 hour report to the HCPR was completed if necessary. The log and the Quality Assurance Event Reports will be maintain month to include the type of injury, the cainjury, and whether a 24 hour report to the HCPR was completed if necessary. The log and the Quality Assurance Event Reports will be maintain month to include the type of injury, the cainjury, and whether a 24 hour report to the HCPR was completed if necessary. The log and the Quality Assurance Event Reports will be maintain month to include the type of injury, the cainjury, and whether a 24 hour report to the HCPR was completed if necessary. The log and the Quality Assurance Event Reports will be maintain month to include the type of injury, the cainjury, and whether a 24 hour report to the HCPR was	pletion mation of S TO AKE INED. AN FOR AN FOR IT'S RATED STEM nce or to the e notified idents of ity reported Manger through nieved A Quality ned by ause of se incident port will appliance nes and	

origin have to be reported to the DON as soon as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
OF CORRI	ECTION	345541	B. WING			C	
NAME O	F PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	08	3/08/2013	
ACCOUNTABLE EN				13825 HUNTON LANE			
OLDE I	(NOX COMMONS AT THE	E VILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078			
(X4) ID PRE FIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX CORRECTIVE ACTION SHOULD BE CRO		(X5) COMPLETION DATE	
F 226	it is a true injury of un investigation will be of 5 day report will be see Personnel Registry. Tinvestigation was to in medical record review interviews, medication skin integrity. The DON stated she indated 06/07/13 for Reshe assessed Reside it as very dark in color and in 2 parts on left sagreed with Nurse #4 by the strap on the sit stated she did not conincident because she of unknown origin. 483.20(d), 483.20(k)(*COMPREHENSIVE COMPREHENSIVE COMPREHENSIV	and Administrator conclude known origin an conducted and a 24 hour and ant to the Health Care he DON stated an include observations, and stated an include observations, and the residents are view, and the residents are view, and the residents are viewed the incident report is sident #51. She reported in the state of the state of the state of the state of the that the bruise and described to stand lift. The DON induct an investigation of the indid not feel it was an injury and the resident's of care. In DEVELOP ARE PLANS The same of the assessment of the resident's includes measurable to be to meet a resident's mental and psychosocial and in the comprehensive ascribe the services that are in or maintain the resident's sysical, mental, and	F 2	The QA Committee will be responsifiant that corrective action is achieved an The QA Committee will be responsifiant implementing new policies and procedures and/or systems if current policies and procedures and/or systems are identificated insufficient to maintain corrective actions. The QA Committee weekly, monthly, and quarterly. **Page 179** **ADDRESS HOW CORRECTIVE ACTIVE	d sustained ole for edures d tified as tion and e meets TION (S) HOSE EN RACTICE: and 8 when a program ent was begin On 08-26-13 or reflect to meet the tal and	09-05-13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES			OME				<u>0. 0938-0391</u>
STATEMEN DEFICIENC OF CORRE	CIES AND PLAN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345541	B. WING	B. WING		C 08/08/2013	
NAME OF	PROVIDER OR SUPPLIER			Τ.	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	00/2010
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OLDE K	NOX COMMONS AT THE	VILLAGES OF MECKLENBURG					
					HUNTERSVILLE, NC 28078		
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FIX TAG					DEFICIENCY)		
IAG					ADDRESS HOW CORRECTIVE ACTIO	NI VA/II I	
F	0	44	_		BE ACCOMPLISHED FOR THOSE	IA AAIPP	
279	Continued From page		F	279	RESIDENTS HAVING POTENTIAL TO	BE	
213		vices that would otherwise			AFFECTED BY THE SAME DEFICIENT		
		83.25 but are not provided			PRACTICE:	_	
		exercise of rights under					
		e right to refuse treatment			On 08-26-13 a revised system was initia		
	under §483.10(b)(4).				ensure all new admits and current reside		
					properly assessed to ensure that approp		
	This DECUMENT	to and and an extension			treatment and services to prevent urinar	TO	
		is not met as evidenced			infection and to restore as much normal		
	by:	ews and record review, the			function as possible are accomplished.	he	
					revised system was developed by the		
		op a care plan to maintain or nary incontinent episodes for			Administrator, DON, MDS Assessment I		
		nts who experienced an			For each resident the bladder baseline for		
8	The second of the commence of the second of	nt episodes (Resident #3).			will be established using 7 days of data		
	increase of incontinen	it episodes (Nesident #3).			MDSMax which tracks ADL and bowel a		
	The findings are:				bladder activity. The baseline data will be	e used	
	The infullys are.				to complete a Bowel and Bladder		
	Resident #3 was read	mitted to the facility on			Comprehensive Assessment for each re		
	03/21/13 with diagnos				by assessing Nurse. The Nurse complet	ng the	
	dementia.	No William Melada			Bowel And Bladder Comprehensive will		
					an appropriate individualized intervention	ı if	
	Review of a bowel and	d bladder comprehensive			necessary to help maintain established by		
		/21/13 revealed Resident #3			and help prevent functional decline. In-s	ervice	
	was able to follow inst	ructions and willing to			training for revised system will be comple		
	participate in a toiletin				09-05-13 for all nursing personal (CNA, I	₋PN,	
					and RN). In-services will be conducted b	y	
	Review of Resident #3	3's admission Minimum			ADON/DON.		
	Data Set (MDS) dated	I 03/27/13 revealed an					
	assessment of intact of	cognition. The MDS			ADDRESS WHAT MEASURES WILL B		
	indicated Resident #3	was occasionally			INTO PLACE OR SYSTEMIC CHANGE		
	incontinent of urine an	d required extensive			MADE TO ENSURE THAT THE DEFICI	ENI.	
	assistance with toileting	ng.			PRACTICE WILL NOT OCCUR:		
					On 08-26-13 a new system was put into	place to	
		ea Assessment (CAA)			track and monitor urinary continence for		
	dated 03/27/13 reveal				resident to ensure proper documentation	of	
		nt of bladder, required			urinary continence episodes which could	result	I
		with toileting, had a history			in a urinary continence decline. A new		
		ns and poor oral intake.			Continence Tracking Form was put into p	place to	
	The problem area of u	rinary incontinence would			record urinary continence.		

STATEMENT OF (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OF CORRECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	00/2010
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG			13825 HUNTON LANE HUNTERSVILLE, NC 28078			
ID (EACH DEFICIENCY MU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (E PREFIX CORRECTIVE ACTION SHOULD BE CRO TAG REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
F 279 Continued From page 12 proceed to care plan. Review of Resident #3's 06/13/13 revealed an assimpaired cognition. The #3 was frequently incont required extensive assist no toileting program. Review of Resident #3's revealed an identified preincontinency of urine, his infections and poor oral if goal was to exhibit no continence and signs a urinary tract infection. In monitoring for signs and infection, use of pull upsed dryness, document continents with Minimum II on 08/07/13 at 3:18 PM review with Minimum II on 08	s quarterly MDS dated seessment of severely MDS indicated Resident tinent of urine and stance with toileting with scare plan dated 06/13/13 roblem of frequent story of urinary tract intake. Resident #3's complications related to and symptoms of a neterventions included symptoms of an solviers to maintain inent/incontinent each Data Set (MDS) Nurse #1 revealed Resident #3's an evaluation of change continent episodes and ia. MDS Nurse #1 would be evaluated and ecame incontinent 100% or of Nursing (DON) on ealed she expected staff as specific to the resident	F	279	Recorded on the Continence Tracking For the urinary continence assessment per Maddition each subsequent MDS assessmurinary continence and function will be conto prior comprehensive urinary continence and function will be conto prior comprehensive urinary continence category. If change is noted in urinary contategory the MDS Nurse will notify the interdisciplinary team for appropriate interventions and actions will completed. The MDS Nurse is responsible to initiate Continence Tracking Form on all new and current residents. All Continence Tracking will be maintained in an alphabetical note the MDS office. The MDS Nurse completed by 09-05-13. DON is conjunction with the QA committer assessment. A Continence Tracking Form in conjunction assessment. A Continence Tracking Form in conjunction assessment. A Continence Tracking Form in conjunction assessment will be completed by 09-05-13. DON is conjunction with the QA committer appropriate interventions at the weekly Contebook which contains the Continence Tracking Forms for each resident that is maintained by the MDS Nurse's to ensure appropriate interventions are put into place appropr	MDS nent compared ce continent revention n to be the d g Forms chook in ing an each with an m on all The ee will A the ce TO AKE NED. N FOR AN OR ITS RATED	

STATEMENT OF DEFICIENCIES AND PLAN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ä	345541	B. WING _		08/08/2013	
NAME OF PROVIDER OR SUPPLIER OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078		
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F 315 SS= D	03/21/13 with diagnos dementia. Review of a bowel and	mitted to the facility on es which included d bladder comprehensive (21/13 revealed Resident #3 ructions and willing to g program. S's admission DS) dated 03/27/13 ent of intact cognition. esident #3 was nt of urine and	F 3	Utilizing the Continence Tracking Form to Nurse will monitor and log all urinary concategory declines. The logs will be taken QA Committee Meeting for review. The Continence Tracking Form will be review monthly at QA Committee meetings for to and tracking of urinary continence decling. The QA Committee will be responsible for implementing new policies and procedure and/or systems if current policies and procedures and/or systems are identified insufficient to maintain corrective action is sustain solution. • F315 ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOS RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACE Corrective action was accomplished and achieved for resident #3 on 08-26-13 whith the theorem in the incontinence program on 08-28-13. On 0 resident #3 care plan was updated to refich the continence program on 08-28-13. On 0 resident #3 care plan was updated to refich anges in incontinent episodes with measurable objective and timetable to more sidents medical, nursing, and mental apsychosocial as identified in subsequent assessments.	ntinent n to the wed rends ne. or res d as and N(S) E TICE: en a pram was in 8-26-13 lect res eet the nd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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345541		345541	B. WING _		08/08/2013	
NAME OF PROVIDER OR SUPPLIER OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078			
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	dated 03/27/13 revea occasionally incontine extensive assistance of urinary tract infection. The problem area of uproceed to care plan. Review of Resident # 06/13/13 revealed an impaired cognition. T #3 was frequently incorrequired extensive as no toileting program. Review of Resident #3 revealed an identified incontinency of urine, infections and poor or goal was to exhibit no incontinence and sign urinary tract infection. monitoring for signs a infection, use of pull undryness, document conshift and assess skin. Interview with Nurse A 2:30 PM revealed Resident #3 incontinence care was incontinence care w	rea Assessment (CAA) led Resident #3 was ent of bladder, required with toileting, had a history ons and poor oral intake. urinary incontinence would 3's quarterly MDS dated assessment of severely he MDS indicated Resident ontinent of urine and sistance with toileting with 3's care plan dated 06/13/13 problem of frequent history of urinary tract al intake. Resident #3's complications related to as and symptoms of a Interventions included and symptoms of an ps/briefs to maintain ontinent/incontinent each Aide (NA) #1 on 08/07/13 at sident #3 did not have a dule. NA #1 explained she every 2 hours to see if a required. NA #1 reported icy to check all incontinent	F3	ADDRESS HOW CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO MAFFECTED BY THE SAME DEFICIENT PRACTICE: On 08-26-13 a revised system was initiatensure all new admits and current reside properly assessed to ensure that approping treatment and services to prevent urinary infection and to restore as much normal by function as possible are accomplished. The revised system was developed by the Administrator, DON, MDS Assessment N For each resident the bladder baseline function will be established using 7 days of data from MDSMax which tracks ADL and bowel are bladder activity. The baseline data will be to complete a Bowel and Bladder Comprehensive Assessment for each resident and appropriate individualized intervention necessary to help maintain established by and help prevent functional decline. In-sectratining for revised system will be compled 09-05-13 for all nursing personal (CNA, Land RN). In-services will be conducted by ADON/DON. ADDRESS WHAT MEASURES WILL BE INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIE PRACTICE WILL NOT OCCUR:	ed to nts are riate riate riate riate riact cladder e urse. Inction rom ad used sident ng the nitiate if aseline ervice ted by PN,	

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F 315	revealed Resident #3 every 2 hours if needs toileting schedule. Interview with NA #2 revealed Resident #3 in order to receive inco Interview with Nurse # 08/07/13 at 2:53 PM r possible candidate for schedule but a consist assigned to Resident Resident #3 was inco the facility's regular 2 Interview with Nurse # revealed Resident #3 during the day shift up #3 explained Resident void. Nurse #3 report in his cooperation with Interview with the Dire at 3:33 PM revealed s	#1 on 08/07/13 at 2:41 PM received incontinence care ed and there was no specific on 08/07/13 at 2:48 PM was checked every 2 hours ontinent care. #2, unit manager, on evealed Resident #3 was a r a prompted toileting tent nurse aide was not # 3. Nurse #2 explained intinent of urine and was on hour check. #3 on 08/07/13 at 3:01 PM was "usually continent" on his readmission. Nurse t #3 required prompting to ed Resident #3 would vary in a prompted toileting. ector of Nursing on 08/07/13 he expected staff to assess ment episodes in order to	F3	315 t (On 08-26-13 a new system was put into track and monitor urinary continence for resident to ensure proper documentation urinary continence episodes which could in a urinary continence decline. A new Continence Tracking Form was put into precord urinary continence. Recorded on the Continence Tracking For the urinary continence assessment per Maddition each subsequent MDS assessment in prior comprehensive urinary continence and function will be continence to prior comprehensive urinary continence attegory. If change is noted in urinary contategory, If change is noted in urinary contategory the MDS Nurse will notify the interdisciplinary team for appropriate interested action. A update to resident care plan to reflect material action. A update to resident care plan to reflect materials and actions. A update to resident care plan to reflect materials action. A update to resident care plan to reflect materials and actions will be completed and action. A update to resident care plan to reflect materials and actions will be completed actions. A update to resident care plan to reflect materials and actions and actions will be completed actions. A update to resident care plan to reflect materials and actions and actions will be completed actions. A update to resident care plan to reflect materials and actions are put into place and actions.	every of result place to orm is fIDS nent ompared ce ontinent evention new ed. the d g Forms ebook in ing an each with an on all The ee will eA the	

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NAME OF PROVIDER OR SUPPLIER OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078	08/08/2013	
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F 315	Continued From page	9.16	F 318	INDICATE HOW THE FACILITY PLANS MONITOR IT'S PERFORMANCE TO M. SURE THAT SOLUTIONS ARE SUSTA THE FACILITY MUST DEVELOP A PLA ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PL MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED F EFFECTIVENESS. THE POC IS INTEGI INTO THE QUALITY ASSURANCE SYS OF THE FACILITY: Utilizing the Continence Tracking Form the Nurse will monitor and log all urinary concategory declines. The logs will be taken QA Committee Meeting for review. The Continence Tracking Form will be review monthly at QA Committee meetings for trand tracking of urinary continence declined tracking of urinary continence declined and/or systems if current policies and procedures and/or systems are identified insufficient to maintain corrective action a sustain solution.	AKE INED. IN FOR AN OR ITS RATED ITEM The MDS tinent to the ed ends e. r es as	