DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COMF	E SURVEY PLETED
		345541	B. WING				C /17/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	3825 HUNTON LANE		
	DX COMMONS AT THE V	ILLAGES OF MECKLENBURG		F	UNTERSVILLE, 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 201 SS=D	483.12(a)(2) REASOU TRANSFER/DISCHA The facility must perm the facility, and not tra resident from the facil discharge is necessar and the resident's near facility; The transfer or discha the resident's health h the resident no longer provided by the facilit The safety of individu endangered; The health of individu otherwise be endange The resident has faile appropriate notice, to under Medicare or Me For a resident who be after admission to a m facility may charge a charges under Medica The facility ceases to This REQUIREMENT by: Based on record revi	NS FOR RGE OF RESIDENT hit each resident to remain in ansfer or discharge the lity unless the transfer or ry for the resident's welfare eds cannot be met in the arge is appropriate because has improved sufficiently so r needs the services y; als in the facility is als in the facility would ered; d, after reasonable and pay for (or to have paid edicaid) a stay at the facility. ecomes eligible for Medicaid hursing facility, the nursing resident only allowable aid; or		201			5/8/15
	allow 1 of 3 sampled facility from an emerg (Resident #4).	residents to return to the lency department visit.	F		DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NO DOES IT CONSTITUTE AN ADMISSIO THAT ANY STATED DEFICIENCY IS TITLE		(X6) DATE

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

05/04/2015

PRINTED: 06/05/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE (CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
							С
		345541	B. WING		04/17/2015		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				13	825 HUNTON LANE		
OLDE KN	OX COMMONS AT THE	VILLAGES OF MECKLENBURG		нι	UNTERSVILLE, NC 28078		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, , , , , , , , , , , , , , , , , , ,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIC
F 201	Continued From page	e 1	F 2	01			
	The findings included				ACCURATE. WE ARE FILING THE PO	C	
					BECAUSE IT IS REQUIRED BY LAW.		
	Resident #4 was adn	nitted to the facility on					
		ses including conversion			ADDRESS HOW CORRECTIVE ACTION	NC	
	disorder, epilepsy, de	epression, neurogenic			(S) WILL BE ACCOMPLISHED FOR		
	bladder, muscle wea			THOSE RESIDENTS FOUND TO HAV	E		
		admitted for short term			BEEN AFFECTED BY THE DEFICIEN	Г	
	rehabilitation.				PRACTICE:		
					Resident # 4 was safely discharged hol		
		Set, a 5 day assessment			by the hospital Discharge Planner, who		
		d she was cognitively intact,			made a safe and coordinated discharge		
	-	5 on the brief interview for			the residents personal home with home health in place for continued convices	ne	
		MDS coded her with verbal on of care and requiring			health in place for continued services.		
		with bed mobility, transfers,			Per chart audits and interview of staff		
	and using a wheelch	-			(Administrator, DON, Medical Records)	no	
					other resident has ever been affected b		
	Nursing notes dated	03/25/14 for 3 PM to 11 PM			the alleged deficient practice.	.)	
		ansferred to a new room on					
	the first shift. She wa	as out of the facility until "hs"			ADDRESS HOW CORRECTIVE ACTION	NC	
	(hour of sleep). She	required 2 staff to assist to			WILL BE ACCOMPLISHED FOR THOS	SE	
	transfer and complain	ned of severe generalized			RESIDENTS HAVING POTENTIAL TO		
	pain for which she re	ceived medication with a			BE AFFECTED BY THE SAME		
	positive effect.				DEFICIENT PRACTICE:		
					The Administrator and DON have been		
	Nursing notes dated				reeducated in the proper understanding	g of	
		ide reported at 3:30 AM			the Regulations covering the Transfer,		
		er room very upset about			Discharge and Admission of Residents		
		resident told the nurse "my			Reeducation was conducted on 04-21- by the Vice President of the facility. Bo		
		om me out of spite because wasn't even saying hello to			voiced understanding and commitment		
		redirected her. Resident #4			upholding the regulations for all	.0	
		and then stated she was			transfers/discharges and admissions for	or	
		gina. The nurse noted "pink			residents as outlined in the regulations.		
		ue" that she used to wipe			An audit of all transfers/discharges since		
	-	athroom. The note went on			03-21-15 has been completed by the V		
		alled the police. As staff			President and President of the facility to		
		ont door she was yelling and			ensure that each transfer and/or		
	Chause	picked up at 4:10 AM and	1		discharge was completed in compliance		1

Facility ID: 990623

If continuation sheet Page 2 of 12

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345541	B. WING			
	ROVIDER OR SUPPLIER	010011		STREET ADDRESS, CITY, STATE, ZIP CODI		4/17/2015
	NOVIDER OR SOLT LIER			13825 HUNTON LANE	-	
OLDE KN	OX COMMONS AT THE	VILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078		
	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC DATE
F 201	Continued From pag	e 2	F 20	1		
		er her request. The note		with the regulations. No other	resident	
		an's group was notified and		has been found to be affected		
		member was notified. The		alleged deficient practice.	-	
	family stated they wo	ould call back with		All transfers/discharges will co		
	information.			reviewed by either the VP or F		
				an additional 60 days with all		
		nursing notes describing any		being reviewed. Then addition		
	further events in the			be conducted for the next 60 of	•	
	responders.	facility with the emergency		at least 10% of the weekly dis reviewed, then the next 90 da	-	
				quarter thereafter for a twelve		
	Social progress note	s dated 03/27/15 noted		period of time ending 05-01-1		
		eiving therapy and preferred		of the weekly discharges revie		
		her paperwork. This note		adherence to the regulations.		
	stated she planned to			Any deficient practice with fac	ility transfers	
	completion of therap	y and when she was		and/or discharges will be disc		
	medically stable.			the facility administrator, DON		
				Medical Director. Reeducatio		
		s dated 03/28/15 noted		where needed will be conduct		
		nsported to (a named)		administrator, DON and facilit	•	
	· · ·	ecided to discharge her back		ADDRESS WHAT MEASURE PUT INTO PLACE OR SYSTE		
	home.			CHANGES MADE TO ENSUE		
	On 04/13/15 at 1:26	PM the Director of Nursing		THE DEFICIENT PRACTICE		
		03/26/15 Resident #4 called		REOCCUR:		
		the night screaming that the		The Administrator and DON h	ave been	
		g care of her and she wanted		reeducated in the proper unde	erstanding of	
		the family had taken home		the Regulations covering the		
		e also complained of		Discharge and Admission of F		
		hich could not be verified		Reeducation was conducted of		
		ment. Resident #4 was		by the Vice President of the fa	•	
		bang on all the residents'		voiced understanding and con		
		sturbing other residents until onders picked her up and		upholding the regulations for a transfers/discharges and adm		
		e hospital. She stated the		residents as outlined in the re		
		in to the facility. DON further		An audit of all transfers/discha		
		nily arrived to obtain a		03-21-15 has been completed		
		Resident #4 back from the		President and President of the	•	
		ld the family that she could		ensure that each transfer and	-	

Facility ID: 990623

If continuation sheet Page 3 of 12

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	. ,	TE SURVEY MPLETED
			A. BUILDING	i		
		345541	B. WING			С
		343341				4/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 280	70	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETIO DATE
F 201	Continued From page	e 3	F 20	1		
		ey needed to find someplace		discharge was comp	pleted in compliance	
	else for her to go.			with the regulations.		
				has been found to be	e affected by the	
		PM a phone interview was		alleged deficient pra		
		ent #4 who stated she			ges will continue to be	
		was bleeding and could not			he VP or President for	
	screaming. She state	She denied yelling and		an additional 60 day	en additional audits will	
		to the hospital emergency			e next 60 days where	
		equest. Resident #4 stated			veekly discharges are	
		returned her to the facility			ext 90 days and every	
	and went in to obtain	a wheelchair to assist her		quarter thereafter for		
		old her family she could not			g 05-01-16 with 10%	h 10%
		nd had all her belonging		of the weekly discha	-	
		She stated she did not leave		adherence to the reg	-	
		lingly when she returned		and/or discharges w	e with facility transfers	
	from the emergency r	0011.		the facility administra		
	A telephone interview	on 04/13/15 at 5:06 PM		Medical Director. Re		
	with the family memb				e conducted with the	
	-	he facility on 03/26/15 from		administrator, DON	and facility staff.	
		tment revealed he was		INDICATE HOW TH	E FACILITY PLANS	
		ischarge and the facility			PERFORMANCE TO	
		police if the family did not		MAKE SURE THAT		
	leave the premises.					
	0n 04/14/15 at 8:46 /	AM the social worker (SW)		DEVELOP A PLAN I	N IS ACHIEVED AND	
		e stated that she was aware		SUSTAINED. THE		
		diagnosis of conversion			D THE CORRECTIVE	
		make sure all the admission		ACTION EVALUATE		
		wed and understood with		EFFECTIVENESS.	THE PoC IS	
		the family. She stated that		INTEGRATED INTO		
		a room change, went out		ASSURANCE SYST	EM OF THE	
		hen she returned she was		FACILITY:	ducted by the VD ar	
		ew room arrangements.		All of the audits cond President will be sub		
		sident got upset and called to the hospital. SW stated		Committee and revie		
	-	day when the resident tried		conformance with th		
	to return to the facility				linated and planned	

Facility ID: 990623

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-039 E SURVEY	
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED	
						С	
		345541	B. WING		04	04/17/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
				13825 HUNTON LANE			
OLDE KN	UX COMMONS AT THE	VILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		N OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	COMPLETIO DATE	
F 201	Continued From pag	e 4	F 20	01			
				discharge for all reside			
		iewed again on 04/14/15 at		The QA Committee wil			
		stated that the third shift		systemic changes to er			
		r her when she arrived for inform her of the events		progress towards imple			
		ning hours involving Resident		corrective action(s) and performance, to ensure	-		
		ty and calling 911. DON		performance is achieve			
		othing regarding this incident		The QA Committee will			
		old about it. Then around 10		facility⊡s progress mor			
		amily returned to the facility		effectiveness and revis			
		air to help her back in the		measures as necessar	•		
	facility. DON stated	she did not see the resident		corrective action is inte	grated and the		
		at the facility could not meet		system is sustained or			
		because residents and		to achieve and maintain	n corrective		
		ned that Resident #4 had		solutions.			
		uring the night. DON stated					
		n't want to be at the facility Is day when she expressed					
		e against medical advice,					
		me and that was what the					
		ould work towards. She					
		nily was not polite and called					
		ally DON threatened to call					
		d not leave the premises.					
		he had not spoken to the					
		ent regarding what was done					
		had not spoken with her					
		d that she informed the events but made the decision					
		ke Resident #4 back into the					
		that after the incident with					
	-	ed a call from the local					
	-	lent #4 showed up in the					
		ent. DON explained her					
		ng to readmit her and the					
	circumstances that o	ccurred during the night.					
	-	hey would see what they					
	could do and the hos	pital made arrangements for					
	Resident #4 to return						

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. (PPROVED
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SU COMPLE	
		345541	B. WING		C 04/17	/2015
	ROVIDER OR SUPPLIER	/ILLAGES OF MECKLENBURG	1382	EET ADDRESS, CITY, STATE, ZIP CODE 25 HUNTON LANE NTERSVILLE, NC 28078		12010
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 201	Continued From page	9 5	F 201			
F 204 SS=D	DON informed him of of the facility. He stat had the responsibility after the emergency r only one in authority find not permitted to return Administrator stated to that the hospital had arrangements for Res home with services in Further interview with 12:35 PM revealed D #4 called the police of facility, she was effect medical advice. The medical record d documentation to sup medical advice. 483.12(a)(7) PREPAR SAFE/ORDERLY TR/ A facility must provide orientation to residem and orderly transfer of In the case of facility the administrator of th written notification pri to the State Survey A ombudsman, residem legal representatives responsible parties, a	 Administrator stated the the events but he was out ted he knew that the facility to take Resident #4 back room visit and he was the to decide if a resident was in to the facility. That his understanding was made home care sident #4 and she went to place. The DON on 04/14/15 at ON thought when Resident in her own to leave the tively signing herself against TRATION FOR ANSFER/DISCHRG E sufficient preparation and ts to ensure safe or discharge from the facility. 	F 204		5/	(8/15

Facility ID: 990623

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CENTER STATEMENT (AND PLAN OF NAME OF PI	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345541	A. BUILDING B. WING S	CONSTRUCTION	FORM OMB NO (X3) DATE COMPI	LETED
		ILLAGES OF MECKLENBORG	н	UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 204	by: Based on record revi interview, resident interview, resident interview, the safe and orderly disch residents. Resident # facility door when she an emergency departs The finding included: Resident #4 was adm 03/21/15 with diagnost disorder, epilepsy, de bladder, muscle weak colostomy. She was rehabilitation. The Minimum Data Se dated 03/25/15, noted scoring a 14 out of 15 mental status. This M behaviors and rejection extensive assistance and using a wheelchat Nursing notes dated 00 noted Resident #4 tra the first shift. She was (hour of sleep). She re transfer and complain pain for which she rece positive effect.	5(r). is not met as evidenced ew, staff interview, family erview and hospital he facility failed to provide a harge for 1 of 3 sampled 44 was turned away at the returned with family from ment visit. itted to the facility on ses including conversion pression, neurogenic mess and a new status post admitted for short term et, a 5 day assessment a she was cognitively intact, on the brief interview for IDS coded her with verbal on of care and requiring with bed mobility, transfers, ir for locomotion. 03/25/14 for 3 PM to 11 PM nsferred to a new room on s out of the facility until "hs" required 2 staff to assist to red of severe generalized perved medication with a	F 204	ADDRESS HOW CORRECTIVE ACTI (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAV BEEN AFFECTED BY THE DEFICIEN PRACTICE: Resident # 4 was safely discharged ho by the hospital Discharge Planner, who made a safe and coordinated discharg the residents □ personal home with hor health in place for continued services. Per chart audits and interview of staff (Administrator, DON, Medical Records other resident has ever been affected to the alleged deficient practice. ADDRESS WHAT MEASURES WILL E PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NO REOCCUR: The Administrator and DON have been reeducated in the proper understanding the Regulations covering the Transfer, Discharge and Admission of Residents Reeducation was conducted on 04-21- by the Vice President of the facility. Bo voiced understanding and commitment upholding the regulations for all transfers/discharges and admissions for residents as outlined in the regulations An audit of all transfers/discharges sind 03-21-15 has been completed by the V President and President of the facility to ensure that each transfer and/or	E T me e to me) no Dy BE T g of 15 oth to pr ce vice	

Facility ID: 990623

If continuation sheet Page 7 of 12

						O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			E SURVEY IPLETED
			A BOILDING			С
		345541	B. WING		04	4/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				13825 HUNTON LANE		
		VILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 204	Continued From pag	e 7	F 20)4		
		ner room very upset about	1 20	discharge was complete	ed in compliance	
		resident told the nurse "my		with the regulations. No		
		om me out of spite because		has been found to be at		
		wasn't even saying hello to		alleged deficient practic		
		redirected her. Resident #4		All transfers/discharges		
		and then stated she was gina. The nurse noted "pink		reviewed by either the an additional 60 days w		
		ue" that she used to wipe		being reviewed. Then a		
	•	pathroom. The note went on		be conducted for the ne		
	to say the resident c	alled the police. As staff		at least 10% of the wee	-	
		ont door she was yelling and		reviewed, then the next		
	-	s picked up at 4:10 AM and		quarter thereafter for a		
		er her request. The note an's group was notified and		period of time ending 05 of the weekly discharge		
		member was notified. The		adherence to the regula		
	family stated they we			Any deficient practice w		
	information.			and/or discharges will b		
				the facility administrator		
		nursing notes describing any		Medical Director. Reed		
	further events in the			where needed will be co		
	responders.	facility with the emergency		administrator, DON and ADDRESS WHAT MEA		
				PUT INTO PLACE OR		
	Social progress note	s dated 03/27/15 noted		CHANGES MADE TO E		
	Resident #4 was rec	eiving therapy and preferred		THE DEFICIENT PRAC	TICE WILL NOT	
		her paperwork. this note		REOCCUR:		
	stated she planned t			The Administrator and [
	completion of therap medically stable.	y and when she was		reeducated in the prope the Regulations coverin		
	medically stable.			Discharge and Admission	-	
	Social progress note	s dated 03/28/15 noted		Reeducation was condu		
	Resident #4 was trai	nsported to (a named)		by the Vice President of		
		ecided to discharge her back		voiced understanding a		
	home.			upholding the regulation		
	On 04/13/15 at 1.26	PM the Director of Nursing		transfers/discharges an residents as outlined in		
		PM the Director of Nursing 03/26/15 Resident #4 called		An audit of all transfers/		
		the night screaming that the		03-21-15 has been com	-	
		g care of her and she wanted		President and Presiden		

Event ID: 25UP11

Facility ID: 990623

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<u>CENTE</u> R	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0	938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SUI COMPLET		
		345541	B. WING		C	C 04/17/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		2015	
				13825 HUNTON LANE			
OLDE KN	OX COMMONS AT THE V	/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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE CONTRACTION SHOULD BE CONTRACT	(X5) OMPLETIC DATE	
F 204		- 8	E 20				
F 204	earlier in the day. She bleeding profusely wi upon nursing assess noted to scream and doors in the halls, dis the emergency respo transported her to the resident did not return stated that when fam wheelchair to bring R hospital, the DON tol- not return and that th else for her to go. On 04/13/15 at 4:43 H conducted with Resid called 911 when she get staff to help her. screaming. She state responders took her f department per her re that when her family and went in to obtain out of the car, DON to return to the facility a packed up already. S the nursing facility wi from the emergency for A telephone interview with the family memb Resident #4 back to to the emergency depart	he family had taken home e also complained of hich could not be verified ment. Resident #4 was bang on all the residents' sturbing other residents until orders picked her up and e hospital. She stated the in to the facility. DON further ily arrived to obtain a resident #4 back from the d the family that she could ey needed to find someplace PM a phone interview was dent #4 who stated she was bleeding and could not She denied yelling and ed the emergency to the hospital emergency equest. Resident #4 stated returned her to the facility a wheelchair to assist her old her family she could not nd had all her belonging She stated she did not leave llingly when she returned room.	F 20	ensure that each transfer discharge was completed with the regulations. No has been found to be affe alleged deficient practice All transfers/discharges v reviewed by either the VF an additional 60 days wit being reviewed. Then ad be conducted for the nex at least 10% of the week reviewed, then the next 9 quarter thereafter for a tw period of time ending 05- of the weekly discharges adherence to the regulati Any deficient practice wit and/or discharges will be the facility administrator, Medical Director. Reedu where needed will be cor administrator, DON and f INDICATE HOW THE FA TO MONITOR IT□S PEF MAKE SURE THAT SOL SUSTAINED. THE FACI DEVELOP A PLAN FOR THAT CORRECTION IS SUSTAINED. THE PLAN IMPLEMENTED AND TH ACTION EVALUATED FO EFFECTIVENESS. THE INTEGRATED INTO THE ASSURANCE SYSTEM FACILITY:	d in compliance other resident ected by the will continue to be P or President for h all records ditional audits will t 60 days where by discharges are 00 days and every welve month 01-16 with 10% reviewed for ions. h facility transfers discussed with DON and cation if and nducted with the facility staff. CILITY PLANS RFORMANCE TO UTIONS ARE LITY MUST ENSURING ACHIEVED AND N MUST BE IE CORRECTIVE OR ITS POC IS E QUALITY		
	leave the premises.	Police if the family did not AM the social worker (SW)		All of the audits conducte President will be submitte Committee and reviewed conformance with the reg	ed to the QA I in QA for		

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE (CONSTRUCTION		10. 0938-03 FE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,				MPLETED
						С	
		345541	B. WING			0	4/17/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE	VILLAGES OF MECKLENBURG			825 HUNTON LANE UNTERSVILLE, NC 28078		
					,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 204	Continued From pag	e 9	F 20	04			
		e stated that she was aware		•	ensure a safe, coordinated and plann	ed	
		diagnosis of conversion			discharge for all residents.		
		make sure all the admission			The QA Committee will review the		
	paperwork was revie			systemic changes to ensure the facilit	y⊡s		
	both the resident and			progress towards implementation of			
		a room change, went out			corrective action(s) and the facility s		
	-	hen she returned she was			performance, to ensure that corrective		
		new room arrangements.			performance is achieved and sustaine	ed.	
		sident got upset and called to the hospital. SW stated			The QA Committee will review the facility s progress monthly for		
		day when the resident tried			effectiveness and revise or develop n	2/4/	
	to return to the facility	-			measures as necessary to ensure that		
		·			corrective action is integrated and the		
	The DON was intervi			system is sustained or revised as nee			
		stated that the third shift			to achieve and maintain corrective		
		r her when she arrived for			solutions.		
		inform her of the events					
		ning hours involving Resident					
		lity and calling 911. DON					
		othing regarding this incident					
		old about it. Then around 10					
		amily returned to the facility air to help her back in the					
	-	she did not see the resident					
		at the facility could not meet					
	-	because residents and					
		ned that Resident #4 had					
		uring the night. DON stated					
		I't want to be at the facility					
		is day when she expressed					
	•	e against medical advice,					
		me and that was what the					
		ould work towards. She hily was not polite and called					
		ally DON threatened to call					
		d not leave the premises.					
		he had not spoken to the					
		ent regarding what was done					
		had not spoken with her					

ID HUMAN SERVICES			FOF	ED: 06/05/2015 RM APPROVED IO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	E SURVEY IPLETED
345541	B. WING		C 04/17/2015	
•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
		13825 HUNTON LANE		
ILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078		
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	I SHOULD BE	(X5) COMPLETION DATE
e 10 d that she informed the events but made the decision e Resident #4 back into the that after the incident with ed a call from the local ent #4 showed up in the ent. DON explained her ng to readmit her and the ccurred during the night. hey would see what they pital made arrangements for home. PM a telephone interview hospital staff #1 from a local department (Hospital #1). d Resident #4 was seen at n on 03/26/15 after having ssion to the nursing facility aviors after the resident amily subsequently took her v was conducted on 04/15/15 ital staff #2 from a different al #2). Hospital staff #2 ent #4 came to the ent from the nursing facility self called 911 on 03/26/15. ed Resident #4 left the department around 10 AM lans to return to the nursing ne hospital notes revealed no scharge back to the nursing med Resident #4 returned to n Hospital #1 was v15 at 1:32 PM via	F 204			
	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345541 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 4 10 4 that she informed the events but made the decision e Resident #4 back into the that after the incident with ed a call from the local ent #4 showed up in the nt. DON explained her ng to readmit her and the courred during the night. Here would see what they pital made arrangements for home. PM a telephone interview hospital staff #1 from a local lepartment (Hospital #1). d Resident #4 was seen at n on 03/26/15 after having ssion to the nursing facility aviors after the resident amily subsequently took her was conducted on 04/15/15 ital staff #2 from a different al #2). Hospital staff #2 ent #4 came to the nt from the nursing facility self called 911 on 03/26/15. ed Resident #4 left the lepartment around 10 AM lans to return to the nursing ned Resident #4 returned to Hospital #1 was	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING 345541 B. WING MILLAGES OF MECKLENBURG ID ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ID ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ID ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ID ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ID ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ID ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ID ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCI DENTIFYING INFORMATION) ID ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCI DENTIFYING INFORMATION) IF 204 A table the incident with that after the incident with that after the incident with the spital staff #1 from a local lepartment (Hospital #1). F 204 PM a telephone interview tospital staff #1 from a local lepartment (Hospital #1). ID M A telephone interview tospital staff #2 from a different al al #2). Hospital staff #2 ent #4 came to the nt from the nursing facility self called 911 on 03/26/15. ID Was conducted on 04/15/15 tatal staff #2 from a different al #2). Hospital staff #2 ent #4 came to the nursing ned Residen	MEDICAID SERVICES (x1) PROVIDERSUPPLER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 345541 B. WING mLLAGES OF MECKLENBURG STREET ADDRESS, CITY, STATE, ZIP COD 13825 HUNTON LANE HUNTERSVILLE, NC 28078 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) PREFIX PREFIX CROSS-REFERENCED TO Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) PREFIX TAG P10 F 204 # 10 <	DI HUMAN SERVICES FOR MEDICAID SERVICES OMB N MEDICAID SERVICES OMB N a BUILDING A BUILDING a BUILDING (x) MULTIFLE CONSTRUCTION a BUILDING A BUILDING atstaft Hange (x) PROVIDERSUPPLERCIA atstaft Hange STREET ADDRESS, CITY, STATE, ZIP CODE tasts HUNTON LANE HUNTERSVILLE, NC 28078 MULTAGES OF MECKLENBURG ID PREFIX PROVIDERS PLAN OF CORRECTION CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCIES ID YMUST BE PRECEDED BY FULL TAG SC IDENTIFYING INFORMATION) TAG at 10 F 204 at the informed the F 204 at the incident with add the decision enterview F 204 at a call from the local ent #4 back into the that after the incident with add a call from the local ent #4 showed up in the int. DON explained her and the scurred during the night. regortment (Locspital #1). d Resident #4 was seen at in on 0.02/6/15 after having solito the nursing facility aviors after the resident anily subsequently took her was conducted on 04/15/15 was conducted on 04/15/15 at all staff #2 from a different al #2). Hospital staff #2 from a different ensing facility self called 911 on 03/26/15. bid Resident #4 teft the expartment rarend to HAM ans to return to the nursing head Resident #4 returned to<

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PRINTED: 06/05/2015

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/05/2015 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345541	B. WING				C 17/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG		-	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 204	Hospital #2 emergence Resident #4 returned family transportation. to take her back. Fam #3 that family took the skilled nursing facility admitted but that nurs family to return to a h subsequently then sh emergency departme staff #3 called the fac previous events invol- herself and the facility when family brought h stated that she subse for Resident #4 to retu- services since she wa admission to the hosp	the emergency responders to by department. From there to the nursing facility with The nursing facility refused hily reported to hospital staff e resident to another local and tried to get her sing facility instructed the ospital. The family owed up at Hospital #1's nt. At that time, hospital ility and was told of the ving the resident calling 911 v not wanting to readmit her her back. Hospital staff #3 quently made arrangements urn home with home care	F	204			

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