PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345541	B. WING _			11/20/2015	_
	ROVIDER OR SUPPLIER OX COMMONS AT THE	VILLAGES OF MECKLENBURG		STREET ADDRESS, CITY, STATE, ZIP CODI 13825 HUNTON LANE HUNTERSVILLE, NC 28078	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		N
F 323 SS=D	HAZARDS/SUPERV The facility must ensenvironment remains as is possible; and e	ISION/DEVICES	F3	323		12/18/15	
	by: Based on observation medical record revies implement a bed/chasorder for a resident was residents reviewed was (Resident #100) The findings included Resident #100 was a 05/16/12. Diagnoses falls, dementia with bosteoarthritis. A fall risk assessment Resident #100 with a for falls) due to intemproblems while walk (antidepressant), a hard predisposing diagnost. A physician's order of Resident #100 would	d: admitted to the facility on a included personal history of pehaviors, depression, and at dated 02/06/15 assessed a total score of 10 (high risk mittent confusion, balance ing, medication istory of falls and ses (dementia). Jated 08/09/15 recorded that d have a bed and chair alarm ms would be checked for		THIS FACILITY S RESPON REPORT OF SURVEY DOES DENOTE AGREEMENT WITH STATEMENT OF DEFICIENCE DOES IT CONSTITUTE AN A THAT ANY STATED DEFICIE ACCURATE. WE ARE FILING BECAUSE IT IS REQUIRED IN F323 483.25(h) Free Of ACCURATE ACCURAT	S NOT H THE CIES; NOR DMISSIO NCY IS G THE PC BY LAW. cident VE ACTIC D FOR D TO HAVE EFICIENT ed alarm in ss howeve the Safet current The bed and new nto place. I on a	N OC ON E	
	·			The resident has been placed toileting program, a anti-skid r	l on a		
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE		(X6) DATE	

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

Electronically Signed 12/17/2015

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.

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		345541	B. WING			C
		343341	D. WING_		I	11/20/2015
	ROVIDER OR SUPPLIER OX COMMONS AT THE	VILLAGES OF MECKLENBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078		
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F 323	10/28/15, assessed cognition, required sidue to unsteady balawalking, use of a was sustained 2 falls with assessment. A care plan updated Resident #100 was a use of an antideprese Interventions include ambulation and use shuffled gait at times all transfers, and be staff to check each side Review of nurse's not revealed Resident # falls with no indication in place at the time of 10/20/15, Resident # her room by staff at position and bed rail fell while trying to ge walker, she lost her sit on her bed; she sassessed without inj request assistance of walker and fell. She hand, left wrist and I negative for a fracture.	n data set assessment dated Resident #100 with impaired supervision with ambulation ance with transitions and sliker for ambulation and nout injury since the last on 10/28/15 identified at risk for falls due to daily ssant and unsteady gait. ed stand by assistant with of a rolling walker due to s, call bell in reach, assist with d/chair alarms at all times, shift. otes and incident reports 100 sustained the following on that a bed/chair alarm was of the fall: #100 was found on the floor in 2 PM. Her bed was in a low s were down. Resident #100 et in bed, using a rollator balance while ambulating to slid to floor. She was ury. She was reminded to	F3	been placed at her bedside to puresident's feet from sliding when attempting to get out of bed. The will be assisted to bed after lunch before dinner as determined by patterns of getting in and out of land DRESS HOW CORRECTIVE WILL BE ACCOMPLISHED FOR RESIDENTS HAVING POTENT BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The DON, and Designee review residents physician's orders to eall resident's with personal alarm other interventions are in place appropriate. A QA Form that has resident's name, if they had a proder, if the resident had a order the personal alarm or intervention was used and they signed off on There were no discrepancies for between the physician's orders a interventions. All devices were in and in working order. In the future to ensure that all alin place and in working order. In the future to ensure that all alin place and in working order. In the future to ensure that all alin place and in working order. In the future to ensure that all alin place and in working order the will utilize a "alarm clock sticker be added to the already existing communication system/device of outside of the resident's room to who has a personal body alarm. resident and family members notified of this symbol communic system/device upon admission that facility. Consent from the resident member is obtained at admission	e resident h and her bed. E ACTION R THOSE IAL TO ed all ensure that has and and and the hysician's then was on in place the form. und and the n place arms are e facility " that will symbol n the indicate All are cation o the nt/family	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION		E SURVEY MPLETED
		345541	B. WING		1.	C 1/ 20/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/20/2013
				13825 HUNTON LANE		
OLDE KN	OX COMMONS AT THE	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 OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	e 2	F 32	23		
	Resident #100 was of at 9:51 AM, 11/19/15 2:25 PM with the ala	observed in bed on 11/19/15 at 11:33 AM and 11/19/15 at rm cord for a personal bed oor, detached from the alarm		consent document is kept in the admission file. They will condurounds on a daily basis for one weekly basis for one (1) month monthly for three (3) months by the housekeeping staff. The	ct QA (1) month, and	
	on 11/19/2015 at 2:2 interview that she wa #100. NA #1 stated F			housekeeping staff will be in-so the DON and Nurse Manager to December 18, 2015 on how to who has a personal alarm and	oy recognize if it is in	
	to the bathroom usin transferred herself in toilet. NA #1 stated s	eting, routinely took herself g a rollator walker and /out of bed and on/off the the rounded on Resident		working order as well as who to the alarm is not in place or app be working properly. The Nurs will be responsible to secure a	pears to not sing staff new alarm	
	Resident had been be that day during the 7 stated that Resident	shift and was aware that the back/forth to the bathroom AM - 3PM shift. NA #1 #100 should be supervised her high risk for falls so that		and put it into place. The House staff will document on their dail assignment sheets that they observed personal body alarm and it was order.	ly oserved the	
	staff could remind he During the interview, observed in bed with from the alarm box a	er to use her rollator walker. Resident #100 was the alarm cord detached and hanging on the floor. NA		In addition the Nursing staff wil in-serviced by December 18, 2 proper placement and function all alarming devices and where	015 on checks on	
	#1 stated the alarm cord should have been attached to the alarm box, she tried to remember to check the alarm when she rounded on Resident #100, but she did not realize the cord was not attached. NA #1 further stated that the		to replace an alarm that is not properly. This will include the Communication Notebook whickept at each Nurses' station the	functioning use of a ch will be at will be		
	the reason the alarm the alarm box.	l was broken and could be cord did not fit securely into		updated by the Medical Record weekly and Nurse Managers a that includes all residents who alarms. The Nursing staff will I	s needed have be	
	AM with the nurse su supervisor stated sho aides to round on the throughout the shift t	e expected nurses and nurse eir assigned residents o ensure alarms were in		responsible to review this combook each shift to determine versidents have assistive devices. Nurses will document on all response alarming devices on their	vhich es. All sidents who Treatment	
	-	pervisor stated that if the clip s broken causing the alarm		Administration Record (TAR) e	-	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	
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		345541	B. WING _				20/2015
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		## L A OFO OF MEOK! ENDUDO		13	3825 HUNTON LANE		
OLDE KNO	DX COMMONS AT THE	VILLAGES OF MECKLENBURG		Н	UNTERSVILLE, NC 28078		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 3	F;	323			
		hed to the alarm box, the			functional. The Housekeeping		
	cord should be replace				Supervisor and/or Maintenance Director	or	
					will be responsible to do a QA on a wee		
	An interview occurred	d on 11/20/15 at 11:59 AM			basis for three (3) months to ensure that		
	with NA #2 and revea	aled she typically worked with			all personal body alarms are in place a		
	Resident #100 on the	e 3PM - 11PM shift. NA #2			in working order. They will document the	nis	
	stated that Resident	#100 ambulated to the			on a QA Form that indicates the above		
		ntly, but at times required			information. The form will be given to t		
	-	eting. NA #2 stated she was			QA Committee on a weekly basis who	will	
	•	Resident #100 when she fell			review to determine if interventions in		
		#2 stated Resident #100			place are appropriate and effective.		
	~	om, forgot her walker and e was not in the room when			ADDRESS WHAT MEASURES WILL E		
		ut NA #2 saw Resident #100			PUT INTO PLACE OR SYSTEMIC) <u> </u>	
		om and told the nurse. NA #2			CHANGES MADE TO ENSURE THAT		
		ware if Resident #100 had			THE DEFICIENT PRACTICE WILL NO	т	
	an alarm. NA #2 state	ed she did not check			REOCCUR:		
	placement for an alar	rm on Resident #100 during					
	the shift when the Re	esident fell because the			In the future to ensure that all alarms a	re	
		hecked to make sure alarms			in place and in working order the facility	/	
	•	orking. NA #2 stated that			will utilize a "alarm clock sticker" that w		
		ambulated in her room with			be added to the already existing symbo	ol	
		k and forth to the bathroom			communication system/device on the		
		for an alarm during the day,			outside of the resident's room to indica	te	
		an alarm before the Resident			who has a personal body alarm. All		
		the Resident could take			resident □s and family members are		
	herself to the bathroo	on during the day.			notified of this symbol communication system/device upon admission to the		
	An interview occurred	d with nurse #1 on 11/19/15			facility. Consent from the resident/famil	v	
		I stated Resident #100 was			member is obtained at admission and	,	
		ue to her non-compliance			consent document is kept in the resider	nt	
	•	ance, unsteady gait, shuffling			admission file. They will conduct QA		
	~	ating, impaired cognition and			rounds on a daily basis for one (1) mon	th,	
	-	#1 stated he rounded on			weekly basis for one (1) month and		
		norning (11/19/15) at 8:30			monthly for three (3) months by utilizing	9	
		m was intact. Nurse #1			the housekeeping staff. The		
		the Resident each shift for			housekeeping staff will be in-serviced by	y	
	•	alarm, but Resident #100			the DON and Nurse Manager by		
	had a history of playi	ng with cords and he was not			December 18, 2015 on how to recognize	ze	

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NAME OF D	ROVIDER OR SUPPLIER	343341	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE		11/20/2015
		VILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078		
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F 323	while she was in bed that when Resident staff member inform not know if an alarm the time of the fall be not indicate the statu. An interview was con PM with the director stated that when a faresponsible for compassessment of the renurse's progress not family/physician. The report and the nurse administrative staff of implemented any fur try and prevent furth did not require nurse alarm at the time of whether or not the alarm to be used staff monitoring to enter the staff of the alarm to be used staff monitoring to enter the staff monitoring to enter the staff member information.	alarm had not been in place of that day. Nurse #1 stated #100 fell in October 2015, a ged him of the fall, but he did was in place and sounded at ecause his nurse's note did us of the alarm. Inducted on 11/20/15 at 3:29 of nursing (DON). The DON fall occurred, the nurse was coleting a head to toe esident, an incident report, a fee and contacting the ed DON reviewed the incident reports are and contacting the fall and ther interventions needed to the falls. The DON stated she are to document the use of an a fall and could not say larm was in use for Resident in October/November 2015. It Resident #100 had a an alarm and she expected an alarm and she expected a staff monitoring residents for	F3	<u> </u>	o report to pears to no pears	ot no lee ng e

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	ROVIDER OR SUPPLIER OX COMMONS AT THE	VILLAGES OF MECKLENBURG	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078		11/20/2015
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F 323	Continued From page	e 5	F 32	SUSTAINED. THE FACILITY DEVELOP A PLAN FOR ENSUTHAT CORRECTION IS ACHI SUSTAINED. THE PLAN MUSTIMPLEMENTED AND THE COACTION EVALUATED FOR IT EFFECTIVENESS. THE POCINTEGRATED INTO THE QUAASSURANCE SYSTEM OF THE FACILITY: In the future to ensure that all in place and in working order the will utilize a "alarm clock stick be added to the already existing communication system/device outside of the resident's room who has a personal body alarm resident and family member notified of this symbol communication system/device upon admission facility. Consent from the resident and monthly conducted and adaily basis for month, weekly basis for one (1) and monthly for three (3) month utilizing the housekeeping staff Nursing staff will be responsible this communication book each determine which residents have devices. The CNA's will be resign a log stating they have recommunication book every she nurses will document on all recommunication and it is have alarming devices on their Administration Record (TAR) ethat devices were properly plant.	URING EVED AND ST BE DRRECTIVE TS IS ALITY HE alarms are the facility er" that will ng symbol to on the to indicate m. All rs are nication n to the dent/family tion and ne resident be one (1) 1) month ths by ff. The le to review n shift to ye assistive sponsible to viewed the nift. All ssidents who r Treatment every shift	

AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520 2 SS=D		ERS/MEET	F 32	functional. The Housekeeping Supervisand/or Maintenance Director will be responsible to do a QA round on a wee basis for three (3) months to ensure thall personal body alarms are in place as in working order. They will document to on a QA Form that indicates the above information. The form will be given to a Administrator who will present the information to the QA Committee on a weekly basis. The QA Committee will review the information to determine if interventions in place are appropriate a effective. If not then new interventions be determined and implemented at that time. The QA Committee will review the systemic changes to ensure the facility progress towards implementation of corrective action(s) and the facility performance, to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility progress monthly for effectiveness and revise or develop ne measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as need to achieve and maintain corrective solutions.	ekly at nd his the and will t

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345541	B. WING		1	C / 20/2015	
	ROVIDER OR SUPPLIER	VILLAGES OF MECKLENBURG		STREET ADDRESS, CITY, STATE, ZIP COD 13825 HUNTON LANE HUNTERSVILLE, NC 28078		111/20/2013	
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F 520	Continued From pag	e 7	F 52	20			
		hysician designated by the 3 other members of the					
	issues with respect to and assurance activities develops and implementation to correct ider	least quarterly to identify to which quality assessment ties are necessary; and nents appropriate plans of utified quality deficiencies.					
	disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.						
		by the committee to identify eficiencies will not be used as					
	by: Based on observation medical record review Assessment and Assimaintain implemented these interventions the in April of 2015. This deficiency which was 2015 on a complaint subsequently recited current recertification in the area of accide the facility during a cand a recent recertification.	s originally cited in March of investigation survey and in November 2015 on a survey. The deficiency was nts. The continued failure of omplaint investigation survey cation survey shows a s inability to sustain an		THIS FACILITY S RESPON REPORT OF SURVEY DOES DENOTE AGREEMENT WIT STATEMENT OF DEFICIENCE DOES IT CONSTITUTE AN A THAT ANY STATED DEFICIE ACCURATE. WE ARE FILIN BECAUSE IT IS REQUIRED F520 483.75 (o)(1) QAA COMED CONTENT Members/Meet Quarterly/Pla ADDRESS HOW CORRECT (S) WILL BE ACCOMPLISHE THOSE RESIDENTS FOUND BEEN AFFECTED BY THE D	S NOT H THE CIES; NOR ADMISSION ENCY IS G THE POC BY LAW. ommittee - ns IVE ACTION ED FOR D TO HAVE		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345541	B. WING _			11/3	20/2015
	ROVIDER OR SUPPLIER OX COMMONS AT THE	VILLAGES OF MECKLENBURG		138	REET ADDRESS, CITY, STATE, ZIP CODE 825 HUNTON LANE JNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	interviews and medifailed to implement a physician's order for sampled residents re (Resident #100) The facility was origithe March 2015 comfailing to implement at risk for falls that for femur for 1 of 3 same An interview with the 5:45 pm revealed the the area of accident communication between the stated he would Director of Nursing to	erenced to: Based on observations, staff cal record review the facility a bed/chair alarm per a resident who fell for 1 of 3 eviewed with a history of falls. Inally cited for F 323 during aplaint investigation survey for fall precautions for a resident tell and sustained a fractured apled residents. (Resident #1) The administrator on 11/20/15 at at he attributed a recitation in	F5	520	PRACTICE: Resident #100 did have an bed alarm place during the survey process however she has been re-evaluated by the Safe Committee to determine if the current intervention/s are appropriate. The bed alarm pad has been removed and new interventions have been put into place. The resident has been placed on a toileting program, a anti-skid mat has been placed at her bedside to prevent resident's feet from sliding when attempting to get out of bed. The resid will be assisted to bed after lunch and before dinner as determined by her patterns of getting in and out of bed. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOS RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The DON, and Designee reviewed all residents physician's orders to ensure all resident's with personal alarms and other interventions are in place and appropriate. A QA Form that has the resident's name, if they had a physician order, if the resident had a order then we the personal alarm or intervention in place was used and they signed off on the form there were no discrepancies found between the physician's orders and the interventions. All devices were in place and in working order. In the future to ensure that all alarms a	er tty d ent ON SE that	

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		345541	B. WING _		11/2	20/2015
	ROVIDER OR SUPPLIER OX COMMONS AT THE	VILLAGES OF MECKLENBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078	,	
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F 520	Continued From pag	e 9	F 5	in place and in working order the facilit will utilize a "alarm clock sticker" that we be added to the already existing symbols communication system/device on the outside of the resident's room to indicate who has a personal body alarm. All resident sand family members are notified of this symbol communication system/device upon admission to the facility. Consent from the resident/family member is obtained at admission and consent document is kept in the reside admission file. They will conduct QA rounds on a daily basis for one (1) month and monthly for three (3) months by utilizing the housekeeping staff. The housekeeping staff will be in-serviced the DON and Nurse Manager by December 18, 2015 on how to recognity who has a personal alarm and if it is in working order as well as who to report the alarm is not in place or appears to be working properly. The Nursing staff will be responsible to secure a new alar and put it into place. The Housekeepin staff will document on their daily assignment sheets that they observed personal body alarm and it was in work order. In addition the Nursing staff will be in-serviced by December 18, 2015 on proper placement and function checks all alarming devices and where and hot to replace an alarm that is not function properly. This will include the use of a Communication Notebook which will be kept at each Nurses' station that will be kept at each Nurses' station that will be	will oil te ly te ly mt hth, g by ze to if not furming the king on w ing e	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 520	Continued From pag	e 10	F 52	updated by the Medical Records Nurs weekly and Nurse Managers as needed that includes all residents who have alarms. The Nursing staff will be responsible to review this communicate book each shift to determine which residents have assistive devices. All Nurses will document on all residents have alarming devices on their Treatm Administration Record (TAR) every she that devices were properly placed and functional. The Housekeeping Supervisor and/or Maintenance Direct will be responsible to do a QA on a web basis for three (3) months to ensure the all personal body alarms are in placed in working order. They will document on a QA Form that indicates the above information. The form will be given to QA Committee on a weekly basis who review to determine if interventions in place are appropriate and effective. ADDRESS WHAT MEASURES WILL PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: In the future to ensure that all alarms a in place and in working order the facilit will utilize a "alarm clock sticker" that be added to the already existing symbol communication system/device on the outside of the resident's room to indicate who has a personal body alarm. All resident and family members are notified of this symbol communication system/device upon admission to the	ed tion who hent ift or eekly hat hand this ethe will BE OT are ty will ol	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION G		E SURVEY IPLETED
		245544	B WING			С
		345541	B. WING _			1/20/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OI DE KN	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		13825 HUNTON LANE		
OLDL KIN	OX COMMONO AT THE	MELAGEO OF MEGREENBORG		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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 520	Continued From page	e 11	F 5:	facility. Consent from the resident/fi member is obtained at admission a consent document is kept in the res admission file. They will conduct Q, rounds on a daily basis for one (1) weekly basis for one (1) month and monthly for three (3) months by util the housekeeping staff. The housekeeping staff will be in-servic the DON and Nurse Manager by December 18, 2015 on how to rec who has a personal alarm and if it i working order as well as who to rep the alarm is not in place or appears be working properly. The Nursing s will be responsible to secure a new and put it into place. The Houseke staff will document on their daily assignment sheets that they observ personal body alarm and it was in v order. These records will be given Housekeeping Supervisor who will present them to the QA Committee weekly. The Nursing staff will be in-serviced December 18, 2015 on proper place and function checks on all alarming devices. This will include the use of Communication Notebook which wi kept at each Nurses' station that wi updated by the Medical Records No weekly and Nurse Managers as ne- that includes all residents who have alarms. The Nursing staff will be responsible to review this communi- book each shift to determine which residents have assistive devices. T CNA's will be responsible to sign a	and sident of the sident of th	

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 _			C 11/20/2 (015	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO	 DE	11/20/20	013	
				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 PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA	SHOULD BE COMPLETION		
F 520	Continued From page	e 12	F	stating they have reviewed to Communication book every Nurses will document on all have alarming devices on the Administration Record (TAR) that devices were properly productional. INDICATE HOW THE FACIL TO MONITOR IT SPERFORMAKE SURE THAT SOLUTING SUSTAINED. THE FACILIT DEVELOP A PLAN FOR ENTHAT CORRECTION IS ACTOR SUSTAINED. THE PLAN MIMPLEMENTED AND THE CACTION EVALUATED FOR EFFECTIVENESS. THE POINTEGRATED INTO THE QUASSURANCE SYSTEM OF FACILITY: In the future to ensure that a in place and in working orde will utilize a "alarm clock stiple added to the already exist communication system/device outside of the resident's room who has a personal body alaresident and family membrotified of this symbol commister system/device upon admissing facility. Consent from the resident of the consent document is kept in admission file. QA rounds with conducted on a daily basis for one and monthly for three (3) more and monthly for three (3) more communication in the conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one and monthly for three (3) more conducted on a daily basis for one conducted on a daily basis for one conducted on a	shift. All residents weir Treatmet) every shift blaced and all laced arm.	ent t S TO ND VE		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345541	B. WING _			C 11/20/2015		
	ROVIDER OR SUPPLIER	ILLAGES OF MECKLENBURG		STREET ADDRESS, CITY, STATE, Z 13825 HUNTON LANE HUNTERSVILLE, NC 28078	IP CODE	11/20/2010		
(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 T DEFICI	ACTION SHOULD BE TO THE APPROPRIA	ULD BE COMPLETION		
F 520	Continued From page	e 13	F	utilizing the housekeepin Nursing staff will be resp this communication boodetermine which resider devices. The CNA's will sign a log stating they have alarming devices of Administration Record (that devices were proper functional. The Houseke and/or Maintenance Directoresponsible to do a QA basis for three (3) monthall personal body alarms in working order. They non a QA Form that indictinformation. The form what Administrator who will prinformation to the QA Committee will systemic changes to ensure performance, to ensure performance, to ensure performance is achieved. The QA Committee will facility progress monteffectiveness and revises measures as necessary corrective action is integrity actions. The VP of O Corporate staff member results of the interventions.	ponsible to review de each shift to ints have assistive to responsible to reviewed the very shift. All in all residents won their Treatment (TAR) every shift erly placed and eeping Supervise to rector will be round on a week to ensure that are in place as will document the eates the above will be given to the facility of the eates the eates the eates the eates the eates the facility of the eates the facility of the facility of the facility of the eates the e	ew ve to ne who ent it sor kly at nd nis he s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3	(X3) DATE SURVEY COMPLETED	
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		345541	B. WING _			11/20/2015	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
OLDE KN	OV COMMONO AT THE V	ULLACES OF MESKI ENDURS		13825 HUNTON LANE			
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG				HUNTERSVILLE, NC 28078			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID		ID	PROVIDER'S PLAN OF CORE		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	'E ACTION SHOULD BE COMPLETION DATE		
F 520	520 Continued From page 14 F 520						
				basis and will attend the QA Con a quarterly basis and will revinformation to determine if inte in place are appropriate and effare being sustained. If not ther interventions will be determined implemented at that time	view the rventions fective and n new		