DUDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG         13825 HUNTON LANE HUNTERSVILLE, NC 28078           (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY ACTION SHOULD BE DEFICIENCY)         COMPLET (EACH DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLET IDATE           F 000         INITIAL COMMENTS         F 000         F 000         F 000           A complaint investigation (Event ID #T0DQ11) was conducted on 12/03/18 through 12/07/18. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of J.         F 000         F 000         F 483.12 at tag F607 at a scope and severity of J.         F 483.12 at tag F607 constituted substandard quality of care.         Immediate Jeopardy began on 08/18/18 and was removed on 12/07/18. An extended survey was completed.         Immediate Jeopardy began on 08/18/18 and was         Immediate Jeopardy began on 08/18/18 and was	345541         E. WING         12/07/2018           SINEET ADDRESS, CITY, SIATE, 201 CODE           SIZE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG           DIDE KNOX COMMONS AT THE VILLAGES OF MECKLEND BY FULL           SIZE KNOX COMMONS AT THE VILLAGES OF MECKLEND BY FULL           SIZE KNOX COMMONS AT THE VILLAGES OF MECKLEND BY FULL           SIZE KNOX COMMONS AT THE VILLAGES OF MECKLEND BY FULL           SIZE KNOX COMMONS AT THE VILLAGES OF MECKLEND BY FULL           SIZE KNOX COMMONS AT THE VILLAGES OF MECKLEND BY FULL           SIZE KNOX COMMONS AT THE VILLAGES OF MECKLEND BY FULL           SIZE KNOX COMMONS AT THE VILLAGES OF MECKLEND BY FULLE, NC 20078           MILE INCLUENT SIZE AD THE VILLAGES OF MECKLEND MECKLEND BY FULLE, NC 20078           F 000           A complaint investigation (Event ID #TODQ11)           Y 000           F 000           A complaint investigation (Event ID #TODQ11)           Y 000           Tages F600 and F607 constituted substandard <t< th=""><th></th><th>OF DEFICIENCIES</th><th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th><th></th><th>CONSTRUCTION</th><th>(X3) DATE SURVEY COMPLETED</th></t<>		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER       Image: Comparison of the co	ANUE OF PROVIDER OR SUPPLIER       Image: Comparison of the co			345541	B. WING		-
CLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG         HUNTERSVILLE, NC 28078           (PNI)D TAG         SUMMARY STRIEMENT OF DEFICIENCIES (EACH EPERCINDUMST ALS TREEMENT ALS TREEMENT)         ID PRETX (EACH EPERCINDUCST OF THE APPROPRIATE DEFICIENCY)           F 000         INITIAL COMMENTS         F 000           A complaint investigation (Event ID #TODO11) was conducted on 12/03/18 through 12/07/18. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of J. CFR 483.12 at tag F607 at a scope and severity of J.         F 000           F 600         Free from Abuse and Neglect SS=J CFR(s): 483.12(a)(1)         F 600           S483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical orchead restraint hor required to treat the resident's medical symptoms.         F 400         Address How Corrective Action (S) Will	DUDE KOOX COMMONS AT THE VILLAGES OF MECKLENBURG       HUNTERSVILLE, NC 28078         (M) ID PRETX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EQUIDECISENCY MIST OF REFORMED BY FULL (EQUIDECISENCY MIST OF REFORMED BY FULL (EQUIDECISENCY)       000000000000000000000000000000000000	NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/07/2018
Image in the second	Image       (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PMERIX TAG       (EACH CORRECT)       CORSIS-REFERENCED TO THE APPROPRIATE       COMMENT DEFICIENCY)         F 000       INITIAL COMMENTS       F 000       F 000       F 000       F 000       CRR 43.12 at tag F600 at a scope and severity of J.       F 000       CRR 43.12 at tag F600 at a scope and severity of J.       F 000       CRR 43.12 at tag F607 at a scope and severity of J.       F 000       Immediate Jeopardy was identified at:       F 000       Immediate Jeopardy began on 08/18/18 and was removed on 12/07/18. An extended survey was completed.       F 600       F 600       I2/12/18         F 600       Free from Abuse and Neglect SS=J       CFR (s): 483.12 (a)(1)       F 600       F 600       I2/12/18         SS=J       CFR(s): 483.12 (a)(1)       F 600       F 600       I2/12/18       I2/12/18         SS=J       CFR (s): 483.12 (a)(1)       F 600       F 600       I2/12/18       I2/12/18         S483.12 (a) The facility must- sincludes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical symptoms.       F 600       Address How Corrective Action (S) Will Be Accomplished For Those Residents       Address How Corrective Action (S) Will	OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			
A complaint investigation (Event ID #T0DQ11) was conducted on 12/03/18 through 12/07/18. Immediate Jeopardy was identified at:         CFR 483.12 at tag F600 at a scope and severity of J.         CFR 483.12 at tag F607 at a scope and severity of J.         Tags F600 and F607 constituted substandard quality of care.         Immediate Jeopardy began on 08/18/18 and was removed on 12/07/18. An extended survey was completed.         F 600 Ss=J         CFR(s): 483.12 (a)(1)         §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.         §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the	A complaint investigation (Event ID #T0DQ11) was conducted on 12/03/18 through 12/07/18. Immediate Jeopardy was identified at:       CFR 483.12 at tag F600 at a scope and severity of J.         CFR 483.12 at tag F607 at a scope and severity of J.       Tags F600 and F607 constituted substandard quality of care.       Immediate Jeopardy began on 08/18/18 and was removed on 12/07/18. An extended survey was completed.       F 600       12/12/18         F 600 SS=       CFR (s): 483.12 a(1)       F 600       12/12/18         §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.       §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by; Based on record reviews and staff interviews the facility failed to protect 2 of 3 residents from staff       Address How Corrective Action (S) Will Be Accomplished For Those Residents	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	COMPLETIC
was conducted on 12/03/18 through 12/07/18. Immediate Jeopardy was identified at:       CFR 483.12 at tag F600 at a scope and severity of J.         CFR 483.12 at tag F607 at a scope and severity of J.       CFR 483.12 at tag F607 at a scope and severity of J.         Tags F600 and F607 constituted substandard quality of care.       Immediate Jeopardy began on 08/18/18 and was removed on 12/07/18. An extended survey was completed.       F 600         Free from Abuse and Neglect       F 600         SS=J       CFR(s): 483.12 (a)(1)       F 600         Sk3.12 Freedom from Abuse, Neglect, and Exploitation       F 600         The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.         Ş483.12(a) The facility must- Ş483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by; Based on record reviews and staff interviews the       Address How Corrective Action (S) Will	was conducted on 12/03/18 through 12/07/18.         Immediate Jeopardy was identified at:         CFR 483.12 at tag F600 at a scope and severity of J.         CFR 483.12 at tag F607 at a scope and severity of J.         Tags F600 and F607 constituted substandard quality of care.         Immediate Jeopardy began on 08/18/18 and was removed on 12/07/18. An extended survey was completed.         F 600         Free from Abuse and Neglect         SS=J         CFR(s): 483.12 (a)(1)         §483.12 Freedom from Abuse, Neglect, and Exploitation         The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.         §483.12(a)(1) Not use verbai, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by;         Based on record reviews and staff interviews the facility failed to protect 2 of 3 residents from staff	F 000	INITIAL COMMENTS		F 000		
of J.       CFR 483.12 at tag F607 at a scope and severity       if         f J.       Tags F600 and F607 constituted substandard       immediate Jeopardy began on 08/18/18 and was         removed on 12/07/18. An extended survey was       completed.       F 600         F 600       Free from Abuse and Neglect       F 600         SS=J       CFR(s): 483.12(a)(1)       F 600         §483.12 Freedom from Abuse, Neglect, and       Exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.       §483.12(a) The facility must-         §483.12(a) The facility must-       §483.12(a) The facility must-       stal. sexual, or physical abuse, corporal punishment, or involuntary seclusion;         This REQUIREMENT is not met as evidenced by;       Based on record reviews and staff interviews the       Address How Corrective Action (S) Will	of J.       CFR 483.12 at tag F607 at a scope and severity         of J.       Tags F600 and F607 constituted substandard         quality of care.       Immediate Jeopardy began on 08/18/18 and was         removed on 12/07/18. An extended survey was       completed.         F 600       Free from Abuse and Neglect       F 600         SS=J       CFR(s): 483.12(a)(1)       F 600         §483.12 Freedom from Abuse, Neglect, and       Exploitation         The resident has the right to be free from abuse,       neglect, misappropriation of resident property,         and exploitation as defined in this subpart. This       includes but is not limited to freedom from         corporal punishment, involuntary seclusion and       any physical or chemical restraint not required to         treat the resident's medical symptoms.       §483.12(a) The facility must-         §483.12(a) The facility must-       §483.12(a)(1) Not use verbal, mental, sexual, or         physical abuse, corporal punishment, or       involuntary seclusion;         This REQUIREMENT is not met as evidenced       b;         Based on record reviews and staff interviews the       Address How Corrective Action (S) Will         Be Accomplished For Those Residents       Address How Corrective Action (S) Will	v li	was conducted on 12	/03/18 through 12/07/18.			
quality of care.       Immediate Jeopardy began on 08/18/18 and wass removed on 12/07/18. An extended survey was completed.       F 600       Free from Abuse and Neglect       F 600       Free from Abuse and Neglect       F 600       F com Abuse and Neglect       F 600       12/12/18         SS=J       CFR(s): 483.12(a)(1)       §483.12 Freedom from Abuse, Neglect, and Exploitation       F 600       12/12/18       12/12/18         statistic and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.       S 483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:       Based on record reviews and staff interviews the       Address How Corrective Action (S) Will	quality of care.Immediate Jeopardy began on 08/18/18 and was removed on 12/07/18. An extended survey was completed.F 600F 600 <th< td=""><td></td><td>of J. CFR 483.12 at tag F6</td><td></td><td></td><td></td><td></td></th<>		of J. CFR 483.12 at tag F6				
removed on 12/07/18. An extended survey was completed.       F 600       Free from Abuse and Neglect       F 600       12/12/18         SS=J       CFR(s): 483.12(a)(1)       F 600       12/12/18         §483.12 Freedom from Abuse, Neglect, and Exploitation       F 600       12/12/18         The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.       §483.12(a) The facility must-         §483.12(a) The facility must-       §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the       Address How Corrective Action (S) Will	removed on 12/07/18. An extended survey was completed.       F 600       Free from Abuse and Neglect       F 600         SS=J       CFR(s): 483.12(a)(1)       F 600       12/12/18         §483.12 Freedom from Abuse, Neglect, and Exploitation       F ere end thas the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.       § 483.12(a) The facility must-         § 483.12(a) The facility must-       § 483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:       Address How Corrective Action (S) Will Be Accomplished For Those Residents		-	constituted substandard			
SS=J       CFR(s): 483.12(a)(1)         §483.12 Freedom from Abuse, Neglect, and         Exploitation         The resident has the right to be free from abuse,         neglect, misappropriation of resident property,         and exploitation as defined in this subpart. This         includes but is not limited to freedom from         corporal punishment, involuntary seclusion and         any physical or chemical restraint not required to         treat the resident's medical symptoms.         §483.12(a) The facility must-         §483.12(a)(1) Not use verbal, mental, sexual, or         physical abuse, corporal punishment, or         involuntary seclusion;         This REQUIREMENT is not met as evidenced         by:         Based on record reviews and staff interviews the	SS=J       CFR(s): 483.12(a)(1)         §483.12 Freedom from Abuse, Neglect, and         Exploitation         The resident has the right to be free from abuse,         neglect, misappropriation of resident property,         and exploitation as defined in this subpart. This         includes but is not limited to freedom from         corporal punishment, involuntary seclusion and         any physical or chemical restraint not required to         treat the resident's medical symptoms.         §483.12(a) The facility must-         §483.12(a)(1) Not use verbal, mental, sexual, or         physical abuse, corporal punishment, or         involuntary seclusion;         This REQUIREMENT is not met as evidenced         by:         Based on record reviews and staff interviews the         facility failed to protect 2 of 3 residents from staff		removed on 12/07/18				
Exploitation         The resident has the right to be free from abuse,         neglect, misappropriation of resident property,         and exploitation as defined in this subpart. This         includes but is not limited to freedom from         corporal punishment, involuntary seclusion and         any physical or chemical restraint not required to         treat the resident's medical symptoms.         §483.12(a) The facility must-         §483.12(a)(1) Not use verbal, mental, sexual, or         physical abuse, corporal punishment, or         involuntary seclusion;         This REQUIREMENT is not met as evidenced         by:         Based on record reviews and staff interviews the	Exploitation         The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.         §483.12(a) The facility must-         §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;         This REQUIREMENT is not met as evidenced by:         Based on record reviews and staff interviews the facility failed to protect 2 of 3 residents from staff			•	F 600		12/12/18
§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;         This REQUIREMENT is not met as evidenced by:         Based on record reviews and staff interviews the    Address How Corrective Action (S) Will	§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;         This REQUIREMENT is not met as evidenced by:         Based on record reviews and staff interviews the facility failed to protect 2 of 3 residents from staff		Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to			
physical abuse, corporal punishment, or         involuntary seclusion;         This REQUIREMENT is not met as evidenced         by:         Based on record reviews and staff interviews the         Address How Corrective Action (S) Will	physical abuse, corporal punishment, or         involuntary seclusion;         This REQUIREMENT is not met as evidenced         by:         Based on record reviews and staff interviews the         facility failed to protect 2 of 3 residents from staff    Address How Corrective Action (S) Will Be Accomplished For Those Residents		§483.12(a) The facilit	y must-			
Based on record reviews and staff interviews the Address How Corrective Action (S) Will	Based on record reviews and staff interviews the facility failed to protect 2 of 3 residents from staffAddress How Corrective Action (S) Will Be Accomplished For Those Residents		physical abuse, corpo involuntary seclusion This REQUIREMENT	oral punishment, or ;			
	ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Based on record rev				

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.

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
			5.11/10/0			С
		345541	B. WING			2/07/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
OLDE KNO	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		13825 HUNTON LANE		
				HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 1	F 600			
	#2). The facility failed	cal abuse (Resident #1 and to protect Resident #1 from		Found To Have Been Affecte Deficient Practice:	ed By The	
	arm which caused a tear. The facility also and #2 from Residen deliberately rolling ow his motorized wheelo Resident #2's feet we nursing staff and did injuries. Immediate Jeopardy Resident #1 when a s the facility) grabbed f 4-centimeter (cm) ski began on 11/25/18 fo #2 when Resident #3 deliberately rolled ow motorized wheelchain removed on 12/07/18 implemented a credit Jeopardy removal. Th	er both residents' feet with hair. Resident #1's and ere assessed by the facility's not experience any physical began on 08/18/18 for Sitter (who was employed by his arm and caused a n tear. Immediate Jeopardy or Resident #1 and Resident intentionally and er their feet with his . Immediate Jeopardy was		The employee in question we the need to come in for anot on 12/05/2018 and she arriv pm at which time an intervie conducted. Per our policy the is suspended now pending at investigation. The facility con- investigation on December conducting another interview employee admitted to the Ad- and Director of Nursing that the circumstances surround incident on 08/18/2018. Whe she stated that she didn tw her job but she had thought this is the reason she report surveyor a different story. If that based on the current infu- understood that this was con- abuse. Therefore employee employment was terminated	ther interview yed at 12:30 wwwas ne employee another ompleted the 12, 2018. After v, the dministrator she lied about ing the en asked why, vant to lose about it and yed to the She stated formation she nsidered e s	
	D (no actual harm with harm that is not Imme	th a potential of minimal ediate Jeopardy) to ensure out into place are effective.		December 12, 2018. The staff intervened with Re	sident #1 and	
	Findings included:			Resident #3 by removing Re from the area and monitorin per #1 Nurse LPN witness s	g Resident #3,	
	01/04/18 with diagno Dementia (LBD) (a P progressively worsen comprehensive Minir assessment dated 06 severe cognitive impa	num Data Set (MDS) //01/18 revealed he had		nurse s note. After the incid Resident #2 and #3 the staf room intervened by assisting from the dining room which when running over resident The #1 Nurse LPN evaluate #1 and #2 s feet at the time were no injuries or complain	dent with f in the dining g Resident #3 was his intent #2⊡s feet. d the resident e and there	

Facility ID: 990623

If continuation sheet Page 2 of 59

	OF DEFICIENCIES	MEDICAID SERVICES				10. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	. ,	IE SURVEY MPLETED
			A. BUILDING			С
		345541	B. WING			
	ROVIDER OR SUPPLIER	010011		STREET ADDRESS, CITY, STAT		2/07/2018
	NOVIDEN ON SOLT EIEN			13825 HUNTON LANE		
OLDE KN	OX COMMONS AT THE	VILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 280	78	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S P	PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENC	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	COMPLETIO
F 600	Continued From page	e 2	F 60	0		
	behaviors documente	ed during the assessment				
	period.			On November 26, 20	018 the DON	
				completed a thoroug		
		1's Care Area Assessment			Resident #2 involved	
		dated 06/01/18 revealed in		in the 11/25/2018 inc		
		agnosis of LBD and had cognitive decline over the		were no noted areas discoloration, scratcl		
	last few months. The	-			t appear to have any	
		r safety awareness and			distress as a result of	
	impulsive behaviors.			the incident as they	mentally appeared to	
				be at their baseline a	and did not express	
	Review of Resident #			any signs of physica	l or mental distress.	
		irt that he had LBD which				
		cognitive decline. The		The Resident #3 was	•	
	-	to maintain the ability to nds by utilizing interventions		Physical Therapy on	dent has the capability	
		g him while speaking to him,		of maneuvering a mo		
		distinctly to him and maintain		independently. It wa		
	eye contact during in			resident has great di		
				decreased space is a		
		Note, written by Nurse #2,		unable to see his fee	et or immediately by	
		:22 AM indicated in part that		his sides due to deci		
		t and verbal with confusion.		He tends to use the		
		I a skin tear to the top of left ured 4 cm long by 1.5 cm		increase his visual fi		
		in tunneling 0.5 cm to the left		turning his head. Re	would turn the chair.	
		Resident #1 was calm and in			would turn the oriall.	
		eatment was being given.		Due to the safety ne	eds of the residents	
	-	he Sitter and he were		the Interdisciplinary		
		e a chunk of meat from his			ed the resident will be	
		her." The note specified,		evaluated on 12/06/2		
		ted that the Sitter said "ha,		wheelchair and place		
		ent #1 stated he felt some		evaluation. Resident	•	
	soreness in his left a			traditional wheelchai	py working with him to	
	Review of Employee	's Accident/Incident Report		be able to maneuver		
		:00 AM written by Nurse		spaces.		
		tated Resident Companion				
		er and stated Resident #1		Address How Correc	ctive Action Will Be	

Facility ID: 990623

						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
						С
		345541	B. WING		1:	2/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI		
				13825 HUNTON LANE		
	OX COMMONS AT THE	VILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 2807	8	
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	(EACH CORRECTI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE	(X5) COMPLETIO DATE
TAG	REGULATORT OR	LISC IDENTIFTING INFORMATION)	TAG		FICIENCY)	
F 600	Continued From non	- 2	<b></b>			
F 000	Continued From pag		F 60			
		ace and she scratched him		Accomplished For Th		
		vas moving his arms out of		Having Potential To B	•	
		hen began to cry and the NS e herself from Resident #1's		Same Deficient Pract		
		e hersen nom Resident #15		1. All interview able	rosidonts woro	
	room.			interviewed by the fac		
	Poviow of the Sitter's	s statement dated 08/18/18		and Director of Nursi		
		Resident #1 was trying to		they had been a recip	-	
		o get him to sit back down in		abuse by a staff mem		
		y. Resident #1 then got very		visitor or another resi	-	
		d the Sitter in the jaw with his		were conducted on 1		
		, the Sitter shoved his arm		were no residents wh		
		anner accidentally digging		or witnessed any abu	-	
		in the process. The Sitter		2. The facility perfo		
i		NS #3 and told her what		of Incident reports, si		
		Sitter went back to the		However, this proces		
		ad his left sleeve rolled up		further to include 24 h		
		that she had unintentionally		reports as well, which	U	
	caused.	that she had unintertionally		incidents involving pc		
				resident altercations,		
	Telenhone interview	with Resident Companion		new process was initi		
		at 3:05 PM she stated		Administrator followin	-	
		ted to stand up and she told		resident altercation o		
		then he reached up with his		date, there have beer		
		ne face. The Sitter stated out		unknown origin to inv	-	
		ed Resident #1's left hand to		Morning Meeting Sig	•	
	•	her again. By this time		reflects the Administr	-	
		ng down so she immediately		Team attendance. Th		
		tation to report what had		able residents have n		
		r stated while she was		incidents		
		o her right jaw they brought		3. The Administrato	or, Director of Nursing	
		esk and when he saw her he		and Corporate Nurse	· · · · · · · · · · · · · · · · · · ·	
	said "Oh, you did this	s" while pointing to his skin		conducted In-service		
	tear. The Sitter state	d Resident #1 was not		beginning on 12/05/2	018 and completed	
	bleeding a lot.			on 12/07/2018 which		
				completed prior to ret		
	On 12/03/18 at 4:30	PM the interview with the		all new hires will be re		
	Sitter continued in pe	erson with demonstration of		the following training		
				working with the resid		1

Facility ID: 990623

If continuation sheet Page 4 of 59

CENTER		ID HUMAN SERVICES MEDICAID SERVICES				/ APPROVE ). 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		LETED
		345541	B. WING			C 107/2018
NAME OF P	ROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	13825 HUNTON LANE		
		ILLAGES OF MECKLENBURG	H	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 4	F 600			
F 600	were watching televis up and she stood up down to him and said sit down and at that ti down then he "hit me with his left hand and arm to keep him from doing so my fingerna arm. The Sitter stated caused the skin tear came to the nurses' s nurse and me his arm resident 's arm) clear fingernails and it was blood." The Sitter exp received training on w became agitated. Review of NS #3's wr and timed 10:00 AM approached her and s an Ativan. NS #3 stated she #1 was doing and the trying to get up and the jaw. NS #3 stated she #1 before she gave h him from his doorway A minute later the Sitt said Resident #1 had	tion when he started to stand in front of him and leaned (Resident #1) you need to ime he had already sat back on the right side of my face out of instinct I grabbed his hitting me again" and in ils caused a skin tear on his d she did not know she to Resident #1's arm until he station later and showed the h. The Sitter stated, "It (the ly had the imprints of my open with small drops of blained that she had not what to do when a resident	F 600	<ul> <li>a. ABUSE - Resident has the right free from abuse, neglect, misappropriation of resident proprexploitation.</li> <li>b. Types of abuse, i.e., (physical chemical, sexual, and resident to abuse.</li> <li>c. What to do if abuse is witnes to report the abuse to, d. How to react to combative beform residents; how to provide cal services to combative residents to abuse to resident(s) or harm to the giver; and</li> <li>e. Dementia training.</li> <li>f. Reporting of ANY SUSPICIO abuse of any type, neglect, exploit and misappropriation of resident to Administrator and the Director of IMMEDIATELY. Failure to notify result in disciplinary action.</li> <li>4. The Administrator and the Di Nursing received additional training Abuse policy and regulations, the investigation process and the reg regarding timely notification by stathen timely reporting of the abuse required agencies and Dementia This was completed on 12/06/201</li> </ul>	erty, and al, verbal, resident seed, who ehavior are and o prevent he care NN of itation property. the Nursing / will frector of ng on the e ulations aff, and e to the Training.	
	NS #3, she stated that came up to her (NS) Resident #1 was tryin (Sitter) tried to restrain (Sitter) in the face. No	AM during an interview with at on 08/18/18 the Sitter and told her (NS) that ng to stand up and she n him and he punched her S #3 stated she called the ursing (IDON) and was		Corporate Nurse Consultant. Address What Measures Will Be Place Or Systemic Changes Mad Ensure That The Deficient Practic Not Recur: 1. The Director of Nursing imple Administrative Nursing Staff round	le To ce Will emented	

Facility ID: 990623

		MEDICAID SERVICES				OMB NO	D. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		E SURVEY PLETED
		345541	B. WING				C
	ROVIDER OR SUPPLIER	343341			REET ADDRESS, CITY, STATE, ZIP CODE	12	/07/2018
	ROVIDER OR SUFFLIER						
	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			825 HUNTON LANE JNTERSVILLE, NC 28078		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETIC
F 600	Continued From page	e 5	F 60	00			
		tement from the Sitter then			resident care units on 10/17/2018		
	send the Sitter home.				(entering rooms and showers where c	are	
					was being provided) and have continu		
	Review of Nurse #2's	written statement (undated			to monitor four (4) times a week to ens		
		d in part that while she was			that care delivery is being conducted in		
	treating Resident #1's	s skin tear he stated that she			way that preserved the resident s		
		rm with her nails then he			privacy, dignity and freedom from abu	se.	
	punched her. Resider	nt #1 continued to state the			There have been no incidents noted s	ince	
	Sitter tempted him to	hit her saying "hit me, hit			that time. These rounds will continue	at	
	me" so Resident #1 s	aid he hit her. Resident #1			four (4) per week (including at least or	ne	
	said they were initially	y scuffling and that she			(1) on the 11-7 shift for the next six (6)	)	
	always does this with	him.			months and then two (2) per week for	the	
					following six (6) months to ensure that	the	
		PM during a telephone			deficient practice does not reoccur.		
		#2 she stated she was			2. The facility has performed ongoin	ng	
	-	ome and note a skin tear on			daily audits of Incident reports, since		
		2 stated that it didn't look			October, 2018. However, this process		
		r and described it as deep,			was escalated further to include 24 ho		
		crescent shaped skin flap.			nursing shift reports as well, which are		
		d there was a moderate			reviewed for possible resident to resid	ent	
		After NS #2 treated the skin			altercations, and or abuse. This new		
		the measurements and			process was initiated by Administrator		
		ted happened in her nurses'			following the resident to resident		
		to NS #3 and called the			altercation on 11/28/2018. To date, the		
	IDON.				have been no injuries of unknown orig		
	Review of the Investi	gation Timeline written by			investigate.		
	IDON and dated 08/2				3. All interview able residents were		
		4/18 revealed the IDON was			interviewed by the facility Social Work	er	
		approximately 10:45 AM			and Director of Nursing to determine if		
		sident #1 had swung at his			they had been a recipient of, or witnes		
		irected to sit down. While			abuse by a staff member, family mem		
	-	dent #1 down he swung at			visitor or another resident. The intervi		
		in the right side of her			were conducted on 12/05/2018 and th		
	-	le the Sitter was trying to			were no residents who had experience		
	-	/ a skin tear was caused on			or witnessed any abuse. The		
	-	sident #1. The IDON told			Administrative Staff conducts QA Rou	nds	
		Resident #1 and the Sitter			on a daily basis and are required to		
		written statement from the			interview at least two (2) residents to		

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If continuation sheet Page 6 of 59

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			TE SURVEY
			A. BUILDIN	G		
		245544	B. WING			С
		345541	B. WING			2/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		13825 HUNTON LANE		
-				HUNTERSVILLE, NC 28078		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	THE APPROPRIATE	COMPLETIC
F 600	Continued From page	e 6	F 60	00		
	Sitter then send her h	nome. The Sitter was noted		determine if they have ex	perienced anv	
		right side of her face/jaw.		type of abuse. None has	•	
		kin tear on his left forearm.				
	The skin tear was tre	ated with normal saline and		4. Staff interviews were	conducted by	
	dressed with a xerofo	orm gauze and dry dressing.		outside RN Consultant or	12/5/2018-	
	The Physician's On-O	Call was notified of the		12/6/2018. The interviews	s involved detail	
	situation and the fam	ily was notified via message.		questioning pertaining to	resident abuse	
	The IDON completed	I a 24-Hour Initial Report and		awareness, prevention ar	nd reporting	
	faxed it to the state a	gency. The IDON also spoke		process of all facility staff	. Interview	
	with Resident #1 and	asked him how he hurt his		results were reviewed by	Administration	
	-	ed "I punched her." however		on December 10, 2018 fo	•	
		a reliable source due to the		concerns. There were no		
	-	e Investigative Timeline		abuse reported in these in	nterviews.	
		on 08/22/18 at 1:30 pm the				
	-	to meet with the IDON and		5. All staff members we		
		provide a verbal statement of		prior to their next tour of c	•	
	the incident. The Sitte			abuse prohibition policy w		
		t Resident #1 to sit back		not only reporting direct k	• •	
		to get agitated with her and		incident, but also immedia		
		her in the right side of her		knowledge of any rumor (	-	
		e to him swinging at her she pushing his arm away from		abuse (of any type), there	• • •	
		room to notify the nurse of		investigation as to the val rumor/hearsay. Failure to		
		ion. Upon returning to the		warrant disciplinary action		
		she and the nurse noted		staff members were addre		
		of his left forearm. When the		revised policy which clear		
		a skin tear was observed.		educational training on de	• •	
		to demonstrate how she		orientation. As a means to	-	
		her since she used the word		ongoing compliance, the		
		IDON and the Administrator		process has been amend		
		on and felt that it was a		integrate dementia trainin	•	
	reaction to being hit a	and she did not mean to		and Nurses, to ensure ca	•	
		nis arm. The Sitter was told		receiving tools to care for	-	
	by the Administrator f	that she was being		residents, as per facility p		
		day, August 27th at which		Additionally, immediate re	-	
	time they would call h	ner and let her know about		rumor or hearsay which c		
	returning to work onc	e the facility's investigation		type of abuse will be add	essed during	
		t time they felt it was not		orientation of newly hired		
	appropriate for her to	work as a Resident		ensure enforcement of fa	cility policy No	

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED
						С
		345541	B. WING		1	2/07/2018
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	OX COMMONS AT THE	VILLAGES OF MECKLENBURG		13825 HUNTON LANE		
				HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 7	F 60	0		
	Companion. The Tim	eline stated, "we did not feel		concerns were revealed b	ased on staff	
		herefore were not able to		interviews. An observation	of the overall	
		ince there were no witnesses		environment and at risk re		
		not a reliable source due to		ongoing and is being cond		
	the diagnosis of Lew	y Body Dementia."		Champion designated lice		
	During on interview v	vith the IDON on 12/04/18 at		(Nurse Managers), and do Behavior monitoring flow s		
	•	ed that she was notified of		flow sheets will be submitt		
	· ·	Resident #1 and the Sitter in		discussed by IDT at daily		
		/18 and arrived at the facility		meeting.		
	-	n. The IDON stated she was		6. Incident Reports and	(24-Hour	
	told by NS #3 that Re			Nursing Report) will be rev	viewed Monday	
		itter and punched her in the		through Friday in morning	-	
		to a scuffle. The IDON stated		any unusual incident to inc		
		to get a statement from the		skin tears and injuries of u	-	
		home. The IDON stated that facility Resident #1's skin		and resident to resident at immediate investigation w		
		ssed and she did not remove		all bruises or unknown orig		
		ss his skin tear. The IDON		unknown origin or any oth		
		ed Resident #1 but because		injury of unknown origin ar		
	of his progressive LB	3D he could not remember		occurrence that is suspect	•	
	the incident. The IDC	ON stated she reviewed the		be reported immediately to	o the	
		d read it as when Resident		Huntersville Police Depart		
	-	she pushed his hand out of		North Carolina Health Car		
		the skin tear. The IDON		Registry. The incident rep		
		at they (Administration) to act out of incident and they		completed electronically b nurses and the nurse supe		
	-	as intentional or abusive.		responsible to print the inc		
				for their unit before the mo	• • • •	
	During an interview v	vith the Administrator on		and are responsible to brir	• •	
	12/04/18 at 3:45 PM			morning meeting. In additi	•	
		aining on residents with		bring the 24-Hour Nursing	Report to the	
	-	direct care staff and she did		meeting and the two docu		
		e done by reporting the		compared to ensure incide		
	incident which she di			origin are investigated and		
		she did not consider the		put into place. In the even		
	abuse.	Sitter and Resident #1		supervisor is absent the re printing the incident report	•	
	ຸລມພຣຣ.			printing the incluent report	s and the	

Facility ID: 990623

If continuation sheet Page 8 of 59

		MEDICAID SERVICES					<u>O. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION		E SURVEY PLETED
							С
		345541	B. WING			12	2/07/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE	VILLAGES OF MECKLENBURG			3825 HUNTON LANE		
	1			H	UNTERSVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 600	Continued From pag	e 8	F 60	00			
		admitted to the facility on	1.00	00	ADON and then to the DON.		
		ses that included: encounter			7. The Corporate Compliance Nurse	will	
	for orthopedic afterca				be responsible to review the	VVIII	
		fied dementia without			Administrative Nursing Staff rounds		
		itive communication deficit			Sheets on a weekly basis for three (3)		
	-	view of Resident #3's most			months; a bi-monthly basis for three (3		
		nent revealed Resident #3			months and then monthly for six (6)		
	was moderately coor	nitively impaired with no			months to determine that facility is in		
		ng the look back period.			compliance with the credible allegation	n of	
		<b>5</b>			compliance and interventions have be		
	A. Review of Resider	nt #3's nurse's notes			put into place. If there are discrepancie		
	revealed a noted dat	ed 11/25/18 at 1:25PM that			in the monitoring tool, the Corporate		
	was written by Nurse	#1. The note specified			Compliance Nurse will be responsible	to	
	Resident #3 was leav	ving the dining room and had			inform the Administrator and conduct a	an	
	an altercation with R	esident #1 in which Resident			investigation to determine why the		
	#3 utilized his motori	zed wheelchair to roll over			discrepancy is there and if needed to		
	Resident #1's feet. F			assist in correcting the issue.			
		ult of Resident #1 being in			8. The Corporate Compliance Nurse		
		#3 and not moving out of the			also conduct rounds on a weekly basis		
		ent #3 wanted. The nurse's			three (3) months; a bi-monthly basis for		
		ent #3 reported that he rolled			three (3) months and then monthly for		
		eet because Resident #1 did			(6) months and conduct interviews with		
		vay so "he had to teach him a			the staff and residents to ensure that a	all	
		ew of the progress note			incidents have been reported and		
		3 appeared to have "no			compare with the Clinical Teams revie	ws	
		again that he had to teach			and interventions.	orina	
		w of the nurse note revealed			9. Resident to resident abuse monito	-	
	incident and noted te	Resident #3 after the			will be conducted every shift on the flo sheet logs, by the appointed licensed	vv	
	behavior would not b				nurse, termed Champion nurse. Thes	P	
					logs are reviewed daily by DON and I		
	Resident #1 was add	nitted to the facility on			10. For any resident with combative		
		ses that included: Dementia			behaviors, only Nurses or CNAs will be	e	
		ementia with behaviors,			allowed to provide any direct care to	-	
	-	ation deficit, major depressive			include sitting with a resident if this is		
		kness, abnormal posture,			indicated in the resident care plan. Du	ırina	
		t, and a history of falling and			the Orientation training the Nurses an		
		of lower leg among others.			CNA s will receive dementia training		
		#1's most recent quarterly			have to demonstrate the ability to work		

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		D. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
						С
		345541	B. WING		12	/07/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE \	/ILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 9	F 600			
	Minimum Data Set (M Resident #1 was cog noted behaviors. Re- requiring extensive at transfer, dressing, toi hygiene. Resident # limited assistance wit unit. A review of Resident revealed no documer Resident #1's feet wh feet on 11/25/18. An interview with Mea at 3:41 PM revealed the hall and heard Re- my way" angrily. She Resident #3 had the wheelchair pushed as towards Resident #1. reported to her that R moved out of his way appeared frightened as space. She stated R wheelchair to be off to Resident #3 continuir over Resident #1's fe surprised Resident #1's fe	ADS) Assessment revealed nitively impaired with no sident #1 was coded as ssistance with bed mobility, let use and personal 1 was coded as requiring th locomotion on & off the #1's medical record need skin assessment of nen Resident #3 ran over his dication Aide #1 on 12/04/18 on 11/25/18 she was out in esident #3 state "get out of		<ul> <li>with combative residents, to de-et the behaviors, and provide care it manner and way that protects the from abuse. They will receive add training at least annually but as r well. The decision to implement procedure was made on October and then re-evaluated on 12/05/2 The staff was educated about thi procedure which on 12/06/2018 I Director of Nursing and Administ all others were required to be in-prior to returning to work.</li> <li>11. As a means of quality assure Administrator shall be responsibl report all allegations and investig initiated, as per policy, to the Pret the company, on a daily basis wh received, in an effort to review ar confirm appropriate immediate at taken, including thorough investig per facility policy.</li> <li>12. All investigations, with sumn findings and resolution, shall be pongoing and reviewed by the QA Committee on a monthly basis to adherence with facility policy, with frequency of review revised only the Committee deem appropriate</li> </ul>	n a e resident ditional heeded as this 17, 2018 2018. s by the rator and serviced ance, the e to hations sident of hen hd ction gation as hary of oresented h should	
	regards to what she w During an interview w 10:12 AM she revealed			Indicate How The Facility Plans <sup>-</sup> Monitor It⊡s Performance To Ma That Solutions Are Sustained. T Facility Must Develop A Plan For That Correction Is Achieved And	ke Sure he	

Facility ID: 990623

ATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE	SURVEY
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	NG	COMP	LETED
						2
		345541	B. WING		12/	07/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE	
				13825 HUNTON LANE		
JLDE KNO	DX COMMONS AT THE V	ILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETIC DATE
F 600	Continued From page	<u>&gt;</u> 10	E	500		
		ne continued, reporting that				
		incident in the nurse's notes		1. The resident care	e unit rounds will be	
		orted it to her. She stated		presented at weekly G		
	after the incident was			monthly to the QAPI C		
		al assessment of Resident		evaluation to determin		
		o injuries and she observed		adequate and if not to	-	
	no broken skin or bru	ising with no complaints of		re-implement a syster	n to ensure that the	
		<ol> <li>She reported notifying the</li> </ol>		alleged deficient pract	tice does not occur	
	-	nessage and received a		again.		
	response of "OK, tha					
		stated she did not set up		2. All incident report		
	any monitoring system			monthly at the QAPI C	-	
	behavior again.	ibiting this inappropriate		for any bruises, skin te unknown origin and in		
	Denavior again.			incidents of unknown		
	An interview with Nur	se Supervisor #1 on		any patterns or practic	-	
		revealed she was informed		considered abuse.		
		se #1. She stated she		<ol> <li>All investigations,</li> </ol>	with summary of	
		to Nurse Supervisor #2 on		findings and resolution		
	11/26/18 who reported	d she would notify the		ongoing and reviewed		
	Director of Nursing. T	he NS indicated she was		Committee on a mont	hly basis to ensure	
		itoring systems that were		adherence with facility		
		ent Resident #3's behavior		frequency of review re	-	
	from happening agair	1.		the Committee deem		
	A	0		4. If any patterns or	-	
	An interview with Nur	•		the QAPI Committee		
		evealed she was notified of 18 during her morning		immediate investigation solutions are put into		
		<sup>4</sup> 3 had run over two different		corrective action is ac		
		y before. She stated she		sustained.		
	-	o complete an incident			ee, QAPI Committee	
		the incident and pass the		and the Medical Direc		
		her report. She stated she		apprised of this plan a	and commit their	
		or of Nursing (DON) that		support to assisting th		
	morning and asked th	e DON about the incidents.		achieving and sustain		
	-	N informed her that she was		this alleged citation. T		
	-	incident and the facility was		was notified on 12/06/	2018.	
	ordering a urinalysis f	or Resident #3.				

Facility ID: 990623

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	F DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIF	PLE CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	MPLETED
						С
		345541	B. WING		1	2/07/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
OLDE KNO	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETIO
F 600	Continued From page	e 11	F 60	00		
	During an interview w	ith the Director of Nursing				
	(DON) on 12/04/18 it	was revealed she had been				
		cident on the morning of				
		d she was scheduled to e Resident				
		ssurance measures that the				
		monitoring. She reported				
	she received a text m	essage the morning of				
		#1 and reported she had				
1	•	d by Nurse Supervisor #2 by				
		eived the text message. She both residents involved in				
		eir general wellbeing but				
		king about the incident with				
	the motorized wheeld	hair. The DON stated both				
		ng any issues or complaints				
		orted she observed and				
		sident #1's feet and found es or problems with redness,				
		n tears or other injuries.				
	The DON reported sh	-				
	Administrator about th	he incident involving				
	Resident #1 and Res	ident #3.				
	An interview with the	Administrator on 12/04/18 in				
		she had been made aware				
	÷	26/18 and reported she				
	re-educated Nurse #1					
		tive staff until someone was				
		she did not start an abuse				
	•	local law enforcement, local ces or the state agency due				
		ncident was not abuse. She				
		ng an internal investigation				
	due to her belief that	the incident was not abuse,				
		ent to resident incident and				
	that is was not report					
	prevent similar incide	erventions to attempt to				

If continuation sheet Page 12 of 59

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		SURVEY PLETED
		345541	B. WING _				07/2018
NAME OF PI	ROVIDER OR SUPPLIER		- I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KNO	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			825 HUNTON LANE UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	PM, written by Nurse an incident with Resid dining room. Further revealed Resident #3 with his motorized wh Resident #2 was in hi the nurse's note indic incident of Resident # resident's feet due to reportedly being in Re nurse's note also reve would continue to mo told Resident #3 that tolerated and passed incident onto the 3rd Resident #2 was adm 5/26/18 with diagnose depressive disorder, of in right and left knee among others. A revi recent MDS Assessm coded as a quarterly Resident #2 to be cog physical and verbal b others occurring 1-3 of period. Resident #2 to extensive assistance locomotion on the uni was coded as being t transfer.	nt #3's nurse's notes the dated 11/25/18 at 7:18 #1, stated Resident #3 had dent #2 while leaving the review of the nurse's note ran over Resident #2's feet neelchair reportedly because is way. Additional review of ated this was the 2nd 43 running over another the other residents esident #3's way. The ealed the nurse stated she nitor Resident #3's behavior, behavior would not be the information of the shift Nurse Supervisor. hitted to the facility on es that included: major chronic kidney disease, pain and restless leg syndrome few of Resident #2's most nent dated 11/24/18 and assessment revealed gnitively impaired with noted ehaviors directed towards days during the look back was coded as requiring with bed mobility, it and dressing. Resident #2 otally dependent with	F	;00	DEFICIENCY)		
	revealed no documer	nted skin assessment of er Resident #3 ran over his					

Facility ID: 990623

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345541	B. WING			C /07/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
OLDE KNOX COMMONS AT THE	VILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 600 Continued From pag	e 13	F 60	0		
<ul> <li>#1 who completed the revealed she did not over Resident #2's fee wheelchair first hand #1 reported the incid nurse's note as a refile was reported to her. assessed Resident # be no injuries and reported by received a by text.</li> <li>An interview with Die 11:15 AM revealed s assisting residents w yell out "oh, oh, he radist she turned around ar continuing to try and Resident #2's feet. See Resident #2's feet. See Resident #2's feet. See Resident #2's foot. Set two residents to see anurse, whom she cout the hall with whom set attement about the forgotten and did not An interview with Nur 12/04/18 at 10:45 AM of the incident by Nu reported the incident</li> </ul>	4/18 at 10:12 AM with Nurse e nurse's note on 11/25/18 witness Resident #3 running eet with his motorized . She reported Dietary Aide ent to her and she wrote her lection of the incident as it She stated she visually 2's feet and noted there to ported no lingering pain. She he incident to the Director of dent by text message and a response of "OK, thanks" etary Aide #1 on 12/04/18 at he was in the dining room then she heard Resident #2 an over my foot." She stated nd observed Resident #3 engage his wheelchair over She reported observing to grab Resident #3 but by 8 had already run over She reportedly ran over to the arate them and informed a uld not identify, walking down he asked for help. Dietary e was asked to write a incident but reported she had complete it until 12/04/18. rse Supervisor #1 on A revealed she was informed rse #1. She stated she to Nurse Supervisor #2 on ed she would notify the				

Facility ID: 990623

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/07/2019 APPROVED D: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		LETED
		345541	B. WING _				C 07/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KNO	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 14	F6	500			
	the incident on 11/26/ Resident #3 had run of feet. She stated she complete an incident incident and pass the report. She stated sh Nursing (DON) that m about the incidents. S informed her that she incident and the facilit for Resident #3. During an interview w (DON) on 12/04/18 at she had been made a morning of 11/26/18 at scheduled to monitor and Resident #3 for o measures that the fac monitoring. She repor residents involved in t general well being but about the incident with The DON stated that current issues or com observed and visually feet on the morning of to have no issues or p bruising, swelling, skii had no complaints of she informed the Adm the incident involving #3.	evealed she was notified of 18 during her report that over two different resident's instructed Nurse #1 to report and document the information on during her e spoke with the Director of iorning and asked the DON She reported the DON was already aware of the ry was ordering a urinalysis ith the Director of Nursing 11:45 AM it was revealed iware of the incident on the ind reported she was the hall where Resident #2 ther quality assurance ility was currently ted she spoke to both the incident about their t denied specifically asking in the motorized wheelchair. both residents reported no plaints. She stated she assessed Resident #1's f 11/26/18 and found them problems with redness, in tears or other injuries and pain. The DON reported inistrator on 11/26/18 about Resident #2 and Resident					
	11:45 AM revealed sh	e had been made aware of					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		NSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345541	B. WING				/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			5 HUNTON LANE TERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 600	the incident regarding motorized wheelchair and Resident #2 on 1 re-educated Nurse #1 contacted administrat reached. She stated investigation, contact adult protective servic to her belief that the in reported not completi due to her belief that stating it was a reside that is was not reports was no further follow- her determination tha running over Residen wheelchair was not al The Administrator wa Jeopardy on 12/05/18 provided an acceptab Immediate Jeopardy 1 10:50 AM which spect Credible Allegation of removal F-600 FREEDOM FROM AE EXPLOITATION Resident has the righ neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	<ul> <li>a Resident #3 running his</li> <li>b over the feet of Resident #1</li> <li>1/26/18 and reported she</li> <li>a on making sure she</li> <li>b on the state agency due</li> <li>b on the incident of Resident #3</li> <li>b on the incident of Resident #3</li> <li>b on the incident of Resident #3</li> <li>b on the facility's</li> <li>b on the facility is one on the facility is on</li></ul>	F 6	500			

Facility ID: 990623

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345541	B. WING				C 07/2018
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
				1	13825 HUNTON LANE		
OLDE KNO	JX COMMONS AT THE V	ILLAGES OF MECKLENBURG		I	HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page treat the resident's ma Address How Correct Accomplished For The Have Been Affected E The following interver the facility: 08/18/2018 Incident: 1. The facility did no Resident #1 on 08/18 Companion was struct Resident Companion a skin tear, based on the facilities' investigat the Resident Companion interview with the emp made to move the em department as a Dieta be able to provide car we were in compliance 2. However due to the the facility for failure the employee's statement has decided to re-ope 3. The Police were 10:00 am and they can 10:30 am at which tim 4. The facility sent	e 16 edical symptoms. tive Action (S) Will Be ose Residents Found To By The Deficient Practice: ntions were put into place by of substantiate the abuse of /2018 when Resident ck by Resident #1 and grabbed his arm resulting in the witness statement and ation at that time. Based on nion's statement we the employee and he investigation was our investigation was our investigation and ployee the decision was inployee to the Dietary ary Aide where she will not re with the residents. Thus we as of the 08/18/2018 date. the complaint survey citing o prevent abuse due to the t on 12/03/2018 the facility en the investigation. notified on 12/05/2018 at une to the facility around		600	DEFICIENCY)		
	5. The employee in need to come in for a	question was notified of the nother interview on arrived at 12:30 pm at which					

Facility ID: 990623

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345541	B. WING				C 107/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
OLDE KN	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	time an interview was the employee is susp investigation. If the in her back to work she orientation at which ti on Abuse, How to rea from residents, and D Therefore the facility environment free from 11/25/2018 Incident: 1. November 25, 20 where Resident #3 ra #1 and Resident #2. Resident #1 and Resi Resident #1 and Resi Resident #1 from the Resident #3, per #1 N statement and nurse! with Resident #2 and room intervened by a the dining room which running over resident LPN evaluated the re the time and there we from the residents pe facility did not identify incident as an abusive incident, the resident" Though Resident #3 s the resident's feet wh further consideration admission could be e acute mental status re Infection. Resident # aggression or alterca for acute UTI. The Re	a conducted. Per our policy ended now pending another vestigation supports bringing will have go through another me she will receive training act to combative behavior bementia Training. has provided an n abuse. 018 there was an incident in over the feet of Resident The staff intervened with ident #3 by removing area and monitoring Nurse LPN witness s note. After the incident #3 the staff in the dining ssisting Resident #3 from n was his intent when *#2's feet. The #1 Nurse sident #1 and #2's feet at ere no injuries or complaints r the nurse's notes. The r the not cause of the e act. At the time of s intent was not clear. stated he meant to run over ien asked by staff, upon by administration, this rroneous due to resident's elated to Urinary Tract 3 does not have a history of tion and was being treated	F	500			

Facility ID: 990623

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMF	
		345541	B. WING				07/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	<ol> <li>On November 26 a thorough skin asses Resident #2 involved and there were no no discoloration, scratch residents did not appe emotional distress as they mentally appears and did not express a mental distress.</li> <li>The Resident #3 Therapy on 12/03/20 resident has the capa motorized chair indep that resident has great space is available. He immediately by his sid field. He tends to use his visual field as opp Required cues to turn turn the chair. Due to residents the Interdist Physician has decide evaluated on 12/06/2 wheelchair and place evaluation.</li> <li>Address How Correct Accomplished For Th Potential To Be Affect Practice:</li> <li>All interview able</li> </ol>	resident to resident abuse. 6, 2018 the DON completed ssment on Resident # 1 and in the 11/25/2018 incidents ted areas of bruising, es and or injury. The ear to have any mental or a result of the incident as ed to be at their baseline my signs of physical or was evaluated by Physical 18 to determine if the ability of maneuvering a bendently. It was determined at difficulty when decreased is unable to see his feet or des due to decreased visual e the wheelchair to increase bosed to turning his head. his head instead, he would b the safety needs of the ciplinary Care Team and d the resident will be 018 for a traditional d in chair after the tive Action Will Be ose Residents Having ted By The Same Deficient	F	600			
		Vorker and Director of if they had been a recipient					

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		ID HUMAN SERVICES			FOF	ED: 01/07/2019 RM APPROVEI
STATEMENT (	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DA	10. 0938-039 TE SURVEY MPLETED
		345541	B. WING		1	C 2/07/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		2/01/2010
				13825 HUNTON LANE		
OLDE KNO	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 OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	member, visitor or an interviews were cond there were no resider witnessed any abuse 2. The facility perfor Incident reports, since this process was esca hour nursing shift rep reviewed for incidents to resident altercation process was initiated the resident to reside To date, there have b origin to investigate. Signature Agenda ref the Clinical Team atter non-interview able resonated incidents 3. The Administrato Corporate Nurse Com In-services with all sta and completed on 12.	the by a staff member, family other resident. The ucted on 12/05/2018 and ints who had experienced or rmed ongoing audits of e October, 2018. However, alated further to include 24 orts as well, which are is involving possible resident as, and or abuse. This new by Administrator following int altercation on 11/28/2018. een no injuries of unknown The Morning Meeting flects the Administrative and endance. Thus all sidents have not had any or, Director of Nursing and isultant conducted aff beginning on 12/05/2018 /07/2018 which is required	F 6			
	new hires will be required following training in o with the resident; a. ABUSE - Reside from abuse, neglect, property, and exploitable. Types of abuse, chemical, sexual, and c. What to do if abureport the abuse to, d. How to react to compare the abuse to compar	rientation prior to working nt has the right to be free misappropriation of resident ation. i.e., (physical, verbal, d resident to resident abuse. use is witnessed, who to combative behavior from vide care and services to to prevent abuse to the care giver; and				

Facility ID: 990623

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM A	01/07/2019 APPROVED 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE SU COMPLE	URVEY
		345541	B. WING		_	C 12/07	7/2018
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		3825 HUNTON LANE IUNTERSVILLE, NC 280	078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETION DATE
F 600	<ul> <li>f. Reporting of ANY any type, neglect, exp misappropriation of reg. Notification of the Administrator and the IMMEDIATELY. Fail disciplinary action.</li> <li>4. The Administrator received additional tra and regulations, the in regulations regarding and then timely report required agencies and was completed on 12 Nurse Consultant.</li> <li>Address What Measu Or Systemic Changes Deficient Practice Wil</li> <li>1. Due to the safety the Interdisciplinary C has decided the Resisi 12/06/2018 for a tradii in chair after the evalue</li> <li>2. The Nursing Staff Nurse Manager of the them to be hyper vigil Resident #3) on 11/25 made aware of the Re- need to be hyper vigil 12/07/2018. The Dire- completed QA rounds exhibit any further belo occur to report immediant.</li> </ul>	Y SUSPICION of abuse of ploitation and esident property. e incident to the e Director of Nursing ilure to notify will result in or and the Director of Nursing aining on the Abuse policy nvestigation process and the timely notification by staff, ting of the abuse to the d Dementia Training. This 2/06/2018 by the Corporate ures Will Be Put Into Place is Made To Ensure That The II Not Recur: y needs of the all residents Care Team and Physician dent #3 will be evaluated on itional wheelchair and placed uation. If were informed by the e incident and instructed lant with observation of 5/2018. All staff has been esident ' s behavior and the lant with observation by	F 600				

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		MEDICAID SERVICES	(X2) MULT		NSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· · ·	MPLETED
							С
		345541	B. WING			1	2/07/2018
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG			HUNTON LANE TERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 600 Continued From page 21 3. The Director of Nursing implemented		F6	500				
	<ul> <li>F 600 Continued From page 21</li> <li>3. The Director of Nursing implemented Administrative Nursing Staff rounds on the resident care units on 10/17/2018 (entering rooms and showers where care was being provided) and have continued to monitor four (4) times a week to ensure that care delivery is being conducted in a way that preserved the resident's privacy, dignity and freedom from abuse. There have been no incidents noted since that time. These rounds will continue at four (4) per week (including at least one (1) on the 11-7 shift for the next six (6) months and then two (2) per week for the following six (6) months to ensure that the deficient practice does not reoccur. The facility performed ongoing daily audits of Incident reports, since October, 2018. However, this process was escalated further to include 24 hour nursing shift reports as well, which are reviewed for possible resident to resident altercations, and or abuse. This new process was initiated by Administrator following the resident to resident altercation on 11/28/2018. To date, there have</li> </ul>						
	4. All interview able by the facility Social V Nursing to determine of, or witnessed abus member, visitor or an interviews were cond	ucted on 12/05/2018 and nts who had experienced or					
	RN Consultant on 12 interviews involved do to resident abuse awa	were conducted by outside /5/2018-12/6/2018. The etail questioning pertaining areness, prevention and all facility staff. Interview d by Administration for					

Facility ID: 990623

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · · ·	IPLETED
						С
		345541	B. WING		1:	2/07/2018
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		325 HUNTON LANE JNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 22	F 600			
possible concerns.						
	their next tour of duty policy with emphasis knowledge of any incorreporting knowledge abuse (of any type), f investigation as to the rumor/hearsay. Failur disciplinary action. Ad were addressed as to clearly specified the e dementia, during orie ensure ongoing comp process has been and dementia training for ensure care givers an combative residents, Additionally, immedia hearsay which could will be addressed dur hired employees to e policy No concerns staff interviews. Obse environment and at right	e validity of the re to do so will warrant dditionally, staff members of the revised policy which educational training on entation. As a means to obliance, the orientation hended to fully integrate CNA's and Nurses, to re receiving tools to care for				
	<ul> <li>monitoring flow sheet</li> <li>submitted to DON an</li> <li>stand up meeting.</li> <li>7. Incident Reports</li> <li>Report) will be review</li> <li>in morning meetings</li> <li>include bruises, skin</li> </ul>	documented on Behavior ts. The flow sheets will be d discussed by IDT at daily and (24-Hour Nursing ved Monday through Friday for any unusual incident to tears and injuries of resident to resident abuse.				

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/07/2019 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		TE SURVEY MPLETED
		345541	B. WING		1:	C 2/07/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO		
		/ILLAGES OF MECKLENBURG		13825 HUNTON LANE		
		MELAGES OF MECKEENBORG		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	origin and any occurr abuse will be reported Huntersville Police De Carolina Health Care incident reports are c the staff nurses and t responsible to print th unit before the mornin responsible to bring t In addition they will b Report to the meeting compared to ensure i are investigated and In the event the nursi responsibility of printi the 24-Hour Nursing ADON and then to the 8. The Corporate C responsible to review Staff rounds Sheets c (3) months; a bi-mont months and then mor determine that facility credible allegation of interventions have be are discrepancies in t Corporate Compliance to inform the Adminis investigation to detern there and if needed to issue. 9. The Corporate C conduct rounds on a months; a bi-monthly and then monthly for	rence that is suspected d immediately to the epartment and the North Personnel Registry. The completed electronically by the nurse supervisors are ne incident report(s) for their ng meeting and are hem to the morning meeting. ring the 24-Hour Nursing g and two documents will be incidents of unknown origin interventions put into place. ng supervisor is absent the ng the incident reports and Report is assigned to the e DON. Compliance Nurse will be the Administrative Nursing on a weekly basis for three thly basis for three (3) nthly for six (6) months to r is in compliance with the	F 60			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	01/07/2019 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			(X3) DATE S COMPL	SURVEY ETED
		345541	B. WING			C <b>12/0</b>	7/2018
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE	, ZIP CODE	-	
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG		3825 HUNTON LANE HUNTERSVILLE, NC 28078	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 600	<ul> <li>conducted every shift the appointed license nurse. These logs are and IDT.</li> <li>11. For any resident only Nurses or CNAs any direct care to incl this is indicated in the the Orientation trainin will receive dementia demonstrate the abilit residents, to de-escal provide care in a man the resident from abu- additional training at l as well. The decision procedure was made then re-evaluated on educated about this p to be completed prior 12/06/2018 by the Dir Administrator.</li> <li>12. As a means of qu Administrator.</li> <li>12. As a means of qu allegations and invest policy, to the Presider basis when received, confirm appropriate in including thorough inv policy.</li> <li>13. All investigations and resolution, shall be reviewed by the QA C</li> </ul>	ent abuse monitoring will be on the flow sheet logs, by d nurse, termed "Champion" e reviewed daily by DON with combative behaviors, will be allowed to provide ude sitting with a resident if resident care plan. During g the Nurses and CNA's training and have to y to work with combative ate the behaviors, and ner and way that protects se. They will receive east annually but as needed to implement this on October 17, 2018 and 12/05/2018. The staff was rocedure which is required to returning to work; on ector of Nursing, vality assurance, the responsible to report all igations initiated, as per nt of the company, on a daily in an effort to review and nmediate action taken, vestigation as per facility , with summary of findings be presented ongoing and committee on a monthly ence with facility policy, with evised only should the	F 600				

Facility ID: 990623

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345541	B. WING				C 07/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			13825 HUNTON LANE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	25	F	600			
	Performance to Make Sustained. The Facil Ensuring That Correct Sustained: 1. The QA Committe Medical Director have and commit their supp with achieving and su this alleged citation. T notified on 12/06/2018 2. The resident care presented at weekly O the QAPI Committee if the system is adequ re-implement a system deficient practice doe 3. All incident report at the QAPI Committee skin tears and injury O investigations of incid determine if any patter may be considered at 4. All investigations and resolution, shall be reviewed by the QA O basis to ensure adher frequency of review re Committee deem app 5. If any patterns or QAPI Committee will investigation to ensure	ee, QAPI Committee and the e been apprised of this plan port to assisting the facility istaining compliance with The QAPI Committee was 8. e unit rounds will be QA meetings and monthly to for evaluation to determine late and if not to devise and m to ensure that the alleged s not occur again. ts will be reviewed monthly ee Meeting for any bruises, of unknown origin and ents of unknown origin to erns or practices exist that buse. , with summary of findings be presented ongoing and Committee on a monthly rence with facility policy, with evised only should the propriate. practices are noted, the					

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			3) DATE S COMPL	ETED
		345541	B. WING			C 12/0	; )7/2018
	ROVIDER OR SUPPLIER	VILLAGES OF MECKLENBURG	STREET ADDRESS, CITY, STATE, ZIP COU 13825 HUNTON LANE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE
F 600 F 607	The facility's credible verified on 12/07/18 a staff were interviewed were in-serviced on t responsibility to repor Develop/Implement A	allegation of IJ removal was at 4:09 PM when the facility d and demonstrated they he topic of abuse and their rt abuse in any form. Abuse/Neglect Policies		600 607			12/12/18
SS=J	§483.12(b) The facilit implement written po §483.12(b)(1) Prohib neglect, and exploitat misappropriation of re §483.12(b)(2) Establit to investigate any suc §483.12(b)(3) Include paragraph §483.95,	ty must develop and licies and procedures that: it and prevent abuse, tion of residents and esident property, ish policies and procedures					
	Based on record rev facility failed to imple the areas of Identifyir Reporting for 2 of 3 F abuse. The facility fai and report to law enfo physical abuse when Resident #1 and caus to his arm. The facilit investigate and repor resident abuse to law survey agency when and deliberately rolle Resident #2's feet wi Resident #1 and Res	Residents reviewed for iled to identity, investigate orcement an incident of a Sitter forcefully grabbed sed a 4-centimeter skin tear y also failed to identify, t an incident of resident to y enforcement and the state Resident #3 intentionally d over Resident #1 and th his motorized wheelchair.			Address How Corrective Action (S) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: 1. The facility did not substantiate the abuse of Resident #1 on 08/18/2018 when Resident Companion was struck by Resident #1 and Resident Companion grabbed his arm resulting in a skin tear, based on the witness statement and the facilities investigation at that time. Based on the Resident Companion s statement we immediately removed the employee and suspended her until the investigation	d	

Event ID: T0DQ11

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	LETED
			A. BUILDING	·		C
		345541	B. WING			。 07/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		0772010
				13825 HUNTON LANE		
OLDE KNO	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLETIC DATE
F 607	Continued From page	e 27	F 60	7		
	physical injuries.			was complete. Based on our	rinvestigation	
				and interview with the employ	yee the	
		began on 08/18/18 for		decision was made to move		
		Sitter (who was employed by		to the Dietary department as		
	the facility) grabbed his arm and caused a			Aide where she will not be at		
	4-centimeter (cm) skin tear. Immediate Jeopardy began on 11/25/18 for Resident #1 and Resident			monitoring or companionship		
	-			residents. Thus we were in o	compliance	
	#2 when Resident #3	5		as of the 08/18/2018 date.		
	deliberately rolled over	r. Immediate Jeopardy was		2. However due to the com citing the facility for failure to		
	removed on 12/07/18			abuse due to the employee		
		ble allegation of Immediate		on 12/03/2018 the facility dec		
	-	-	re-open the investigation.			
		r scope and severity level of		3. The Police were notified on		
	D (no actual harm with	th a potential of minimal		12/05/2018 at 10:00 am and	they came to	
	harm that is not Imme	ediate Jeopardy) to ensure		the facility around 10:30 am a	at which time	
	monitoring systems p	out into place are effective.		<ul><li>we made a report.</li><li>4. The facility sent in a 24</li></ul>	Hour Report	
	The finding included:			to NCDHSR to indicate that t re-opened the investigation.	hey had	
	Review of the facility'			5. The employee in questic	on was	
		05/05 revealed in part, area		notified of the need to come i		
		d "(Facility) will follow up with		interview on 12/05/2018 and		
		that occur to ensure that		at 12:30 pm at which time an		
	-	t have not occurred." In		was conducted. Per our poli	-	
		on, the facility "will review all e, if possible, the cause of		employee was suspended pe	-	
		y that may have occurred."		another investigation. The fa	•	
		orough follow up will be		12, 2018. After conducting ar		
	<i>'</i>	the cause of all injuries. 2)		interview, the employee adm		
		s will be conducted with the		Administrator and Director of		
	-	he foremost concern in order		she lied about the circumstar	•	
	-	t from future harm. In further		surrounding the incident on 0	8/18/2018.	
	-	eporting/Response read in		When asked why, she stated		
		nts/accidents that are		didn⊡t want to lose her job b	ut she had	
	-	glect, or misappropriation,		thought about it and this is th		
		s may be contacted: A)		reported to the surveyor a dif	-	
	North Carolina Division	an of Facility Comission (state		She stated that based on the	ourront	

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	F DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED
						С
		345541	B. WING		1:	2/07/2018
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
				13825 HUNTON LANE		
	JX COMMONS AT THE V	ILLAGES OF MECKLENBURG	HUNTERSVILLE, NC 28078		8	
(X4) ID		ATEMENT OF DEFICIENCIES	ID		AN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	COMPLETIC
F 607	Continued From page	e 28	F 60	7		
				considered abuse. The		
		/'s policy (dated 04/05/05)		employee s employn		
		/ and Procedures" revealed		on December 12, 201		
		nt Abuse". Review of this		6. For Resident #1 updated on 08/30/201	•	
	section revealed subs			to reflect how to appre	-	
		be conducted of all reports		providing care and se		
		t and/or family to resident		his behaviors and to g		
		vestigation will be conducted		to always have two st	aff members when	
		fety as the foremost concern		providing his care; to	-	
		e resident or residents from		voice what is going to		
	future harm.			resident before startir care if resident becon		
	1 Resident #1 was a	dmitted to the facility on		to re-approach after h		
		ses which included Lewy		and cooperative to fin		
	-	) (a Parkinson like dementia				
	that progressively wo	rsens). The most recent				
	comprehensive Minin					
		01/18 revealed he had				
	severe cognitive impa	-		For the incident on N	oversher 05, 0010	
	activities of daily living	ssistance with most of his		For the incident on No the following applies:	ovember 25, 2018	
		ed during the assessment		the following applies.		
	period.			1. Where Resident	#3 ran over the feet	
				of Resident #1 and R	esident #2 the staff	
		1's Care Area Assessment		intervened with Resid		
		lated 06/01/18 revealed in		#3 by removing Resid		
	•	gnosis of LBD and had		and monitoring Resid	· •	
		cognitive decline over the		LPN witness stateme		
	last few months. The Resident #1 had poor	CAA also indicated		2. With the second Resident #2 and #3 th		
	impulsive behaviors.	Salety awareness dilu		room intervened by a	-	
				from the dining room		
	Review of Resident #	1's Care Plan dated		when running over re		
		rt that he had LBD which		The #1 Nurse LPN ev		
	resulted in his rapid c			#1 and #2⊡s feet at tl		
	-	to maintain the ability to		were no injuries or co	-	
	follow simple comman which included facing	nds by utilizing interventions		residents per the nurs	se⊟s notes. ot identify the root	

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		MEDICAID SERVICES				O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		. ,	E SURVEY IPLETED
			A. BUILDING	3		С
		345541	B. WING		1.	2/07/2018
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		2/07/2010
				13825 HUNTON LANE		
DLDE KNO	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	O THE APPROPRIATE	COMPLETIO DATE
F 607	Continued From page	e 29	F 60	7		
	speaking slowly and	distinctly to him and maintain		cause of the incident as a	an abusive act.	
	eye contact during int			At the time of incident, th	e resident⊡s	
				intent was not clear. Th	-	
		Note, written by Nurse #2,		#3 stated he meant to run		
		22 AM indicated in part that		resident s feet when as		
		t and verbal with confusion.		further consideration by a		
		a skin tear to the top of left		this admission could be e		
		ured 4 cm long by 1.5 cm in tunneling 0.5 cm to the left		resident⊡s acute mental Urinary Tract Infection. F		
	-	Resident #1 was calm and in		not have a history of agg		
		eatment was being given.		altercation and was being		
	Resident #1 stated "ti			acute UTI. The Resident	-	
	scuffling, and she tore	e a chunk of meat from his		Altercation resulted in no	physical harm to	
	-	her." The note specified,		Resident #1 and #2. The	•	
		ed that the Sitter said "ha,		submit a report, as per re	esident to	
		ent #1 stated he felt some		resident abuse.		
	soreness in his left ar	m.		4. On November 26, 20		
	Poviow of the Sitter's	statement dated 08/18/18		completed a thorough sk on Resident # 1 and Res		
		esident #1 was trying to		in the 11/25/2018 inciden		
		b get him to sit back down in		no noted areas of bruisin		
		y. Resident #1 then got very		scratches and or injury. F	•	
	-	the Sitter in the jaw with his		#2 did not appear to have		
	-	the Sitter shoved his arm		emotional distress as a re		
		anner accidentally digging		incident as they mentally		
		in the process. The Sitter		at their baseline and did		
	•	NS #3 and told her what		signs of physical or ment		
		Sitter went back to the ad his left sleeve rolled up		5. Resident #3 was eva Physical Therapy on 12/0		
		that she had unintentionally		determine if the resident		
	caused.			of maneuvering a motoriz		
				independently. It was de		
	Review of Employee'	s Accident/Incident Report		resident has great difficul		
		00 AM written by Nurse		decreased space is avail	-	
		tated Resident Companion		unable to see his feet or		
		er and stated Resident #1		his sides due to decrease		
	-	ce and she scratched him		He tends to use the whee		
	accidentally as she w	as moving his arms out of		increase his visual field a	is opposed to	

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		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	E SURVEY
						С
		345541	B. WING			2/07/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 607	Continued From page	e 30	F 60	17		
	#3 told her to remove herself from Resident #1's room.			his head instead, he would tu Due to the safety needs of th the Interdisciplinary Care Tea	e residents am and	
	Telephone interview with Resident Companion (Sitter) on 12/03/18 at 3:05 PM she stated Resident #1 had started to stand up and she told him to sit back down then he reached up with his			Physician has decided the re evaluated on 12/06/2018 for wheelchair and placed in cha evaluation. Resident was pla	a traditional iir after the	
	hand and hit her in th of instinct she grabbe keep him from hitting Resident #1 was sittir	e face. The Sitter stated out d Resident #1's left hand to her again. By this time ng down so she immediately		traditional wheelchair on 12/0 continues with therapy workin be able to maneuver the cha spaces.	)6/2018 and ng with him to	
	happened. The Sitter holding an ice pack to Resident #1 to the de said "Oh, you did this tear. The Sitter stated	ation to report what had stated while she was o her right jaw they brought sk and when he saw her he " while pointing to his skin d Resident #1 was not		Address How Corrective Acti Accomplished For Those Res Having Potential To Be Affect Same Deficient Practice:	sidents	
	Sitter continued in pe incident. The Sitter st were watching televis	PM the interview with the rson with demonstration of ated she and Resident #1 ion when he started to stand in front of him and leaned		1. All interviewable residen interviewed by the facility So and Director of Nursing to de they had been a recipient of, abuse by a staff member, far visitor or another resident. T	cial Worker termine if or witnessed nily member,	
	up and she stood up in front of him and leaned down to him and said (Resident #1) you need to sit down and at that time he had already sat back down then he "hit me on the right side of my face with his left hand and out of instinct I grabbed his arm to keep him from hitting me again" and in			<ul> <li>were conducted on 12/05/20</li> <li>were no residents who had e or witnessed any abuse.</li> <li>2. The facility performed or of Incident reports, since Oct</li> </ul>	18 and there xperienced ngoing audits	
	doing so my fingernal arm. The Sitter stated caused the skin tear t came to the nurses' s	ils caused a skin tear on his d she did not know she to Resident #1's arm until he station later and showed the		However, this process was e further to include 24 hour nur reports as well, which are rev incidents involving possible r	scalated sing shift viewed for esident to	
	resident's arm) clearly fingernails and it was	n. The Sitter stated, "It (the y had the imprints of my open with small drops of plained that she had not		resident altercations, and or a new process was initiated by Administrator following the re resident altercation on 11/28/	esident to	

Facility ID: 990623

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						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY
			A. BUILDING			С
		345541	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		2/07/2018
				13825 HUNTON LANE		
OLDE KN	OX COMMONS AT THE	VILLAGES OF MECKLENBURG	HUNTERSVILLE, NC 28078			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	N OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE IENCY)	COMPLETIO DATE
F 607	Continued From page	e 31	F 60	7		
				abuse to investigate. T	he Morning	
	Review of NS #3's w	ritten statement (undated)		Meeting Signature Age		
	and timed 10:00 AM			Administrative and the		
		stated Resident #1 needed		attendance. Thus all n		
		ed the Sitter what Resident		residents have not had	any noted	
		e Sitter stated that he kept hat he punched her in the		incidents.		
		e wanted to assess Resident		a. The Administrator,	Director of Nursing	
		nim an Ativan and observed		and Corporate Nurse C		
		y smiling and seemed okay.		conducted In-services		
	A minute later the Sit	ter approached NS #3 and		beginning on 12/05/201		
		a skin tear that he had		the majority on 12/07/2	-	
	-	e grabbed his arm to push		else they were required	-	
	him away and (cause	eu a) skin lear.		education prior to return the following; and all ne	-	
	On 12/04/18 at 10:04	AM during an interview with		required to complete th		
		at on 08/18/18 the Sitter		in orientation prior to we		
	came up to her (NS)	and told her (NS) that		resident.	•	
		ng to stand up and she		b. ABUSE - Resident		
		in him and he punched her		free from abuse, negled		
		S #3 stated she called the		misappropriation of res	ident property, and	
		ursing (IDON) and was atement from the Sitter then		exploitation. c. Types of abuse, i.e	(physical yorbal	
	send the Sitter home			c. Types of abuse, i.e chemical, sexual, and r abuse.		
	Review of Nurse #2's	s written statement (undated			e is witnessed, who	
		ed in part that while she was		to report the abuse to,		
	-	s skin tear he stated that she		e. How to react to con		
		Irm with her nails then he		from residents; how to		
	-	nt #1 continued to state the hit her saying "hit me, hit		services to combative r		
		said he hit her. Resident #1		abuse to resident(s) or giver; and		
		y scuffling and that she		f. Dementia training		
	always does this with			g. Reporting of ANY S	SUSPICION of	
	On 12/03/19 at 5:21	PM during a tolophone		abuse of any type, neg	-	
		PM during a telephone #2 she stated she was		and misappropriation of h. Notification of the i		
		ome and note a skin tear on		Administrator and the D		
		<sup>4</sup> 2 stated that it didn't look		IMMEDIATELY. Failu	-	

Facility ID: 990623

		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			TE SURVEY MPLETED
			A. DOILDING			С
		345541	B. WING		1	2/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				13825 HUNTON LANE		
	OX COMMONS AT THE V	VILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLETIC DATE
F 607	Continued From page	e 32	F 60	17		
	like a normal skin tea	ar and described it as deep,		result in disciplinary action.		
		crescent shaped skin flap.		3. The Administrator and	the Director of	
	The Nurse also state	d there was a moderate		Nursing received additional	training on the	
	amount of bleeding.	After NS #2 treated the skin		Abuse policy and regulation	•	
	tear, she documented	d the measurements and		investigation process and the	ne regulations	
	what Resident #1 sta	ted happened in her nurses'		regarding timely notification	by staff, and	
	notes and reported it	to NS #3 and called the		then timely reporting of the	abuse to the	
	IDON.			required agencies and Dem	entia Training.	
				This was completed on 12/0		
	Review of the Investi	gation Timeline written by		Corporate Nurse Consultan	t.	
	IDON and dated 08/2	24/18 and signed by				
	Administrator on 08/2	24/18 revealed the IDON was				
		approximately 10:45 AM		Address What Measures W		
		sident #1 had swung at his		Place Or Systemic Change		
	-	lirected to sit down. While		Ensure That The Deficient I	Practice Will	
		ident #1 down he swung at		Not Recur:		
		in the right side of her				
		ile the Sitter was trying to				
	-	y a skin tear was caused on		1. Due to the safety need		
		esident #1. The IDON told		residents the Interdisciplina		
		Resident #1 and the Sitter		and Physician decided that		
		written statement from the		was evaluated on 12/06/20		
		nome. The Sitter was noted		traditional wheelchair and p	laced in chair	
		right side of her face/jaw.		after the evaluation.	<b>5</b> (1	
		kin tear on his left forearm.		2. All staff has been made		
		ated with normal saline and		resident s behavior and for	•	
	dressed with an occlu	•		future behaviors and the ne		
		ian's On-Call was notified of		vigilant with observation. Th		
		family was notified via		Nursing has completed QA		
	-	completed a 24-Hour Initial		resident does not exhibit an behaviors/abuse. If this doe	•	
		o the state agency. The h Resident #1 and asked him		report immediately any con		
	how he hurt his arm i			resident behaviors to the Di	-	
		ver Resident #1 was not a		Nursing and Administrator.		
	-	the diagnosis of LBD. The		3. All interviewable reside	ents were	
		e continued to indicate on		interviewed by the facility S		
		the Sitter was brought in to		and Director of Nursing to d		
		and the Administrator to		they had been a recipient o		
					, or whiteboou	1

Facility ID: 990623

If continuation sheet Page 33 of 59

						IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			TE SURVEY MPLETED
	-		A. BUILDING	3		
		345541	B. WING			С
		345541				2/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
OLDE KN	OX COMMONS AT THE	VILLAGES OF MECKLENBURG		13825 HUNTON LANE		
				HUNTERSVILLE, NC 28078		
(X4) ID			ID			(X5) COMPLETIC
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE) CROSS-REFERENCED DEFICI	TO THE APPROPRIATE	DATE
F 607	Continued From page	e 33	F 60	7		
	Sitter reported she w	as attempting to redirect		visitor or another reside	nt. The interviews	
		ck down and he began to get		were conducted on 12/0	5/2018 and there	
		l swung at her hitting her in		were no residents who h		
	the right side of her f	ace/jaw. In response to him		or witnessed any abuse		
		eacted by forcefully pushing		4. Staff interviews wer		
	his arm away from her face. She left the room to			outside RN Consultant o		
	-	e increase in agitation. Upon		12/6/2018. The interview		
		with the nurse she and the		questioning pertaining to		
		the sleeve of his left		awareness, prevention a		
		leeve was rolled up a skin		process of all facility sta		
		he Sitter was asked to e reacted when he hit her		results were reviewed b on December 10, 2018		
		ord "forcefully." Both the		concerns. There were n		
		istrator witnessed her		abuse reported in these		
		it was a reaction to being hit		5. All staff members w		
		n to cause a skin tear to his		on 12/06/2018 as to the		
		old by the Administrator that		policy with emphasis on		
		ended until Monday, August		direct knowledge of any		
		ey would call her and let her		immediately reporting ki		
	know about returning	to work once the facility's		rumor or hearsay of abu	ise (of any type),	
		mplete. At that time they felt it		thereby promoting inves	•	
		for her to work as a Resident		validity of the rumor/hea		
	•	eline stated, "we did not feel		so will warrant disciplina	•	
		herefore were not able to		Additionally, staff memb		
		ince there were no witnesses		addressed as to the rev		
		not a reliable source due to		clearly specified the edu	÷	
	the diagnosis of Lew	y body Dementia".		on dementia, during orie		
	During an interview w	vith the IDON on 12/04/18 at		means to ensure ongoir orientation process has		
		ed that she was notified of		fully integrate dementia		
		Resident #1 and the Sitter in		CNA s and Nurses, to		
		/18 and arrived at the facility		are receiving tools to ca	-	
	-	n. The IDON stated she was		residents, as per facility		
	told by NS #3 that Re			Additionally, immediate		
	-	itter and punched her in the		rumor or hearsay which		
		to a scuffle. The IDON stated		type of abuse will be ad		
		to get a statement from the		orientation of newly hire	-	
		home. The IDON stated that		ensure enforcement of f		
	when she got to the f					

Facility ID: 990623

If continuation sheet Page 34 of 59

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OM	IB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3	) DATE SURVEY COMPLETED
		345541	B. WING			C
	ROVIDER OR SUPPLIER	545541		STREET ADDRESS, CITY,		12/07/2018
NAIVIE OF P	ROVIDER OR SUPPLIER			13825 HUNTON LANE	STATE, ZIP CODE	
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	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 607	Continued From page	e 34	F 60	17		
	tear was already drest the dressing to assess stated she interviewe of his progressive LB the incident. The IDO Sitter's statement and #1 went up to hit her the way and caused to did not consider the in why it was not reporte continued to state that brought the Sitter in to did not feel the act was During an interview w 12/04/18 at 3:45 PM received the same tra agitation as the other (Sitter) did what she s reporting the incident The Administrator sta state abuse the incide enforcement about th not see it as abuse.	assed and she did not remove as his skin tear. The IDON d Resident #1 but because D he could not remember N stated she reviewed the d read it as when Resident she pushed his hand out of the skin tear. She added she ncident as abuse which was ed to the police. The IDON at they (Administration) o act out of incident and they as intentional or abusive.		<ul> <li>environment and ongoing and is be Champion desigr (Nurse Managers Behavior monitor flow sheets will b discussed by IDT meeting.</li> <li>6. Incident Rep Nursing Report) of through Friday in any unusual incid skin tears and inj and resident to re immediate invest all bruises or unk unknown origin o injury of unknowr occurrence that is be reported immed Huntersville Polic North Carolina H Registry. The ind completed elector</li> </ul>	s suspected abuse will	
	05/14/18 with diagnost for orthopedic afterca amputation, unspecifi behaviors, and cognit among others. A revi recent MDS Assessm	ses that included: encounter ire following surgical ied dementia without tive communication deficit iew of Resident #3's most nent revealed Resident #3		responsible to pri for their unit befo and are responsi morning meeting bring the 24-Hou meeting and two	int the incident report(s) re the morning meeting ble to bring them to the . In addition they will r Nursing Report to the documents will be	
	noted behaviors durir A. Review of Resider			origin are investig put into place. In supervisor is abs	ure incidents of unknown gated and interventions n the event the nursing sent the responsibility of	
	reported Resident #3	ed 11/25/18 at 1:25 PM that was leaving the dining room n with Resident #1 in which			ent reports and the Report is assigned to the to the DON.	

Facility ID: 990623

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	· · · ·	MPLETED
						С
		345541	B. WING		1	2/07/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		13825 HUNTON LANE		
				HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 607	Continued From page	e 35	F 60	7		
		nis motorized wheelchair to		7. The Corporate Complian	nce Nurse will	
	roll over Resident #1'	s feet. Per the nurse's note,		be responsible to review the		
	the altercation was a	result of Resident #1 being		Administrative Nursing Staff	rounds	
	-	nt #3 and not moving out of		Sheets on a weekly basis for		
		esident #3 wanted. The		months; a bi-monthly basis f		
		Resident #3 reported that		months and then monthly for		
	he rolled over Reside			months to determine that fac		
		nove out of his way so "he soon." Further review of the		compliance with the credible		
		ed Resident #3 appeared to		compliance and intervention put into place. If there are dis		
		d stated again that he had to		in the monitoring tool, the Co		
	teach him a lesson."			Compliance Nurse will be re-		
				inform the Administrator and	•	
	Resident #1 was adm	nitted to the facility on		investigation to determine w		
	01/04/18 with diagnos	ses that included: Dementia		discrepancy is there and if n	-	
	with Lewy bodies, de	mentia with behaviors,		assist in correcting the issue		
	cognitive communica	tion deficit, major depressive		8. The Corporate Complia	nce Nurse will	
		kness, history of falling and		also conduct rounds on a we		
		of lower leg among others.		three (3) months; a bi-month	•	
		1's most recent quarterly		three (3) months and then m		
	-	1DS) Assessment revealed		(6) months and conduct inter		
		gnitively impaired with no		the staff and residents to ens		
		sident #1 was coded as		incidents have been reported		
	transfer, dressing, toi	ssistance with bed mobility,		compare with the Clinical Tea and interventions.	and reviews	
		1 was coded as requiring		9. Resident to resident abu	ise monitoring	
		h locomotion on & off the		will be conducted every shift		
		y dependent of others in		sheet logs, by the appointed		
	bathing.	,		nurse (Nurse Managers), ter		
				Champion nurse. These log		
	A review of Resident	#3's nurse's notes revealed		reviewed daily by DON and	DT.	
		18 at 1:25PM that reported				
		ring the dining room and had		10. For any resident with co		
		esident #1 in which Resident		behaviors, only Nurses or Cl		
		zed wheelchair to roll over		allowed to provide any direct		
		er the nurse's note, the		include sitting with a residen		
		ult of Resident #1 being in		indicated in the resident care		
	way as fast as Reside	#3 and not moving out of the		the Orientation training the I	NUISES and	

Facility ID: 990623
		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	. ,	TE SURVEY MPLETED
			A. BUILDING	9		С
		345541	B. WING		1	2/07/2018
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				13825 HUNTON LANE		
	OX COMMONS AT THE	/ILLAGES OF MECKLENBURG		HUNTERSVILLE, NC 28078		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	COMPLETIC DATE
F 607	Continued From page	e 36	F 60	70		
	note revealed Reside	ent #3 reported that he rolled		have to demonstrate the	ability to work	
		et because Resident #1 did		with combative residents	, to de-escalate	
		ay so "he had to teach him a		the behaviors, and provid		
		ew of the progress note		manner and way that pro		
		appeared to have "no		from abuse. They will rec		
	him a lesson."	again that he had to teach		training at least annually well. The decision to imp		
				procedure was made on		
	A review of facility or	ovided incident logs revealed		and then re-evaluated or		
		umented incidents regarding		The staff was educated a		
	Resident #1 or Resid			procedure which is requi		
				completed prior to return	ing to work; on	
		dication Aide #1 on 12/04/18		12/06/2018 by the Direct	or of Nursing,	
		on 11/25/18 she was out in		Administrator.		
		esident #3 state "get out of		11. As a means of qualit	•	
	my way" angrily. She			Administrator shall be re-	-	
		control stick to his motorized s far to the left as it would go		report all allegations and initiated, as per policy, to		
		. She stated Resident #3		the company, on a daily		
		Resident #1 should have		received, in an effort to re		
	•	. She reported Resident #1		confirm appropriate imme		
		and scared, staring off into		taken, including thorough		
		esident #3's motorized		per facility policy.	-	
		palance at times due to		12. All investigations, wi		
		ng to try and traverse up and		findings and resolution, s		
		eet. She stated she was		ongoing and reviewed by		
	-	3 did not tip the motorized		Committee on a monthly		
		e stated she separated the iately reported the incident to		adherence with facility po frequency of review revis		
		at she had not been asked		the Committee deem app	-	
	-	provide a statement in		13. The Corporate Com	-	
	regards to what she			be responsible to review		
				Administrative Nursing R		
	-	vith Nurse #1 on 12/04/18 at		a weekly basis for three		
		ed that she did not witness		bi-monthly basis for three		
	-	over Resident #1's feet first		then monthly for six (6) n		
		d that it was reported to her		determine that facility is i	-	
		he continued, reporting that incident in the nurse's notes		with the credible allegation and interventions have b		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		345541	B. WING		4	C 2/07/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		2/07/2010
		/ILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 607	Continued From page	e 37	F 60	7		
F 607	as Nurse Aide #1 rep after the incident was completed only a visu #1's feet and noted m no broken skin or bru pain from Resident # DON through a text m response of "OK, that message. The Nurse any monitoring syster prevent him from exh behavior again. An interview with Nur 12/04/18 at 10:45AM of the incident by Nur reported the incident 11/26/18 who reporte Director of Nursing. T not aware of any mor put into place to preve from happening again An interview with Nur 12/04/18 at 1:35PM r the incident on 11/26/ report that Resident # resident's feet the day instructed Nurse #1 to report and document information on during spoke with the Director morning and asked th She reported the DOI	orted it to her. She stated reported to her, she al assessment of Resident o injuries and she observed ising with no complaints of 1. She reported notifying the nessage and received a nks" in a return text stated she did not set up ms for Resident #3 to ibiting this inappropriate se Supervisor #1 on revealed she was informed se #1. She stated she to Nurse Supervisor #2 on d she would notify the The NS indicated she was nitoring systems that were ent Resident #3's behavior n. se Supervisor #2 on evealed she was notified of (18 during her morning #3 had run over two different y before. She stated she o complete an incident the incident and pass the her report. She stated she or of Nursing (DON) that ne DON about the incidents. N informed her that she was incident and the facility was	F 60	place. She will also condu- weekly basis for three (3) bi-monthly basis for three then monthly for six (6) mo- conduct interviews with the residents to ensure that al been reported and compal Clinical Teams reviews an 14. Resident to resident a will be conducted every sh sheet logs, by the appointe nurse, termed Champion n logs are reviewed daily by 15. If there are discrepan- monitoring tool, the Corpo Compliance Nurse will be inform the Administrator an investigation to determine discrepancy is there and if assist in correcting the iss 16. For any resident with behaviors, only Nurses or allowed to provide any dire include sitting with a reside indicated in the resident ca the Orientation training the CNA swill receive demen- have to demonstrate the a with combative residents, the behaviors, and provide manner and way that prote from abuse. They will receive training at least annually b well. The decision to impli- procedure was made on C and then re-evaluated on	months; a (3) months and onths and e staff and l incidents have re with the d interventions. abuse monitoring hift on the flow ed licensed nurse. These DON and IDT. cies in the rate responsible to nd conduct an why the f needed to ue. combative CNAs will be ect care to ent if this is are plan. During e Nurses and ntia training and ubility to work to de-escalate e care in a ects the resident sive additional out as needed as ement this Dotober 17, 2018	
		vith the Director of Nursing t 11:45 am it was revealed		The staff was educated ab procedure on 12/06/2018 of Nursing, Administrator.		

Facility ID: 990623

		MEDICAID SERVICES			OMB NO. 0938-
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
			A. BUILDING	3	
		345541	B. WING		С
		545541			12/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
OLDE KN	OX COMMONS AT THE V	/ILLAGES OF MECKLENBURG		13825 HUNTON LANE	
	1			HUNTERSVILLE, NC 28078	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLE E APPROPRIATE DAT
F 607	Continued From page	e 38	F 60	70	
	she had been made a			17. All residents who desire	to use a
		it #1's feet on the morning of		Motorized Wheelchair will ha	
	-	d she was scheduled to		assessed by the therapy dep	
	monitor the hall where	e Resident #1 and Resident		to use of the chair. The thera	-
	#3 for other quality as	ssurance measures that the		department will use a standa	ardized
		monitoring. She reported		Electric Wheelchair Assessn	
	-	sidents involved in the		residents. If at any time the	
		eneral wellbeing but denied		considered unsafe, the Inter	
		out the incident with the		Care Team will review the as	
		<ul> <li>The DON stated both of any issues or complaints</li> </ul>		and make any recommenda necessary. The family will b	
	at that time and Resid			the therapy will evaluate for	
		g pain. She reported		the therapy will evaluate for	
		strator of Resident #3			
		at #1's feet on 11/26/18.		Indicate How The Facility Pla	ans To
				Monitor It⊡s Performance To	
	An interview with the	Administrator on 12/04/18 at		That Solutions Are Sustained	d. The
		he had been made aware of		Facility Must Develop A Plan	U
		Resident #3 running over		That Correction Is Achieved	And
		th his motorized wheelchair		Sustained:	
		rted she re-educated Nurse			
		ne contacted administrative		4 The maridant same units	e constant constituite e
		as reached. She stated she		1. The resident care unit re	
		e investigation, contact local al adult protective services		presented at weekly QA mee monthly to the QAPI Commi	-
		ue to her belief that the		evaluation to determine if the	
	incident was not abus			adequate and if not to devise	-
		al investigation due to her		re-implement a system to en	
		it was not abuse, stating it		alleged deficient practice do	
		ident incident and that it was		again.	
	not reportable.			2. All incident reports will t monthly at the QAPI Commi	
	B. Review of Resider	nt #3's nurse's notes		for any bruises, skin tears ar	-
	revealed a note dated	d 11/25/18 at 7:18PM, written		unknown origin and investig	ations of
	by Nurse #1, stated F	Resident #3 had an incident		incidents of unknown origin	to determine if
		e leaving the dining room.		any patterns or practices exi	st that may be
		nurse's note revealed		considered abuse.	
		Resident #2's feet with his		3. All investigations, with s	
	motorized wheelchair	reportedly because		findings and resolution, shal	I be presented

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	IO. 0938-039 E SURVEY
IND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		IPLETED C
		345541	B. WING		1	2/07/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C		
OLDE KN	OX COMMONS AT THE \	/ILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 607	Continued From page	e 39	F 60	)7		
	7 Continued From page 39 Resident #2 was in his way. Additional review of the nurse's note indicated this was the 2nd incident of Resident #3 running over another resident's feet due to the other residents reportedly being in Resident #3's way. The nurse's note also revealed the nurse stated she would continue to monitor Resident #3's behavior and passed the information of the incident onto the 3rd shift Nurse Supervisor. Resident #2 was admitted to the facility on 5/26/18 with diagnoses that included: major depressive disorder, chronic kidney disease, pain in right and left knee and restless leg syndrome among others. A review of Resident #2's most recent MDS Assessment dated 11/24/18 and coded as a quarterly assessment revealed Resident #2 to be cognitively impaired with noted physical and verbal behaviors directed towards others occurring 1-3 days during the look back period. Resident #2 was coded as requiring extensive assistance with bed mobility, locomotion on the unit, dressing and was coded as being totally dependent with transfers. A review of facility provided incident logs revealed no filed reported/documented incidents regarding Resident #2 or Resident #3.			<ul> <li>ongoing and reviewed by th Committee on a monthly ba adherence with facility polic frequency of review revised the Committee deem approd 4. If any patterns or pract the QAPI Committee will be immediate investigation to solutions are put into place corrective action is achieve sustained.</li> <li>5. The QA Committee, Quant and the Medical Director has apprised of this plan and co support to assisting the fac achieving and sustaining co this alleged citation. The Qu was notified on 12/06/2018</li> </ul>	asis to ensure cy, with d only should opriate tices are noted, egin an ensure that to ensure ed and API Committee ave been ommit their ility with ompliance with API Committee	
	#1 who completed the revealed she did not over Resident #2's fe wheelchair first hand.	4/18 at 10:12 am with Nurse e nurse's note on 11/25/18 witness Resident #3 running et with his motorized . She reported Dietary Aide ent to her and she wrote her				
	nurse's note as a refl was reported to her. assessed Resident #	ection of the incident as it She stated she visually 2's feet and noted there to ported no lingering pain. She				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/07/2019 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345541	B. WING				C 07/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	Nursing after the incidereportedly received a text. An interview with Diet 11:15 AM revealed shassisting residents whyell out "oh, oh, he rashe turned around an continuing to try and a Resident #2's feet. SResident #2's feet. SResident #2's foot. Stwo residents to sepa nurse, whom she cout the hall with whom shaide #1 reported she statement about the inforgotten and did not An interview with Nurr 12/04/18 at 10:45AM of the incident by Nurreported the incident to 11/26/18 who reported the incident to 11/26/18 who reported the incident to 11/26/18 at 1:35PM reported the incident to 11/26/18 at 1:35PM reported the incident to 11/26/18 who reported the incident to 11/26/18	the incident to the Director of dent by text message and response of "OK, thanks" by tary Aide #1 on 12/04/18 at he was in the dining room hen she heard Resident #2 n over my foot." She stated d observed Resident #3 engage his wheelchair over he reported observing to grab Resident #3 but by had already run over he reportedly ran over to the rate them and informed a ld not identify, walking down he asked for help. Dietary was asked to write a ncident but reported she had complete it until 12/04/18. se Supervisor #1 on revealed she was informed se #1. She stated she to Nurse Supervisor #2 on d she would notify the	F	607			

Facility ID: 990623

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		LETED
		345541	B. WING			C 07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	•	
OLDE KN	OX COMMONS AT THE \	/ILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 607	Continued From page	e 41	F 6	07		
	informed her that she was already aware of the incident and the facility was ordering a urinalysis for Resident #3.					
(I s ru 1 m fa s ir s n # fa s ir s s n # # # A 1 t t F o # s d la o ir c b w	(DON) on 12/04/18 a she had been made a running over Resider 11/26/18 and reporter monitor the hall when #3 for other quality as facility was currently she spoke to both res incident about their g specifically asking ab motorized wheelchair #2 voiced no complain reported informing the	with the Director of Nursing t 11:45 am it was revealed aware of Resident #3 at #1's feet on the morning of d she was scheduled to e Resident #2 and Resident assurance measures that the monitoring. She reported sidents involved in the eneral wellbeing but denied yout the incident with the r. The DON stated Resident ints of pain or injury. She e Administrator of Resident dent #2's feet on 11/26/18.				
	An interview with the 11:45 am revealed sh the incident involving Resident #2's feet with on 11/26/18 and report #1 on making sure sh staff until someone w did not start an abuse law enforcement, loca or the state agency d incident was not abuse completing an interna- belief that the incident	Administrator on 12/04/18 at ne had been made aware of Resident #3 running over th his motorized wheelchair orted she re-educated Nurse ne contacted administrative ras reached. She stated she e investigation, contact local al adult protective services ue to her belief that the				
	The Administrator wa Jeopardy on 12/05/18	is informed of Immediate 8 at 11:00 am. The facility ble credible allegation of				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345541	B. WING				C 07/2018	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page Immediate Jeopardy 11:41 am which speci	removal on 12/06/18 at	F	607				
	CORRECTIVE ACTIO F- 607	ON PLAN						
	policies and procedur abuse, neglect and ex misappropriation of re policies and procedur	and implement written res that; Prohibit and prevent xploitations of residents and esident property, Establish res to investigate any such de training as required.						
		tive Action (S) Will Be ose Residents Found To By The Deficient Practice:						
	08/18/2018 INCIDEN	Т						
	Resident #1 on 08/18 Companion was struct Resident Companion a skin tear, based on the facilities' investigat the Resident Companies immediately removed suspended her until the complete. Based on interview with the emi- made to move the emi- department as a Dieta be able to provide can we were in compliance 2. However due to the	ck by Resident #1 and grabbed his arm resulting in the witness statement and ation at that time. Based on nion's statement we the employee and he investigation was our investigation was our investigation and ployee the decision was nployee to the Dietary ary Aide where she will not re with the residents. Thus we as of the 08/18/2018 date.						
		o prevent abuse due to the t on 12/03/2018 the facility						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345541	B. WING				C 07/2018	
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
OLDE KNO	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 607	<ol> <li>10:00 am and they can an and they can and the composite the employee in the composite the employee is supprive to the employee is supprive to the to work she orientation at which the and the to the to an and the transformer the transformer that the the to approach him when services to minimize the composition to the totic to the totic to the totic totic to the totic totic</li></ol>	en the investigation. notified on 12/05/2018 at ame to the facility around he we made a report. in a 24 Hour Report to that they had re-opened the question was notified of the nother interview on arrived at 12:30 pm at which is conducted. Per our policy ended now pending another vestigation supports bringing will have go through another me she will receive training to to combative behavior bementia Training. has provided an in abuse. his care plan was updated MDS Nurse to reflect how in providing care and his behaviors and to gain his are; to explain in a calm o be done to the resident and to re-approach after he d cooperative to finish care. T D18 there was an incident	F	607				
	where Resident #3 ra	018 there was an incident In over the feet of Resident The staff intervened with						

nd plan of	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345541	B. WING		1:	C 2/07/2018
	ROVIDER OR SUPPLIER	/ILLAGES OF MECKLENBURG	13	TREET ADDRESS, CITY, STATE, ZIP CODE 3825 HUNTON LANE UNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 607	with Resident #2 and room intervened by a the dining room which running over resident LPN evaluated the re- the time and there we from the residents pe facility did not identify incident as an abusiv- incident, the resident" Though Resident #3 the resident's feet wh further consideration admission could be e acute mental status re- Infection. Resident # aggression or alterca for acute UTI. The Re- Altercation resulting in Resident #1 and #2. report, as per resident 2. On November 26 a thorough skin asses Resident #2 involved and there were no no discoloration, scratch #1 and #2 did not app emotional distress as they mentally appear.	ident #3 by removing area and monitoring Nurse LPN witness s note. After the incident #3 the staff in the dining ssisting Resident #3 from n was his intent when #2's feet. The #1 Nurse sident #1 and #2's feet at ere no injuries or complaints r the nurse's notes. The the root cause of the e act. At the time of s intent was not clear. stated he meant to run over en asked by staff, upon by administration, this rroneous due to resident's elated to Urinary Tract 3 does not have a history of tion and was being treated esident to Resident n no physical harm to The facility did not submit at to resident #1 and in the 11/25/2018 incident	F 607			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345541	B. WING				C 107/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	Y FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 607	resident has the capa motorized chair indep that resident has grea space is available. He immediately by his sid field. He tends to use his visual field as opp Required cues to turn turn the chair. Due to residents the Interdise Physician has decide evaluated on 12/06/2 wheelchair and place evaluated on 12/06/2 wheelchair and place evaluated on 12/06/2 wheelchair and place evaluation. Address How Correct Accomplished For Th Potential To Be Affect Practice: 1. All interview able by the facility Social W Nursing to determine of, or witnessed abus member, visitor or an interviews were cond there were no resider witnessed any abuse 2. The facility perfor Incident reports, since this process was esca hour nursing shift rep reviewed for incidents to resident altercation process was initiated the resident to reside To date, there have b	ability of maneuvering a bendently. It was determined at difficulty when decreased e is unable to see his feet or des due to decreased visual e the wheelchair to increase bosed to turning his head. In his head instead, he would be the safety needs of the ciplinary Care Team and d the resident will be 018 for a traditional d in chair after the two Action Will Be ose Residents Having red By The Same Deficient e residents were interviewed Worker and Director of if they had been a recipient e by a staff member, family other resident. The ucted on 12/05/2018 and nts who had experienced or	F	607			

If continuation sheet Page 46 of 59

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP		
		345541	B. WING				07/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 607	The Morning Meeting the Administrative and attendance. Thus all have not had any note a. The Administrato Corporate Nurse Com In-services with all sta and completed on 12, to be completed prior following; and all new complete the following to working with the re b. ABUSE - Reside from abuse, neglect, for property, and exploita c. Types of abuse, chemical, sexual, and d. What to do if abu report the abuse to, e. How to react to co residents; how to prov combative residents to residents; how to prov combative residents to resident; how to prov combative residents to f. Dementia trainin g. Reporting of ANN any type, neglect, exp misappropriation of re h. Notification of the Administrator and the IMMEDIATELY. Fai disciplinary action. 3. The Administrato received additional tra and regulations, the in regulations regarding and then timely repor	Signature Agenda reflects d the Clinical Team non-interview able residents ed incidents. r, Director of Nursing and sultant conducted aff beginning on 12/05/2018 (07/2018 which is required to returning to work; on the hires will be required to g training in orientation prior sident. nt has the right to be free misappropriation of resident tion. i.e., (physical, verbal, I resident to resident abuse. ise is witnessed, who to ombative behavior from vide care and services to o prevent abuse to the care giver; and g. ' SUSPICION of abuse of ploitation and esident property. e incident to the	F	607				

Facility ID: 990623

If continuation sheet Page 47 of 59

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345541	B. WING _				C 07/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
OLDE KNO	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			8825 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	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 607	Nurse Consultant. Address What Measu Or Systemic Changes Deficient Practice Wil 1. Due to the safety Interdisciplinary Care decided the Resident 12/06/2018 for a tradi in chair after the evalu 2. The Nursing Staf Nurse Manager of the them to be hyper vigil Resident #3) on 11/25 made aware of the re need to be hyper vigil 12/07/2018. The Direc completed QA rounds exhibit any further bel occur to report immed resident behaviors to Administrator. 3. All interview able by the facility Social V Nursing to determine of, or witnessed abus member, visitor or any interviews were condu- there were no resider witnessed any abuse. 4. Staff interviews were RN Consultant on 12/ interviews involved de	V06/2018 by the Corporate res Will Be Put Into Place a Made To Ensure That The I Not Recur: r needs of the residents the Team and Physician has #3 will be evaluated on tional wheelchair and placed uation f were informed by the e incident and instructed ant with observation of 5/2018. All staff has been sident's behavior and the ant with observation by ctor of Nursing has a ensure resident does not haviors/abuse. If this does diately any concerning the Director of Nursing and residents were interviewed Vorker and Director of if they had been a recipient e by a staff member, family other resident. The ucted on 12/05/2018 and nts who had experienced or vere conducted by outside (5/2018-12/6/2018. The etail questioning pertaining	F	607			
		areness, prevention and					

Facility ID: 990623

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		IO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:			CON	<b>MPLETED</b>
		B. WING			С	
	AME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		2/07/2018
NAME OF F	LDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG			3825 HUNTON LANE		
OLDE KN	OX COMMONS AT THE	VILLAGES OF MECKLENBURG	H	IUNTERSVILLE, 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 607	Continued From pag	e 48	F 607			
		all facility staff. Interview	1 007			
		d by Administration for				
	possible concerns.					
	5. All staff members were addressed prior to					
		as to the abuse prohibition				
	policy with emphasis	on not only reporting direct				
		cident, but also immediately				
	abuse (of any type),	of any "rumor" or hearsay of				
	investigation as to th					
		re to do so will warrant				
		dditionally, staff members				
		o the revised policy which educational training on				
		entation. As a means to				
		pliance, the orientation				
		nended to fully integrate				
		CNA's and Nurses, to receiving tools to care for				
		as per facility policy.				
		ate reporting of any rumor or				
	-	indicate any type of abuse				
		ring orientation of newly				
		ensure enforcement of facility were revealed based on				
		ervations of the overall				
		isk residents is ongoing and				
	-	y the Champion designated				
		documented on Behavior				
	•	ts. The flow sheets will be nd discussed by IDT at daily				
	stand up meeting.					
	6. Incident Reports	and (24-Hour Nursing				
	-	ved Monday through Friday				
	in morning meetings	for any unusual incident to				
	include bruises, skin					
	unknown origin and r	resident to resident abuse	1	1		1

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CENTERS FOR MEDICARE & MED STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE S	0938-039	
AND PLAN OF CORRECTION						COMPLETED	
					с		
	345541		B. WING	······		7/2018	
NAME OF PI	ME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP			
	OX COMMONS AT THE	VILLAGES OF MECKLENBURG		13825 HUNTON LANE			
-				HUNTERSVILLE, NC 28078			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 607	Continued From pa	ae 49	F 60	7			
1 001	-	stigation will be started for all	1 00				
		origin, skin tears of unknown					
		ncident or injury of unknown					
	<b>u</b>	irrence that is suspected					
	-	ted immediately to the					
		Department and the North					
		re Personnel Registry. The					
the st respo		completed electronically by					
		the nurse supervisors are					
		the incident report(s) for their ning meeting and are					
		them to the morning meeting.					
		bring the 24-Hour Nursing					
		ng and two documents will be					
		e incidents of unknown origin					
	are investigated and	d interventions put into place.					
		sing supervisor is absent the					
		nting the incident reports and					
		g Report is assigned to the					
	ADON and then to t	the DON.					
	7. The Corporate	Compliance Nurse will be					
		w the Administrative Nursing					
	Staff rounds Sheets	s on a weekly basis for three					
		onthly basis for three (3)					
		onthly for six (6) months to					
		ity is in compliance with the					
	credible allegation of						
		been put into place. If there n the monitoring tool, the					
		nce Nurse will be responsible					
		istrator and conduct an					
		ermine why the discrepancy is					
	•	to assist in correcting the					
	issue.	Ŭ					
	8. The Corporate	e Compliance Nurse will also					
	-	r · · · · · · · · · · · · · · · · · · ·					
	conduct rounds on a	a weekly basis for three (3)					

Facility ID: 990623

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 01/07/2019 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			-	(X3) DATE COMP	SURVEY LETED
		345541	B. WING			( 12/0	C 07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 2	28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	<ul> <li>and then monthly for sinterviews with the stat that all incidents have compare with the Clinin interventions.</li> <li>9. Resident to resid conducted every shift the appointed licenser nurse. These logs and IDT.</li> <li>10. For any resident only Nurses or CNAs any direct care to inclithis is indicated in the the Orientation trainin will receive dementia demonstrate the abilit residents, to de-escal provide care in a man the resident from abus additional training at l as well. The decision procedure was made then re-evaluated on educated about this p to be completed prior 12/06/2018 by the Dir Administrator.</li> <li>11. As a means of quadministrator shall be allegations and invest policy, to the Presider basis when received, confirm appropriate in the resident in the resident in the the Direntation shall be allegations and invest policy.</li> </ul>	six (6) months and conduct aff and residents to ensure been reported and ical Teams reviews and ent abuse monitoring will be on the flow sheet logs, by d nurse, termed "Champion" e reviewed daily by DON with combative behaviors, will be allowed to provide ude sitting with a resident if resident care plan. During g the Nurses and CNA's training and have to y to work with combative ate the behaviors, and ner and way that protects se. They will receive east annually but as needed to implement this on October 17, 2018 and 12/05/2018. The staff was rocedure which is required to returning to work; on ector of Nursing,	F 60	7			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345541	B. WING			C 12/07/2018	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE KN	OX COMMONS AT THE V	ILLAGES OF MECKLENBURG			3825 HUNTON LANE IUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page 12. All investigations and resolution, shall the reviewed by the QA C basis to ensure adhen frequency of review re Committee deem app 13. The Corporate C responsible to review Rounds Sheet on a w months; a bi-monthly and then monthly for that facility is in comp allegation of complian been put into place. So on a weekly basis for the monthly for six (6) mon with the staff and resi incidents have been re the Clinical Teams rese 14. Resident to reside conducted every shift the appointed license nurse. These logs ar and IDT. 15. If there are discret tool, the Corporate Cor responsible to inform conduct an investigat	e 51 , with summary of findings be presented ongoing and Committee on a monthly rence with facility policy, with evised only should the propriate. ompliance Nurse will be the Administrative Nursing veekly basis for three (3) basis for three (3) months six (6) months to determine liance with the credible nee and interventions have She will also conduct rounds three (3) months; a nree (3) months; and then onths and conduct interviews dents to ensure that all reported and compare with views and interventions. Then the flow sheet logs, by d nurse, termed "Champion" e reviewed daily by DON epancies in the monitoring ompliance Nurse will be		607			
	only Nurses or CNAs	with combative behaviors, will be allowed to provide ude sitting with a resident if					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/07/201 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345541		B. WING		C 12/07/2018
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C	
	OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG			13825 HUNTON LANE	
-				HUNTERSVILLE, NC 28078	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 607	Continued From page	e 52	F 6	07	
	the Orientation trainin will receive dementia demonstrate the abili residents, to de-esca provide care in a mar the resident from abu additional training at as well. The decision procedure was made then re-evaluated on educated about this p to be completed prior 12/06/2018 by the Di Administrator 17. All residents who Wheelchair will have therapy department p therapy department p therapy department v Electric Wheelchair Al If at any time the resi the Interdisciplinary C assessment and mak necessary. The fami therapy will evaluate	ty to work with combative late the behaviors, and oner and way that protects use. They will receive least annually but as needed in to implement this on October 17, 2018 and 12/05/2018. The staff was procedure which is required to returning to work; on rector of Nursing, b desire to use a Motorized to be assessed by the prior to use of the chair. The will use a standardized assessment on the residents. dent is considered unsafe, Care Team will review the se any recommendations ly will be notified and the for another chair. acility Plans To Monitor It's e Sure That Solutions Are lity Must Develop A Plan For			
	Medical Director have and commit their sup with achieving and su	tee, QAPI Committee and the e been apprised of this plan port to assisting the facility ustaining compliance with The QAPI Committee was 8.			

Facility ID: 990623

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		3) DATE SURVEY COMPLETED
		345541	B. WING		C 12/07/2018	
NAME OF PROVIDER OR SUPPLIER OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG				STREET ADDRESS, CITY, STATE, ZIP COD 13825 HUNTON LANE	E	
	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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From page 2. The resident care	e 53 e unit rounds will be	F 60	70		
	the QAPI Committee if the system is adequ	QA meetings and monthly to for evaluation to determine late and if not to devise and m to ensure that the alleged s not occur again.				
	at the QAPI Committe skin tears and injury of investigations of incid	ents of unknown origin to erns or practices exist that				
	and resolution, shall the reviewed by the QA C basis to ensure adhered	, with summary of findings be presented ongoing and Committee on a monthly rence with facility policy, with evised only should the propriate				
	QAPI Committee will investigation to ensur	practices are noted, the begin an immediate e that solutions are put into ctive action is achieved and				
	verified on 12/07/18 a staff were interviewed were in-serviced on the identification of abuse	allegation of IJ removal was at 4:09 pm when the facility and demonstrated they ne topic of abuse including; a, investigating an allegation sponsibility to report abuse in				
F 609 SS=D	1 0 0		F 60	09		12/12/18

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		ND HUMAN SERVICES			PRINTED: 01/07/201 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345541	B. WING		C 12/07/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG			825 HUNTON LANE JNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 609	neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, negl mistreatment, includi source and misappro are reported immedia hours after the allega that cause the allega serious bodily injury, the events that cause abuse and do not res the administrator of th officials (including to adult protective servit for jurisdiction in long accordance with Stat procedures. §483.12(c)(4) Report investigations to the adesignated represent accordance with Stat Survey Agency, withi incident, and if the all	se to allegations of abuse, or mistreatment, the facility e that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, ately, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if e the allegation do not involve sult in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides i-term care facilities) in e law through established	F 609		
	by: Based on record rev facility failed to report resident abuse to the	is not met as evidenced iew and staff interviews the t an allegation of staff to state agency within 2 hours Resident #1) reviewed for		Address How Corrective Action (S) W Be Accomplished For Those Residen Found To Have Been Affected By The Deficient Practice:	ts e
	The finding included: Resident #1 was adn	nitted to the facility on		<ol> <li>In-services were conducted for a staff members on 12/5/2018 &amp; 12/6/2 to address the expectation and requirement that all suspected or actu</li> </ol>	018

Event ID: T0DQ11

Facility ID: 990623

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	<u> 0938-039</u>
AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	E SURVEY PLETED
						С
		345541	B. WING			/07/2018
NAME OF P	ME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	OX COMMONS AT THE V	VILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 609	Continued From page	e 55	F 60	9		
	01/04/18 with diagnos Body Dementia (LBD Parkinson like demention comprehensive Minim 06/01/18 revealed he impairment and requitivity also indicated he had back period. Review of a Nurses M dated 08/18/18 at 10: Resident #1 was aler Resident #1 was aler Resident #1 received forearm which measu wide with a flap of ski side of the skin tear. I good a mood while the Resident #1 stated "th scuffling, and she tore arm then he punched Resident #1 also stat ha, ha I won." Reside soreness in his left ar Telephone interview w (Sitter) on 12/03/18 a Resident #1 had start him to sit back down	ses which included Lewy ) (which is a progressive ntia). His most recent num Data Set (MDS) dated had severe cognitive red extensive assistance tites of daily living. The MDS no behaviors within the look Note, written by Nurse #2, 22 AM indicated in part that t and verbal with confusion. a skin tear to the top of left ured 4 cm long by 1.5 cm in tunneling 0.5 cm to the left Resident #1 was calm and in eatment was being given. he Sitter and he were e a chunk of meat from his l her." The note specified, ed that the Sitter said "ha, ent #1 stated he felt some m. with Resident Companion		violations involving abuse exploitation or mistreatme injuries of unknown source misappropriation of reside MUST be reported to Adm (Administrator and Directo IMMEDIATELY so that a r made to the Health Care I Registry, the State Survey adult protective services v hours after the allegation 2. The facility Social Wo Director of Nursing intervi- oriented residents to deter been a recipient of or with a staff member, another re anyone else. These inter completed on 12/05/2018 able residents reported th been the victims of any at misappropriation of prope witness any other residen victim either. Staff intervie conducted by an outside I on 12/5/2018 □ 12/6/2018 their awareness of what c or misappropriation, preve and misappropriation and process if abuse or misap occurs.	ent, including e and ent property inistration or of Nursing) eport made be Personnel y Agency and within two (2) is made. orker and ewed all alert an rmine if they had uessed abuse by esident of views were . All interview at they had not ouse or rty and had not t being the ews were RN Consultant 8 concerning onstitutes abuse ention of abuse the reporting	
	keep him from hitting Resident #1 was sittin went to the nurses' st happened. The Sitter holding an ice pack to	ed Resident #1's left hand to her again. By this time ng down so she immediately ation to report what had stated while she was o her right jaw they brought		Address How Corrective A Accomplished For Those Having Potential To Be Aft Same Deficient Practice:	Residents fected By The	
	said "Oh, you did this	esk and when he saw her he " while pointing to his skin d Resident #1 was not		1. Beginning 12/7/2018 perform ongoing audits of as well as 24 hour nursing	incident reports	

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		MEDICAID SERVICES				<u>D. 0938-039</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			
		345541	B. WING			С
		345541				/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
	OX COMMONS AT THE	VILLAGES OF MECKLENBURG		13825 HUNTON LANE		
				HUNTERSVILLE, NC 28078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE 1 TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 609	Continued From page	e 56	F 60	9		
	bleeding a lot.			any possible abuse or	resident to resident	
				altercations that result		
		PM the interview with the		will be reviewed in the	morning meeting	
		erson with demonstration of		Monday thru Friday for		
		tated she and Resident #1		any abuse has occurre		
		sion when he started to stand		in-serviced on the requ	•	
		in front of him and leaned		any suspected or actua		
		d (Resident #1) you need to		Administrator and Dire	•	
		ime he had already sat back on the right side of my face		policy is not followed, t		
		l out of instinct I grabbed his		disciplined by terminati		
		hitting me again" and in		beginning 1-1-2019 (af		
	-	ils caused a skin tear on his		nurse managers and c		
		d she did not know she		the new procedure), th	-	
	caused the skin tear	to Resident #1's arm until he		for each shift seven da	-	
	came to the nurses'	station later and showed the		the Administrator at the	e end of their shift	
		n. The Sitter stated, "It (the		and report off on any re		
		y had the imprints of my		or staff actions that cou	•	
	-	open with small drops of		as abuse or any suspic		
	-	plained that she had not		form or manner. This	-	
		what to do when a resident		for 30 days, then ever	-	
	became agitated.			days and will be reeval		
	Peview of Nurse #2's	s written statement (undated		for the need to continu	<del>.</del>	
		ed in part that while she was		Address What Measure	es Will Re Put Into	
		s skin tear he stated that she		Place Or Systemic Cha		
		irm with her nails then he		Ensure That The Defic		
		nt #1 continued to state the		Not Recur:		
		hit her saying "hit me, hit				
		said he hit her. Resident #1		1. The facility began	a Quality	
	said they were initiall	y scuffling and that she		Improvement Performa	ince Improvement	
	always does this with	n him.		Project on 12/13/2018		
				issues with abuse in th		
		PM during a telephone		reporting of abuse time		
		#2 she stated she was		Assurance and Perform		
		ome and note a skin tear on		Improvement Committe		
		2 stated that it didn't look		the following compone		
		ar and described it as deep,		Performance Improven	-	
	Lunneling, and had a	crescent shaped skin flap.	1	will assess these each	week at the QAPI	1

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SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page he Nurse also stated mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	I there was a moderate fter NS #2 treated the skin the measurements and ed happened in her nurses' to NS #3 and called the rsing (IDON).	A. BUILDIN B. WING	NG STF 138 HU X 609	CONSTRUCTION REET ADDRESS, CITY, STATE, ZIP CODE 825 HUNTON LANE JNTERSVILLE, NC 28078 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) sub committee meetings: 1. Identify root cause analysis, 2. identify residents with behaviors that are higher risk for abuse,	TE DATE
COMMONS AT THE V SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page he Nurse also stated mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it to nterim Director of Nur Review of the 24-Hou ate and time of the a	ILLAGES OF MECKLENBURG	ID PREFIX TAG	STF 138 HU X 609	825 HUNTON LANE UNTERSVILLE, NC 28078 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) sub committee meetings: 1. Identify root cause analysis, 2. identify residents with behaviors	12/07/2018 E (X5) TE DATE
COMMONS AT THE V SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page he Nurse also stated mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it to nterim Director of Nur Review of the 24-Hou ate and time of the a	ILLAGES OF MECKLENBURG	ID PREFIX TAG	STF 138 HU X 609	825 HUNTON LANE UNTERSVILLE, NC 28078 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) sub committee meetings: 1. Identify root cause analysis, 2. identify residents with behaviors	E (X5) E COMPLE TE DATE
COMMONS AT THE V SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page he Nurse also stated mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it to nterim Director of Nur Review of the 24-Hou ate and time of the a	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 57 I there was a moderate fter NS #2 treated the skin the measurements and ed happened in her nurses' to NS #3 and called the rsing (IDON).	PREFIX	138 HU × 609	825 HUNTON LANE UNTERSVILLE, NC 28078 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) sub committee meetings: 1. Identify root cause analysis, 2. identify residents with behaviors	E COMPLE TE DATE
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page he Nurse also stated mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 57 I there was a moderate fter NS #2 treated the skin the measurements and ed happened in her nurses' to NS #3 and called the rsing (IDON).	PREFIX	ни × 609	JNTERSVILLE, NC 28078 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) sub committee meetings: 1. Identify root cause analysis, 2. identify residents with behaviors	E COMPLE TE DATE
(EACH DEFICIENCY REGULATORY OR L continued From page he Nurse also stated mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 57 I there was a moderate fter NS #2 treated the skin the measurements and ed happened in her nurses' to NS #3 and called the rsing (IDON).	PREFIX	609	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) sub committee meetings: 1. Identify root cause analysis, 2. identify residents with behaviors	E COMPLE TE DATE
REGULATORY OR L Continued From page he Nurse also stated mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	SC IDENTIFYING INFORMATION) 57 I there was a moderate fter NS #2 treated the skin the measurements and ed happened in her nurses' to NS #3 and called the rsing (IDON).	TAG	609	cross-referenced to the APPROPRIA DEFICIENCY) sub committee meetings: 1. Identify root cause analysis, 2. identify residents with behaviors	TE DATE
he Nurse also stated mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	I there was a moderate fter NS #2 treated the skin the measurements and ed happened in her nurses' to NS #3 and called the rsing (IDON).	F 6		<ol> <li>Identify root cause analysis,</li> <li>identify residents with behaviors</li> </ol>	
he Nurse also stated mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	I there was a moderate fter NS #2 treated the skin the measurements and ed happened in her nurses' to NS #3 and called the rsing (IDON).			<ol> <li>Identify root cause analysis,</li> <li>identify residents with behaviors</li> </ol>	
mount of bleeding. A ear, she documented that Resident #1 stat otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	fter NS #2 treated the skin the measurements and ed happened in her nurses' to NS #3 and called the rsing (IDON).			<ol> <li>Identify root cause analysis,</li> <li>identify residents with behaviors</li> </ol>	
ear, she documented hat Resident #1 stat otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	the measurements and ed happened in her nurses' to NS #3 and called the rsing (IDON).			2. identify residents with behaviors	
that Resident #1 stat otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	ed happened in her nurses' to NS #3 and called the rsing (IDON).				
otes and reported it t nterim Director of Nur Review of the 24-Hou ate and time of the a	to NS #3 and called the rsing (IDON).				
nterim Director of Nur Review of the 24-Hou ate and time of the a	rsing (IDON).			3. review all injuries of unknown	
leview of the 24-Hou ate and time of the a				source,	
ate and time of the a	r Initial Report revealed the			4. track any suspicions of abuse,	
ate and time of the a	Review of the 24-Hour Initial Report revealed the			actual abuse, injuries of unknown sourc	æ.
				reporting times of any incident of	
08/18/18 at 10:00 am. The allegation described in				suspicion or abuse or actual abuse	
	eceived a skin tear to his left			5. Develop a system to inform care	
	post incident with the Sitter"			givers of residents with behaviors or	
	y the facility). The report			resistive to care	
	ruck the Sitter in the right			6. In-service incorporated into new	
				hire orientation on timely reporting	
im to sit back down.	The Sitter reported she			<ol><li>All current staff were in-serviced</li></ol>	k
ied to get his arms a	way, a skin tear resulted.			on 12/05/2018 and 12/06/2018 concern	ing
esident stated she to	ore into his skin during a			the requirement of timely reporting as	-
cuffle. The Sitter was	s removed from Resident #1			outlined in the facility's policies and	
nd facility pending in	vestigation."			procedures.	
				Staff engagement to improve moral	le
leview of the Fax Tra	insmittal Form the 24-Hour			and change general attitude towards	
	ed to the state agency on			ownership of job and responsibilities to	
8/18/18 at 8:49 pm.				residents.	
				2. The QAPI Subcommittee will monit	
				each of these components of the project	
					o
				• •	
during the morning of 08/18/18 and arrived at the					
• •				•	
-				-	lity
	-				
				• •	
				achieved and sustained.	
-					
				Indicate Llow The Desility Dises T-	
	-				
icirie e con enile e con	de of the face/jaw as in to sit back down. ed to get his arms a esident stated she to uffle. The Sitter was d facility pending in eview of the Fax Tra- tial Report was faxe /18/18 at 8:49 pm. uring an interview w :47 AM she reporte e incident between I ring the morning of cility in the early afte e was told by NS #3 mbative with the Sit ce after they got into e instructed NS #3 tter then send her h d not report the alter d the Sitter within 2 ie IDON stated she	de of the face/jaw as she attempted to redirect in to sit back down. The Sitter reported she ed to get his arms away, a skin tear resulted. esident stated she tore into his skin during a uffle. The Sitter was removed from Resident #1 id facility pending investigation." eview of the Fax Transmittal Form the 24-Hour tial Report was faxed to the state agency on /18/18 at 8:49 pm. uring an interview with the IDON on 12/04/18 at :47 AM she reported that she was notified of e incident between Resident #1 and the Sitter	de of the face/jaw as she attempted to redirect in to sit back down. The Sitter reported she ed to get his arms away, a skin tear resulted. esident stated she tore into his skin during a uffle. The Sitter was removed from Resident #1 d facility pending investigation." eview of the Fax Transmittal Form the 24-Hour tial Report was faxed to the state agency on 1/18/18 at 8:49 pm. uring an interview with the IDON on 12/04/18 at :47 AM she reported that she was notified of e incident between Resident #1 and the Sitter ring the morning of 08/18/18 and arrived at the cility in the early afternoon. The IDON stated e was told by NS #3 that Resident #1 became mbative with the Sitter and punched her in the ce after they got into a scuffle. The IDON stated e instructed NS #3 to get a statement from the tter then send her home. The IDON stated she d not report the altercation between Resident #1 d the Sitter within 2 hours to the state agency. the IDON stated she reported the incident to the	de of the face/jaw as she attempted to redirect in to sit back down. The Sitter reported she ed to get his arms away, a skin tear resulted. esident stated she tore into his skin during a uffle. The Sitter was removed from Resident #1 d facility pending investigation." eview of the Fax Transmittal Form the 24-Hour tial Report was faxed to the state agency on 1/8/18 at 8:49 pm. uring an interview with the IDON on 12/04/18 at :47 AM she reported that she was notified of e incident between Resident #1 and the Sitter ring the morning of 08/18/18 and arrived at the cility in the early afternoon. The IDON stated e was told by NS #3 that Resident #1 became mbative with the Sitter and punched her in the ce after they got into a scuffle. The IDON stated e instructed NS #3 to get a statement from the tter then send her home. The IDON stated she d not report the altercation between Resident #1 d the Sitter within 2 hours to the state agency. the IDON stated she reported the incident to the	<ul> <li>de of the face/jaw as she attempted to redirect m to sit back down. The Sitter reported she ed to get his arms away, a skin tear resulted.</li> <li>esident stated she tore into his skin during a uffle. The Sitter was removed from Resident #1 d facility pending investigation."</li> <li>eview of the Fax Transmittal Form the 24-Hour tial Report was faxed to the state agency on /18/18 at 8:49 pm.</li> <li>uring an interview with the IDON on 12/04/18 at :47 AM she reported that she was notified of e incident between Resident #1 and the Sitter ring the morning of 08/18/18 and arrived at the cility in the early afternoon. The IDON stated e was told by NS #3 that Resident #1 became mbative with the Sitter and punched her in the ce after they got into a scuffle. The IDON stated e instructed NS #3 to get a statement from the ter then send her home. The IDON stated be inclead NS #3 to get a statement from the ter then send her home. The IDON stated e instructed NS #3 to get a statement from the ter then send her home. The IDON stated e instructed NS #3 to get a statement from the ter then send her home. The IDON stated e instructed NS #3 to get a statement from the ter then send her home. The IDON stated she e IDON stated she reported the incident to the</li> </ul>

Facility ID: 990623

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				(X3) DATE SURVEY COMPLETED	
CORRECTION	A. BUIL	A. BUILDING		C	
	345541	B. WING		12/07/2018	
ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
DLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG		13825 HUNTON LANE HUNTERSVILLE, NC 28078			
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
Continued From pag	e 58	F 609		Ensuring itor project ject to nd ned. ne ponsibility s that	
	SUMMARY S (EACH DEFICIENC REGULATORY OR	CORRECTION IDENTIFICATION NUMBER: 345541 ROVIDER OR SUPPLIER OX COMMONS AT THE VILLAGES OF MECKLENBURG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         345541       B. WING	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         345541         STREET ADDRESS, CITY, STATE, ZIP CODE         TREET ADDRESS, CITY, STATE, ZIP CODE         0X COMMONS AT THE VILLAGES OF MECKLENBURG         STREET ADDRESS, CITY, STATE, ZIP CODE         OX COMMONS AT THE VILLAGES OF MECKLENBURG         SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BO FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECT         (EACH DEFICIENCY MUST BE PRECEDED BO FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECT         (Continued From page 58       F 609       That Solutions Are Sustained. Th Facility Must Develop A Plan For E ThAT Correction Is Achieved And Sustained:         The QAPI Subcommittee will mon each of these components of the p and will assess and adjust the pro ensure that facility performance an solutions are achieved and sustain The Subcommittee will report to th Monthly QAPI which has the respu to ensure that the Subcommittee in performing in a manner to ensure facility performance and solutions	

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