STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING _____ B. WING _____	C 06/21/2012

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

(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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation. Event ID # 1ZV611.	F 000	OLDE KNOX COMMONS RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, and staff interviews the facility failed to post the survey results in a place that was accessible to residents. The findings are: On 6/18/12 at 9:00 AM observation of facility entrance hallway revealed a sign posted on the wall stating survey results were located at the nursing station. On 6/20/12 at 11:30 AM Resident #15, stated she was not sure where the state survey results were kept. She further stated that to find out where they were located she would ask the Activity Coordinator.	F 167	• F167 : ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Corrective action was accomplished and achieved for residents on 07-02-12 when the two Survey Notebooks which were located at nursing station # 1 and nursing station # 2 were relocated. One survey notebook was openly placed on a table in the reception area of the facility. The second was openly placed in the Activity Room. On 07-02-12 the sign notification located in the hallway at the main entrance was updated to reflect the new locations of the Survey Notebooks. A Resident Council meeting was conducted by the Activity Director on 7-9-12 with all residents invited for the purpose of discussing the Survey Results and to make all residents aware of the changes being made as a result of the Survey to include the updated location of the Survey Notebooks. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	07-16-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jimmy D. Sellers	Administrator	7-12-12

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

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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

(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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 1 On 6/20/12 at 12:50 PM observation of nursing station #1 revealed the binder labeled "State Survey Results"stacked underneath a binder that was labeled "Resident Sign-out book" behind the desk. The binder containing the state survey results was located behind the desk where residents/visitors would have to ask staff permission to view. On 6/20/12 at 1:10 PM observation of nursing station #2 revealed the binder labeled "State Survey Results" stacked underneath two binders behind the desk; one was labeled "Resident Sign-out book" and the other "Lab book." The binder containing the state survey results was located behind the desk where residents/visitors would have to ask staff permission to view. Interview with the Activity Coordinator on 6/21/12 at 2:52 PM revealed that the survey results were located at the nursing station. During an interview on 6/21/12 at 2:52 p.m. the activity coordinator observed the survey results binder positioned underneath two white binders behind the nurses' station. She stated that none of the residents had asked to view the results. Interview with Nurse in Charge #2 on 6/21/12 at 3:01pm revealed that the survey results were located underneath two other white binders behind the desk. She stated occasionally visitors would ask to view the survey results and could not access the binder without asking staff.	F 167	Corrective action was accomplished and achieved for residents on 07-02-12 when the two Survey Notebooks which were located at nursing station # 1 and nursing station # 2 were relocated. One survey notebook was openly placed on a table in the reception area of the facility. The second was open placed in the Activity Room. On 07-02-12 the sign notification located in the hallway at the main entrance was updated to reflect the new locations of the Survey Notebooks. A Resident Council meeting was conducted on 7-9-12 by the Activity Director with all residents invited for the purpose of discussing the Survey Results and to make all residents aware of the changes being made as a result of the Survey to include the updated location of the Survey Notebooks. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: On 07-02-12 both publicly available Survey Notebooks were relocated from the nurses stations to the reception area located at the main entrance and to the Activity Room. Both Survey Notebooks are openly displayed and accessible to both residents and family for viewing without having to ask for the Survey Results.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		

INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:

The facility receptionist will visually inspect the Receptionist Area location and the Activity Room on a weekly basis to ensure Survey Notebooks are located in their designated locations. Receptionist will maintain a log of her weekly inspections. The logs will be taken to the QA Committee Meeting for review. The QA Committee is responsible to ensure the solutions are achieved and sustained.

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OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

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F 280	Continued From page 2 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to document the intervention of an alarming device for one (1) of two (2) sampled residents with wandering behaviors and involve two (2) of three (3) sampled residents in the development of the care plan (Residents #156, #45 and #160) The findings are: 1. Resident # 156 was admitted to the facility on 3/20/12 with diagnoses that included dementia. His most recent Minimum Data Set (MDS) dated 5/20/12 specified the resident had severe cognitive impairment and wandered in the facility.	F 280	• F280: ADDRESS HOW CORRECTIVE ACTION S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 06-28-12 an Elopement Risk Assessment was conducted on resident # 156 which determined that resident was potentially at risk for elopement due to mobility and confusion. Based upon assessment the resident was determined to be appropriate for a wanderguard bracelet as a preventive measure to prevent elopement. On 06-28-12 a MD order was obtained for the placement of the wanderguard bracelet. Resident's care plan was updated by the MDS Nurse on 06-29-12 to reflect potential for elopement risk with appropriate intervention of wanderguard bracelet which would activate the automatic door lock maglock system. Resident # 45 and Resident # 160 were invited by the MDS Nurse and attended a Resident Care plan meeting with the interdisciplinary team on 06-21-12. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	07-16-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 3 On 6/19/12 at 8:50 a.m. Resident #156 was observed wandering the 700 Hall and noted to have a wanderguard bracelet (an alarming device used to alert staff of attempts to exit the building) attached to his left ankle. A second observation was made of Resident #156 on 6/20/12 at 3:30 p.m. beside an exterior exit door wandering. He was observed to have a wanderguard bracelet attached to his left ankle. Review of Resident #156's medical record revealed his care plan updated on 6/14/12 specified the resident wandered in halls. The care plan outlined interventions to keep the resident safe but did not specify the resident required a wanderguard bracelet. On 6/20/12 at 12:00 p.m. the Nurse in Charge #1 was interviewed and reported that Resident #156 required a wanderguard due to his wandering behaviors. She was unaware of when the wanderguard was placed on the resident but stated it was not a new intervention. She also reviewed the medical record and was unable to determine when the wanderguard had been placed on the resident. The Nurse in Charge also reported the facility did not assess residents for risk for elopement. She stated Resident #156 needed the wanderguard because of his mobility and confusion. On 6/21/12 at 2:20 p.m. MDS Coordinator #1 was interviewed and reported that she was responsible for updating residents' care plans. She stated that she updated Resident #156's care plan on 6/14/12. She stated that she reviewed the medical record, Physician's orders, spoke with staff and visualized residents to	F 280	On 07-02-12 a new system was implemented for all new admissions were an Elopement Risk Assessment Form will be completed as part of the initial new admission assessment documentation and Quarterly thereafter on every new resident. Current residents previously cared for by the facility will have an Elopement Risk Assessment completed on them when their scheduled quarterly assessment is due and quarterly thereafter. The nurse who is initiating the Elopement Risk Assessment is responsible to place any intervention(s) as deemed applicable by the assessment on the resident's care plan. On 07-02-12 a system was put in place to ensure that all residents who have not been adjudged incompetent or otherwise found to be incapacitated under the laws of the State are notified of a scheduled care plan meeting and given the opportunity to participate in the planning of their care and treatment or changes in their care and treatment. All residents who have not been adjudged incompetent or otherwise found to be incapacitated will be given a written notification in the form of an internal memo of their scheduled care plan meeting which will be provided to the residents internally as part of the daily mail delivery by the activity department staff.	

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F 280	Continued From page 4 determine if changes in the resident had occurred since the previous care plan. She stated that wanderguard bracelets would be care planned but she was unaware Resident #156 had a wanderguard. She added that Resident #156 needed the wanderguard bracelet because of his wandering behavior and confusion. 2. Resident #45 was admitted on 5/25/12 to the facility with diagnoses which included Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease and Cerebral Vascular Accident with left sided weakness. The admission Minimum Data Set (MDS) dated 6/1/12 assessed intact cognition and documented resident participation in the assessment with an active discharge plan to return to the community. Review of Resident #45's care plan dated 6/1/12 revealed documentation of planned interventions to address Resident #45's mood, activities of daily living, nutritional needs, respiratory status, pressure sore risk and requirement for contact precautions. Interview on 6/20/12 at 4:11 PM with Resident #45 revealed he would like to attend a care plan meeting about his treatments and plan for discharge. Resident #45 explained he would like to talk to staff about his legs swelling, his diet and his lungs. Resident #45 reported he did not receive an invitation to a care plan meeting. Interview on 6/20/12 at 5:41 PM with MDS Nurse #1 revealed she arranged the care plan meeting after completion of the MDS. She reported she sent an invitation to Resident #45's family on 6/12/12 and the family did not schedule a	F 280	In the event the resident is unable to read the notification it will be read for them by the activity staff member. For those residents who are unable to notify the MDS department of their intention to attend or not attend; the activity staff will notify the MDS department on behalf of the resident by indicating on the internal memo their intention to attend or not attend. The activity staff member will deliver that memo back to the MDS nurse. The MDS nursing department will maintain a Care Planning Conference Notebook that documents notification and attendance of residents and family members at care planning conferences. The MDS department will complete a Family Conference Notes Form documenting attendees and a written summary of each care plan conference. The completed Family Conference Notes Form will be filed in the Care Planning Conference Notebook. **ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:**	

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F 280	Continued From page 5 meeting. MDS Nurse #1 explained residents' families or responsible parties were invited to care plan meetings by mailed letter. She reported she did not invite residents to the care plan meetings but would often visit residents in their rooms and present the care plan. MDS Nurse #1 could not provide a reason why Resident #45 was not invited to the care plan meeting. Interview with the Director of Nursing on 6/20/12 at 6:14 PM revealed she expected residents to be involved and invited to care plan meetings. 3. Resident #160 was initially admitted to the facility on 4/6/12 and readmitted on 5/24/12 with diagnoses which included Congestive Heart Failure, Obstructive Sleep Apnea, and Hypertension. Review of resident #160's admission Minimum Data Set (MDS) dated 5/31/12 assessed intact cognition and documented the resident's participation in the assessment. Resident #160's care plan dated 5/31/12 included interventions to prevent falls and increase independence in activities of daily living. Interview with Resident #160 on 6/20/12 at 4:03 PM revealed he would like to be included in his schedules and his plan to get stronger. Resident #160 explained he would like to talk to staff about his falls because he fell when he did not ask for help. Interview with MDS Nurse #1 on 6/20/12 at 5:53 PM revealed Resident #160's family received a letter of invitation to the care plan meeting in April	F 280	On 07-02-12 a system was put in place to ensure that all residents who have not been adjudged incompetent or otherwise found to be incapacitated under the laws of the State are notified of a scheduled care plan meeting and given the opportunity to participate in the planning of their care and treatment or changes in their care and treatment. All residents who have not been adjudged incompetent or otherwise found to be incapacitated will be given a written notification in the form of an internal memo of their scheduled care plan meeting which will be provided to the residents internally as part of the daily mail delivery by the activity department staff. In the event the resident is unable to read the notification it will be read for them by the activity staff member. For those residents who are unable to notify the MDS department of their intention to attend or not attend; the activity staff will notify the MDS department on behalf of the resident by indicating on the internal memo their intention to attend or not attend. The activity staff member will deliver that memo back to the MDS nurse.	

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The MDS nursing department will maintain a Care Planning Conference Notebook that documents notification and attendance of residents and family members at care planning conferences. The MDS department will complete a Family Conference Notes Form documenting attendees and a written summary of each care plan conference. The completed Family Conference Notes Form will be filed in the Care Planning Conference Notebook.

INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:

The weekly QA Committee will monitor all residents who are identified as requiring an intervention of a wanderguard bracelet as a result of the Elopement Risk Assessment and will ensure that the resident's care plans are updated with the appropriate interventions.

The weekly QA Committee will review the Care Planning Conference Notebook to monitor compliance and documentation of care plan meetings. After weekly review for a period of three months the QA Committee will make recommendations for continued monitoring and review. The QA Committee is responsible to ensure the solutions are achieved and sustained.

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F 280	Continued From page 6 after his initial admission. She did not know if Resident #160's family letter had been sent yet. MDS Nurse #1 could not provide a reason why Resident #160 was not invited to the care plan meeting. Interview with the Director of Nursing on 6/20/12 at 6:14 PM revealed she expected residents to be involved and invited to care plan meetings.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to maintain a catheter below the bladder level during transfer for one (1) of two (2) residents with an indwelling catheter (Resident #172). The findings are: Resident #172 was admitted to the facility with diagnoses which included Alzheimer's Disease and a history of Urine Retention.	F 315	• F315: ADDRESS HOW CORRECTIVE ACTION S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 06-28-12 revisions were made to the Policy and Procedure for CNA's regarding Catheter and Drainage Bag care. All CNA's will receive in-service re-education by a qualified staff nurse on the revised policy and procedure by 07-16-12. Annual in-service education will be provided thereafter by a qualified staff nurse. The revised policy and procedure has been added to the new employee orientation as of 07-09-12. Competency check off for CNA's will be verified by their training nurse. On 06-21-12 resident # 172 care plan was updated MDS Nurse to reflect that resident has a Foley catheter in place. The weekly QA Committee will review all residents with catheters to ensure that the residents care plans are updated by MDS.	07-16-12

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F 315	Continued From page 7 Review of physician's orders dated 5/28/12 revealed direction to obtain a urine specimen by catheter and begin antibiotic therapy for a Urinary Tract Infection (UTI). Resident # 172's admission Minimum Data Set dated 5/30/12 listed frequent incontinence of urine. Resident #172's care plan dated 5/30/12 documented Resident #172 required incontinence care and should be monitored for signs and symptoms of UTIs. Review of physician's orders dated 6/7/12 revealed direction to begin antibiotic therapy for a UTI. Review of a physician's order dated 6/11/12 revealed direction for an in and out catheterization if Resident #172 was unable to void in 12 hours and if the residual amount of urine was over 300 cc (cubic centimeters), the urinary catheter could remain. Review of a nursing note dated 6/11/12 revealed Resident #172 did not void in 12 hours and an indwelling urinary catheter was inserted due to a urine residual amount of 1000 cc. Observation on 6/20/12 at 9:15 AM revealed Nursing Assistant (NA) # 1 transferred Resident #172 from a geriatric chair to bed. During the transfer, NA #1 held the urinary catheter bag approximately 2 inches below Resident #172's shoulders when Resident #172 stood during the stand and pivot transfer. After the transfer, NA #1 placed the catheter bag on Resident #172's feet. After NA #1 moved the geriatric chair into the bathroom, NA #1 secured the catheter bag to	F 315	**ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** On 06-28-12 revisions were made to the Policy and Procedure for CNA's regarding Catheter and Drainage Bag care. All CNA's will receive in-service re-education by a qualified staff nurse on the revised policy and procedure by 07-16-12. Annual in-service education will be provided thereafter by a qualified staff nurse. The revised policy and procedure has been added to the new employee orientation as of 07-09-12. Competency check off for CNA's will be verified by their training nurse. On 06-21-12 resident # 172 care plan was updated MDS Nurse to reflect that resident has a Foley catheter in place. The weekly QA Committee will review all residents with catheters to ensure that the residents care plans are updated by MDS. **ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:** On 06-28-12 revisions were made to the Policy and Procedure for CNA's regarding Catheter and Drainage Bag care.	

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F 315	Continued From page 8 gravity below Resident #172's waist. The indwelling urinary catheter bag contained approximately 100 cc of clear amber urine. Observation on 6/20/12 at 12:35 PM revealed NA #1 and NA #2 transferred Resident #172 from the bed to a geriatric chair. During this transfer, NA #1 unhooked the bag from the bed frame and placed the tubing, which contained urine, and bag on the bed next to Resident #172's shoulders on the bed. NA #1 and NA #2 assisted Resident to a sitting position on the edge of the bed. NA #1 held the catheter bag approximately 6 inches above Resident #172's waist while NA #2 transferred Resident #172. After the transfer, NA #1 placed the indwelling urinary catheter bag in a privacy cover attached to the foot of the chair. Interview with NA #1 on 6/20/12 at 12:50 PM revealed she forgot to keep the indwelling urinary catheter tubing and bag below Resident #172's waist during both transfers. NA #1 reported she should have made certain the bag was as low as possible during the two transfers. Interview with the Director of Nursing (DON) on 6/21/12 at 8:50 AM revealed she expected nursing staff to keep the catheter bag below the bladder level during transfers to prevent backflow of urine.	F 315	All CNA's will receive in-service re-education by a qualified staff nurse on the revised policy and procedure by 07-16-12. Annual in-service education will be provided thereafter. The revised policy and procedure has been added to the new employee orientation as of 07-09-12. Competency check off for CNA's will be verified by their training nurse. On 06-21-12 resident # 172 care plan was updated by the MDS Nurse to reflect that resident has a Foley catheter in place. The weekly QA Committee will review all residents with catheters and ensure that the residents care plans are updated by MDS. A unit nurse will complete QA Action Round to observe CNA's while transferring residents with catheters to ensure they are following the correct protocol. A unit nurse will document these action rounds on a QA Action Rounds Log form. The QA Committee will review the QA Action Rounds observations for properly handling of catheters on a weekly basis for one month and then monthly for three months and will then re-evaluate.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 333		

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INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:

The weekly QA Committee will review all residents with catheters and ensure that the residents care plans are updated by MDS. The QA Committee will review the QA Action Rounds observations for properly handling of catheters on a weekly basis for one month and then monthly for three months and will then re-evaluate. The QA Committee is responsible to ensure the solutions are achieved and sustained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING _____ B. WING _____	C 06/21/2012

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

(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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 9 by: Based on observation, staff, nurse practitioner and pharmacist interviews, and record review, the facility failed to administer the correct dose of Digoxin (for heart failure) to one (1) of twelve (12) residents observed during medication pass (Resident #149). The findings are: Resident #149 was readmitted to the facility on 5/24/12 with diagnoses which included Congestive Heart Failure. Readmission medication orders included Digoxin 0.125 milligrams (mg.) daily. Review of Resident #149's Digoxin level dated 6/6/12 revealed a result of 0.9 nanograms per milliliter (ng/ml) with a reference range of 0.8 ng/ml to1.5 ng.ml. (A Digoxin level identifies and measures the amount of Digoxin in the blood.) Review of a physician's order dated 6/7/12 revealed direction to increase the Digoxin dose to 0.250 mg. daily. Review of the June 2012 electronic Medication Administration Record (eMAR) for Resident #149 revealed direction dated 6/7/12 to administer Digoxin 0.250 mg. The Digoxin 0.125 mg. was discontinued on the eMAR. Review of the eMAR revealed documentation of daily administration of the 0.250 mg. dose from 6/7/12 to 6/19/12. Observation on 6/19/12 at 4:10 PM revealed Licensed Nurse (LN) #1 took Resident #149's radial pulse and administered Digoxin 0.125 mg. to Resident #149. LN #1 reported to Resident	F 333	• F333: ADDRESS HOW CORRECTIVE ACTION S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 06-19-12 request was made to the pharmacy for correct dose of Digoxin for resident # 149. The old medication card with incorrect dose was removed from the medication cart and disposed of according to facility policy and procedure. The nurse responsible for the medication error received immediate re-education and in-service by the Staff Development Coordinator regarding the facility medication administration policy and procedure. The medication error has been reported to Medication Error Quality Initiative (MEQI) by the DON. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All facility nurses will be in-serviced by 07-16-12 on prevention of medication errors, as well as proper procedures when medications are discontinued by the Staff Development Coordinator. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:	07-16-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 10 #149, a pulse of 76 heartbeats per minute. Interview with LN #1 on 6/19/12 at 4:25 PM revealed she did not notice the direction to administer Digoxin 0.250 mg. and administered one tablet of 0.125 mg. LN #1 explained she administered one Digoxin 0.125 mg tablet to Resident #149 on a daily basis. LN #1 reported the new dosage of Digoxin should be available in the medication cart. Observation on 6/19/12 at 4:27 PM of the medication cart with LN #1 revealed one medication card of Digoxin 0.125 mg. available for administration to Resident #149. Observation on 6/19/12 at 4:30 PM of the Digoxin medication card revealed 5 tablets of Digoxin 0.125 mg. remained available for administration. The pharmacy label directed daily dose of 0.125 mg. with a dispense date of 5/24/12 of 30 tablets. (Daily administration of 0.125 mg from 5/25/12 to 6/19/12 would be 25 doses with 5 remaining tablets.) Interview with the Nurse Practitioner on 6/20/12 at 9:46 AM revealed Resident #149 should have received Digoxin 0.250 mg. which the cardiologist recommended. Interview with the facility's pharmacy representative on 6/20/12 at 10:30 AM revealed 30 tablets of Digoxin 0.125 mg. were delivered on 5/24/12. He reported the first request for 0.250 mg. occurred on 6/19/12. Interview with the Director of Nursing (DON) on 6/20/12 at 11:15 AM revealed she expected	F 333	The Nurse Manager on 3rd shift is responsible to take all telephone orders for the past 24-hours and check to determine if medications have been discontinued. If so she/he will go to the medication cart to determine if the discontinued medication has been removed. If not she/he will remove. The 3rd shift Nurse will initial the Telephone Orders to indicate she has checked and followed the procedure. All facility nurses will be in-serviced by 07-16-12 on prevention of medication errors, as well as proper procedures when medications are discontinued. **INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:** The DON/Designee will complete a weekly check of orders and medications to determine if new procedure is being followed. A QA Action Round log will be completed. This will be done weekly for 1 month, monthly for 3 months and then will be reviewed by the Medication Management Committee.	

The Quarterly Medication Management Committee consisting of the Medical Director, Pharmacist, Administrator, DON, and other invited attendees will continue to review all medication errors and follow all recommendations by the committee. The QA Committee is responsible to ensure the solutions are achieved and sustained.

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F 333	Continued From page 11 nurses to administer the correct dosage of medication using the eMAR as a guide. The DON provided a medication error report related to Resident #149's Digoxin dosage dated 6/19/12 for review.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and documentation review the facility failed to ensure the walk-in freezer functioned properly to keep internal food items frozen and failed to discard food past the use by date. The findings are: 1. An initial tour of the kitchen was made on 6/18/12 at 9:35 a.m. that revealed the internal temperature of the walk-in freezer was 18 degrees Fahrenheit. The contents of the freezer were also observed and revealed individual cartons of ice cream were soft to touch. A 3 gallon container of partially consumed ice cream was observed to have ice cream that had melted. A second observation of the walk-in freezer was	F 371	• F371 : ADDRESS HOW CORRECTIVE ACTION S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 06-20-12 the facility maintenance supervisor conducted a maintenance inspection on the walk-in freezer and consulted with an outside licensed refrigerant specialist concerning the temperature range on the walk-in freezer. On 06-20-12 adjustments were made to freezer to correct the temperature which resulted in the freezer temperatures on the next day 06-21-12 being below zero. On 06-21-12 a new Freezer Temperature Log sheet was put into effect to be used on all refrigerator's and freezers in the facility kitchen. The new Temperature log sheet requires that dietary staff check the temperatures of the refrigerator's and freezers twice daily, once first thing in the morning and once prior to departure of the evening shift and record these temperatures on the sheet.	07-16-12

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OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

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F 371	Continued From page 12 made on 6/20/12 at 11:20 a.m. that revealed the internal temperature was 10 degrees Fahrenheit. Dietary Manager (DM) #1 was present for the observation and reported the freezer ' s temperature should be 0 degrees Fahrenheit. He stated that dietary staff monitored and recorded internal temperatures on a daily log sheet. He added the staff were instructed to notify one of the two (2) dietary managers if the temperature was not at 0 degrees Fahrenheit. The daily temperature log sheet for the month of 6/12 was reviewed and revealed the following: 6/18/12 at 5:00 a.m. 12 degrees Fahrenheit 6/19/12 at 5:00 a.m. 2 degrees Fahrenheit 6/20/12 at 5:00 a.m. 4 degrees Fahrenheit On 6/20/12 at 11:30 a.m. the morning cook was interviewed and reported she was assigned to monitor and record the walk-in freezer's temperature. She added she was trained to report concerns with the temperature above 0 degrees Fahrenheit to her manager. She stated she had not reported the freezer's temperature being above 0 degrees Fahrenheit to her manager and offered no explanation why she failed to do so. On 6/20/12 at 11:35 a.m. Dietary Manager #2 reported that she did not review the monthly temperature log and relied on her staff to report concerns. She stated she was unaware of any concerns with the temperature of the walk-in freezer. She stated the cook should have reported the concerns with the morning temperature of the walk-in freezer. 2. On 6/18/12 at 9:55 a.m. nourishment room #1	F 371	In addition with the new Temperature Log Sheet the daily temperature checks are to be verified by a kitchen supervisor and signed off on the sheet that temperatures were logged and re-verify that temperatures are in range and if not kitchen supervisor is to ensure that maintenance request is made to maintenance department for correction/service of equipment. On 06-18-12 Dietary Manager removed and discarded outdated ice cream from nourishment room #1. On 06-20-12 Dietary Manager removed and discarded soft ice cream identified as to touch and a 3 gallon container of partially consumed ice cream from freezer. **ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** On 06-21-12 a new Freezer Temperature Log sheet was put into effect to be used on all refrigerator's and freezers in the facility kitchen.	

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F 371	Continued From page 13 refrigerator was observed and revealed a one (1) gallon container of ice cream dated 3/22/12 stored ready for use. The inside of the ice cream container was observed and revealed thick ice crystalline growth and evidence of freezer burn on the partially consumed ice cream. Dietary Manager #2 was present for the observation and reported that dietary staff were responsible for removing leftover food items stored after three (3) days. She confirmed the ice cream should not have been allowed to remain in the freezer. She offered no explanation why the ice cream had been stored past the use by date.	F 371	The new Temperature log sheet requires that dietary staff check the temperatures of the refrigerator's and freezers twice daily, once first thing in the morning and once prior to departure of the evening shift and record these temperatures on the sheet. In addition with the new Temperature Log Sheet the daily temperature checks are to be verified by a kitchen supervisor and signed off on the sheet that temperatures were logged and re-verify that temperatures are in range and if not kitchen supervisor is to ensure that maintenance request is made to maintenance department for correction/service of equipment. All dietary staff will be in-serviced and re-educated by the Dietary Manger by 07-16-12 on proper procedures of recording and verify daily temperature check of kitchen refrigerator's and freezers and completing a maintenance request form to reflect any item that needs attention to include refrigerator's and freezer temperature. Staff will be in-serviced and re-educated educated by the Dietary Manger on identifying and removing any old or outdated food item in any facility refrigerator or freezer to include unit nourishment rooms.	

ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:

On 06-21-12 a new Freezer Temperature Log sheet was put into effect to be used on all refrigerator's and freezers in the facility kitchen. The new Temperature log sheet requires that dietary staff check the temperatures of the refrigerator's and freezers twice daily, once first thing in the morning and once prior to departure of the evening shift and record these temperatures on the sheet. In addition with the new Temperature Log Sheet the daily temperature checks are to be verified by a kitchen supervisor and signed off on the sheet that temperatures were logged and re-verify that temperatures are in range and if not kitchen supervisor is to ensure that maintenance request is made to maintenance department for correction/service of equipment.

INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:

The weekly QA committee will monitor and review the Temperature Log Sheets for a period of three months to assure the effectiveness of the system. Dietary monitoring of kitchen refrigerator's and freezers temperature will be followed quarterly thereafter for a period of 6 months.

The QA Committee is responsible to ensure the solutions are achieved and sustained.