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 08/08/2013

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 NC00090353.	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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225	• **F225** **ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRATICE:** A system was put into place on 08-19-13 for this resident, a body audit to be completed by each shift by Nurse. Each Nurse is directed to document on Body Audit Form. A system was put into place for this; all ADL's assistance provided by CNA's to be supervised by a Nurse for 30 days to ensure CNA's provide appropriate approach while providing care. The Nurse supervising ADL care is to also provide observation and documentation of resident's behaviors that could result in unintentional self-inflicted injury as a direct result of those behaviors and not a suspicious injury of unknown origin. At the end of 30 days, then every other day for two (2) weeks, then three (3) times a week for two (2) weeks, then weekly for two (2) weeks. At this time the need to supervise the residents will be re-evaluated by the Administrator and DON. In-service training by the ADON/DON, on incident reporting, proper identification of potential injury of unknown origin and appropriate reporting to the Administrator/DON to determine the necessity of 24 hour report completion and submission to the NC State Personnel Registry will be completed on all Nurse's by 09-05-13.	09-05-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-16-13

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.

DSR/HFE Branch Received SEP 1 0 2013 by: PRM

original signature 8-30-13 mh

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F 225	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to file a 24 hour and 5 day report to the state's Health Care Personnel Registry (HCPR) for 1 of 3 residents (Resident #51) reviewed for injuries of unknown origin. The findings are: Resident #51 was admitted to the facility on 12/27/10 with diagnoses of hypertension, Alzheimer's disease and dysphasia. A review of the most recent quarterly Minimum Data Set (MDS) dated 05/14/13 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS further indicated Resident #51 was totally dependent on staff for transfers and activities of daily living and exhibited physical behavioral symptoms directed toward others 4-6 days but less than daily. A review of an incident report dated 06/07/13 revealed Resident #51 was noted to have a large bruise covering her left side. The incident report indicated an unidentified nurse aide (NA) informed Nurse #4 during the 7:00 AM to 3:00 PM shift of the bruise. The report noted Nurse #4 concluded the bruise was caused from the sit-to-stand lift straps used to transfer Resident #51. There was no documentation on the report describing the measurements of the bruise.	F 225	**ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** An educational training tool has been developed by the DON that defines what an injury of unknown origin is and the appropriate reporting process for all levels of staff. This training also will be inserted into the new employee orientation process to ensure all future employees are properly educated on the appropriate reporting process to include completion and submission of a 24 hour report. Training provides detailed instruction on: • Identification and notification of potential injury of unknown origin. • CNA Staff or non-nursing staff are to immediately notify a Nurse or Nurse – in-charge as soon as you observe the presence of an injury. • CNA staff when providing care to observe anything that is out of the ordinary such as; bruising, redness, skin tear or any signs or symptoms of pain. • Staff should never make an assumption that injury has already been reported to a nurse, but must always report. • The Nurse receiving the report will immediately initiate an internal investigation process obtaining all applicable medical records, witness statements, employee interviews, MARS, body audit, and completion of Quality Assurance Event Report.	

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F 225	Continued From page 2 A review of the nurse's note dated 06/07/13 7-3 PM revealed Resident #51 was combative with care, hitting, pushing and slapping NAs. No new skin injuries to report. Nurse's note dated 06/08/13 revealed the bruise covering Resident #51 left side measured 18cm x 5cm. Review of Weekly Skin Assessment of 06/07/13 revealed no new skin issues. The 06/14/13 assessment indicated a resolving bruise (no measurements noted) on the left side with no new skin issues. Interview with NA #3 on 08/08/13 at 8:17 AM revealed she worked with Resident #51 on 06/07/13 and observed a large dark colored bruise covering Resident #51 left side when she changed the resident's clothes that morning. NA #3 stated she reported the bruise to Nurse #4. NA #3 reported she was not interviewed by anyone about the cause of the bruise. NA #3 reported Resident #51 could be very combative when being transferred with the sit-to-stand lift, the resident would take her arms out of the sling and the NAs would sit her down, let her calm down and try the transfer again. NA #3 stated Resident #51 could be transferred without the sit-to-stand lift by 2 people when the resident wasn't being combative. NA #3 reported the non-weight bearing mechanical lift had never been used to transfer Resident #51. She stated she was unaware of how the resident sustained the bruise. She also explained that it wasn ' t likely the bruise was caused by the sit-to-stand lift because the bruising was only on the resident ' s left side and the resident had never exhibited bruising from the sit to stand lift in the past.	F 225	• Ensure appropriate intervention is in place to meet the needs of resident. • Notify Physicians Elder Care via triage line. • Notify resident responsible party. • Question your information, i.e.; can resident state what happened or did someone witness the cause of injury and provide witness documentation. • Notified Nurse is to immediately notify the Nurse Manager. • Both the Nurse and Nurse Manager are to notify the Administrator/DON. • The Nurse and Nurse Manager are to immediately start notification of the Administrator/DON and are to continue to make calls until they reach a live person. Voice mails and texts are not appropriate and will not be utilized. • Administrator/DON will make the determination whether the completion and submission with fax confirmation of the 24 hour report is necessary. This training will be completed with all Nurses by 09-05-13. **ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:** An educational training tool has been developed by the DON that defines what an injury of unknown origin is and the appropriate reporting process for all levels of staff. This training also will be inserted into the new employee orientation process to ensure all future employees are properly educated on the appropriate reporting process to include completion and submission of a 24 hour report. Training provides detailed instruction on:	

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F 225	Continued From page 3 Interview with Nurse #4 on 08/08/13 at 9:15 AM revealed she assessed a large bruise on Resident #51 left side on 06/07/13 and felt the straps on the sit-to-stand lift had caused the bruise due to the bruise matching the straps of the lift. She also reported Resident #51 was combative with care and would fight staff when in the sit-to-stand lift. Nurse #4 reported she was new to the facility and was instructed to complete an incident report for all injuries and accidents and to inform the charge nurse or DON of any injury of unknown origin as soon as possible. Nurse #4 stated she did not feel the bruise was from an injury of unknown origin so she did not inform the charge nurse or the DON. Nurse #4 further stated she did not interview any direct care staff that worked with Resident #51 on or around 06/07/13 to gather any additional information to make her determination for the cause of the bruise. An observation was made on 08/08/13 at 1:56 PM of NA #3 and NA #4 transferring Resident #51 from the wheelchair to the bathroom to the bed with the sit-to-stand lift revealed the resident was very cooperative during the transfer. The straps on the sling of the sit-to-stand lift were positioned properly under Resident #51 arms with no movement of the sling during the transfer. Interview with NA #4 on 08/08/13 at 2:15 PM revealed she observed a large bruise on the left side of Resident #51 on 06/07/13 and was not questioned by anyone on how the bruise occurred. NA #4 stated she didn ' t think the bruise matched the straps of the sit-to-stand lift due to the large size of the bruise. She stated she was unaware of how Resident #51 sustained the bruise.	F 225	• Identification and notification of potential injury of unknown origin. • CNA Staff or non-nursing staff are to immediately notify a Nurse or Nurse – in-charge as soon as you observe the presence of an injury. • CNA staff when providing care to observe anything that is out of the ordinary such as; bruising, redness, skin tear or any signs or symptoms of pain. • Staff should never make an assumption that injury has already been reported to a nurse, but must always report. • The Nurse receiving the report will immediately initiate an internal investigation process obtaining all applicable medical records, witness statements, employee interviews, MARS, body audit, and completion of Quality Assurance Event Report. • Ensure appropriate intervention is in place to meet the needs of resident. • Notify Physicians Elder Care via triage line. • Notify resident responsible party. • Question your information, i.e.; can resident state what happened or did someone witness the cause of injury and provide witness documentation. • Notified Nurse is to immediately notify the Nurse Manager. • Both the Nurse and Nurse Manager are to notify the Administrator/DON. • The Nurse and Nurse Manager are to immediately start notification of the Administrator/DON and are to continue to make calls until they reach a live person. Voice mails and texts are not appropriate and will not be utilized. • Administrator/DON will make the determination whether the completion and submission with fax confirmation of the 24 hour report is necessary.	

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F 225	Continued From page 4 Interview with Nurse #2 on 08/08/13 at 2:22 PM revealed she reviewed the incident report dated 06/07/13 for Resident #51 then sent the report to the DON. Nurse #2 reported she assessed Resident #51's bruise to the left side, she reported Resident #51 had a significant bruise that covered the ribs beginning under the arm to the waist with an area not bruised around the waist and then bruise continued to the hip bone. Nurse #2 stated she did not think the bruise occurred from the sit-to-stand lift straps due to the positioning of the bruise and only occurring on the left side of the body. Nurse #2 reported Resident #51 tries to get out of the bed by rolling onto the side rails and she felt that was how the bruise occurred. Interview with the DON conducted on 08/08/13 2:40 PM revealed all incident reports were reviewed by her, she further stated it was the responsibility of the nurse who completed the incident reports' to conduct an investigation of the incident. She reported all injuries of unknown origin have to be reported to the DON as soon as possible. If the DON and Administrator conclude it is a true injury of unknown origin an investigation will be conducted and a 24 hour and 5 day report will be sent to the Health Care Personnel Registry. The DON stated an investigation was to include observations, medical record review, staff, resident, and family interviews, medication review, and the residents skin integrity. The DON stated she reviewed the incident report dated 06/07/13 for Resident #51. She reported she assessed Resident #51 bruise and described it as very dark in color, very significant bruising	F 225	This training will be completed with all Nurses by 09-05-13. **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 IT'S EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:** Nurses are to turn in any Quality Assurance Event Reports to the Nurse Manager prior to the end of their shift for review by the Nurse Manager. The Administrator/DON will be notified by the Nurse Manager regarding any incidents of unknown origin upon receipt of the Quality Assurance Event Report. The Administrator/DON will determine if an investigation is to be initiated along with reported to NCHPR via 24 hour report. The Administrator/DON will direct the Nurse Manger to initiate the investigation. In addition, Administrator/DON/ will review all Quality Assurance Event Reports daily Monday through Friday to ensure compliance is being achieved and staff is appropriately following facility process and documentation. A log of the Quality Assurance Event Reports will be maintained by month to include the type of injury, the cause of injury, and whether a 24 hour report to the HCPR was completed if necessary. The incident log and the Quality Assurance Event Report will be reviewed by the Quality Assurance Committee to ensure the facility is in compliance with facility/state/federal policies,	

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	Continued From page 5			
F 225	and in 2 parts on the left side. The DON stated she agreed with Nurse #4 that the bruise was caused by the strap on the sit-to-stand lift because the bruise matched the strap on the sit-to-stand lift. The DON stated the strap could have slipped down around the residents' waist during the transfer causing the bruise to be on the upper left side and lower left side of the resident. The DON reported she did not think the bruise was an injury of unknown origin so she did not make a 24 hour report for the incident and did not follow up with a 5 day investigative report to the Health Care Personnel Registry.	F 225	guidelines and laws on reporting all incidents of injuries and/or unknown origin. The QA Committee will be responsible to ensure that corrective action is achieved and sustained. The QA Committee will be responsible for implementing new policies and procedures and/or systems if current policies and procedures and/or systems are identified as insufficient to maintain corrective action and sustain solutions. The QA Committee meets weekly, monthly, and quarterly.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on a record review and staff interviews, the facility failed to follow their abuse policy and procedures by not investigating an injury of unknown origin for 1 of 3 residents (Resident #51). The findings are: The facility's undated Abuse Policy and Procedures read in part: · The facility will identify and investigate any and all "cause unknown" injuries to ensure	F 226	• **F226** **ADDRESS HOW CORRECTIVE ACTION(S) WILL BE ACCOMLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** A system was put into place on 08-19-13 for this resident, a body audit to be completed by each shift by Nurse. Each Nurse is directed to document on Body Audit Form. A system was put into place for this; all ADL's assistance provided by CNA's to be supervised by a Nurse for 30 days to ensure CNA's provide appropriate approach while providing care. The Nurse supervising ADL care is to also provide observation and documentation of resident's behaviors that could result in unintentional self-inflicted injury as a direct result of those behaviors and not a suspicious injury of unknown origin. At the end of 30 days, then every other day for two (2) weeks, then three (3) times a week for two (2) weeks, then weekly for two (2) weeks. At this time the need to supervise the residents will be re-evaluated by the Administrator and DON.	09-05-13

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F 226	Continued From page 6 abuse and neglect has not occurred. · A Quality Assurance Event Report will be completed for each incident/accident to assure abuse/neglect has not occurred. The report will include the nature of the injury, when it was discovered, who discovered it and the cause of the injury if known. The report will then be forwarded to the Director of Nursing (DON) for follow up. · All bruises, skin tears of unknown origin will be reviewed to determine the cause. Incidents and accidents that can not be reasonably determined will be brought to the attention of the Administrator. Resident #51 was admitted to the facility on 12/27/10 with diagnoses of hypertension, Alzheimer's disease and dysphasia. A review of the most recent quarterly Minimum Data Set (MDS) dated 05/14/13 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS further indicated Resident #51 was totally dependent on staff for transfers and activities of daily living and exhibited physical behavioral symptoms directed toward others 4-6 days but less than daily. A review of an incident report dated 06/07/13 revealed Resident #51 was noted to have a large bruise covering her left side. The incident report indicated an unidentified nurse aide (NA) informed Nurse #4 during the 7:00 AM to 3:00 PM shift of the bruise. The report noted Nurse #4 concluded the bruise was caused from the sit to stand lift straps used to transfer Resident #51. There was no documentation on the report describing the measurements of the bruise.	F 226	In-service training by the ADON/DON, on incident reporting, proper identification of potential injury of unknown origin and appropriate reporting to the Administrator/DON to determine the necessity of 24 hour report completion and submission to the NC State Personnel Registry will be completed on all Nurse's by 09-05-13. **ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** An educational training tool has been developed by the DON that defines what an injury of unknown origin is and the appropriate reporting process for all levels of staff. This training also will be inserted into the new employee orientation process to ensure all future employees are properly educated on the appropriate reporting process to include completion and submission of a 24 hour report. Training provides detailed instruction on: • Identification and notification of potential injury of unknown origin. • CNA Staff or non-nursing staff are to immediately notify a Nurse or Nurse – in-charge as soon as you observe the presence of an injury. • CNA staff when providing care to observe anything that is out of the ordinary such as; bruising, redness, skin tear or any signs or symptoms of pain. • Staff should never make an assumption that injury has already been reported to a nurse, but must always report.	

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F 226	Continued From page 7 A review of the nurse's note dated 06/07/13 7-3 PM revealed Resident #51 was combative with care, hitting, pushing and slapping NAs. No new skin injuries to report. Review of Weekly Skin Assessment of 06/07/13 revealed no new skin issues. The 06/14/13 assessment indicated a resolving bruise (no measurements noted) on the left side with no new skin issues. Review of nurse's note dated 06/08/13 revealed the bruise covering Resident #51 left side measured 18cm x 5cm. Interview with NA #3 on 08/08/13 at 8:17 AM revealed she worked with Resident #51 on 06/07/13 and observed a large dark colored bruise covering Resident #51 left side when she changed the resident ' s clothes that morning. NA #3 stated she reported the bruise to Nurse #4. NA #3 reported she was not interviewed by anyone about the cause of the bruise. NA #3 reported Resident #51 could be very combative when being transferred with the sit to stand lift, the resident would take her arms out of the sling and the NAs would sit her down, let her calm down and try the transfer again. NA #3 stated Resident #51 could be transferred without the sit to stand lift by 2 people when the resident wasn't being combative. NA #3 reported the non weight bearing lift had never been used to transfer Resident #51. She stated she was unaware of how the resident sustained the bruise. She also explained that it wasn't likely the bruise was caused by the sit to stand lift because the bruising was only on the resident's left side and the resident had never exhibited bruising from the	F 226	• The Nurse receiving the report will immediately initiate an internal investigation process obtaining all applicable medical records, witness statements, employee interviews, MARS, body audit, and completion of Quality Assurance Event Report. • Ensure appropriate intervention is in place to meet the needs of resident. • Notify Physicians Elder Care via triage line. • Notify resident responsible party. • Question your information, i.e.; can resident state what happened or did someone witness the cause of injury and provide witness documentation. • Notified Nurse is to immediately notify the Nurse Manager. • Both the Nurse and Nurse Manager are to notify the Administrator/DON. • The Nurse and Nurse Manager are to immediately start notification of the Administrator/DON and are to continue to make calls until they reach a live person. Voice mails and texts are not appropriate and will not be utilized. • Administrator/DON will make the determination whether the completion and submission with fax confirmation of the 24 hour report is necessary. **ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:** An educational training tool has been developed by the DON that defines what an injury of unknown origin is and the appropriate reporting process for all levels of staff. This training also will be inserted into the new employee orientation process to ensure all future employees are properly educated on the appropriate reporting process to include completion and submission of a 24 hour report.	

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

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F 226	Continued From page 8 sit to stand lift in the past. Interview with Nurse #4 on 08/08/13 at 9:15 AM revealed she assessed a large bruise on Resident #51 left side on 06/07/13 and felt the straps on the sit to stand lift had caused the bruise due to the bruise matching the straps of the lift. She also reported Resident #51 was combative with care and would fight staff when in the sit to stand lift. Nurse #4 reported she was new to the facility and was instructed to complete an incident report for all injuries and accidents and to inform the charge nurse or DON of any injury of unknown origin as soon as possible. Nurse #4 stated she did not feel the bruise was from an injury of unknown origin so she did not inform the charge nurse or the DON. Nurse #4 further stated she did not interview any direct care staff that worked with Resident #51 on or around 06/07/13 to gather any additional information to make her determination for the cause of the bruise. An observation was made on 08/08/13 at 1:56 PM of NA #3 and NA #4 transferring Resident #51 from the wheelchair to the bathroom to the bed with the sit to stand lift revealed the resident was very cooperative during the transfer. The straps on the sling of the sit to stand lift were positioned properly under Resident #51 arms with no movement of the sling during the transfer. Interview with Resident #51 family on 08/08/13 at 2:00PM revealed they discovered the bruise to the resident ' s left side on 06/08/13 and reported it to the nurse on the hall and asked her to measure it. The family reported they had a meeting with the DON regarding the bruise and how it happened and was told by the DON she	F 226	Training provides detailed instruction on: • Identification and notification of potential injury of unknown origin. • CNA Staff or non-nursing staff are to immediately notify a Nurse or Nurse – in-charge as soon as you observe the presence of an injury. • CNA staff when providing care to observe anything that is out of the ordinary such as; bruising, redness, skin tear or any signs or symptoms of pain. • Staff should never make an assumption that injury has already been reported to a nurse, but must always report. • The Nurse receiving the report will immediately initiate an internal investigation process obtaining all applicable medical records, witness statements, employee interviews, MARS, body audit, and completion of Quality Assurance Event Report. • Ensure appropriate intervention is in place to meet the needs of resident. • Notify Physicians Elder Care via triage line. • Notify resident responsible party. • Question your information, i.e.; can resident state what happened or did someone witness the cause of injury and provide witness documentation. • Notified Nurse is to immediately notify the Nurse Manager. • Both the Nurse and Nurse Manager are to notify the Administrator/DON. • The Nurse and Nurse Manager are to immediately start notification of the Administrator/DON and are to continue to make calls until they reach a live person. Voice mails and texts are not appropriate and will not be utilized.	

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	345541	A. BUILDING _____ B. WING _____	C 08/08/2013

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

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F 226	Continued From page 9 would look into the issue. The family stated they had not been informed of how the bruise happened or what type of investigation was conducted. Interview with NA #4 on 08/08/13 at 2:15 PM revealed she observed a large bruise on the left side of Resident #51 on 06/07/13 and was not questioned by anyone on how the bruise occurred. NA #4 stated she didn't think the bruise matched the straps of the sit to stand lift due to the large size of the bruise. She stated she was unaware of how Resident #51 sustained the bruise. Interview with Nurse #2 on 08/08/13 at 2:22 PM revealed she reviewed the incident report dated 06/07/13 for Resident #51 then sent the report to the DON. Nurse #2 reported she assessed Resident #51's bruise to the left side, she reported Resident #51 had a significant bruise that covered the ribs beginning under the arm to the waist with an area not bruised around the waist and then bruise continued to the hip bone. Nurse #2 stated she did not think the bruise occurred from the sit to stand lift straps due to the positioning of the bruise and only occurring on the left side of the body. Nurse #2 reported Resident #51 tries to get out of the bed by rolling onto the side rails and she felt that was how the bruise occurred. Interview with the DON conducted on 08/08/13 2:40 PM revealed all incident reports were reviewed by her, she further stated it was the responsibility of the nurse who completed the incident report to conduct an investigation of the incident. She reported all injuries of unknown origin have to be reported to the DON as soon as	F 226	• Administrator/DON will make the determination whether the completion and submission with fax confirmation of the 24 hour report is necessary. **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 IT'S EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:** Nurses are to turn in any Quality Assurance Event Reports to the Nurse Manager prior to the end of their shift for review by the Nurse Manager. The Administrator/DON will be notified by the Nurse Manager regarding any incidents of unknown origin upon receipt of the Quality Assurance Event Report. The Administrator/DON will determine if an investigation is to be initiated along with reported to NCHPR via 24 hour report. The Administrator/DON will direct the Nurse Manger to initiate the investigation. In addition, Administrator/DON will review all Quality Assurance Event Reports daily Monday through Friday to ensure compliance is being achieved and staff is appropriately following facility process and documentation. A log of the Quality Assurance Event Reports will be maintained by month to include the type of injury, the cause of injury, and whether a 24 hour report to the HCPR was completed if necessary. The incident log and the Quality Assurance Event Report will be reviewed by the Quality Assurance Committee to ensure the facility is in compliance with facility/state/federal policies, guidelines and laws on reporting all incidents of injuries and/or unknown origin.	

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F 226	Continued From page 10 possible. If the DON and Administrator conclude it is a true injury of unknown origin an investigation will be conducted and a 24 hour and 5 day report will be sent to the Health Care Personnel Registry. The DON stated an investigation was to include observations, medical record review, staff, resident, and family interviews, medication review, and the residents skin integrity. The DON stated she reviewed the incident report dated 06/07/13 for Resident #51. She reported she assessed Resident #51 bruise and described it as very dark in color, very significant bruising and in 2 parts on left side. The DON stated she agreed with Nurse #4 that the bruise was caused by the strap on the sit to stand lift. The DON stated she did not conduct an investigation of the incident because she did not feel it was an injury of unknown origin.	F 226	The QA Committee will be responsible to ensure that corrective action is achieved and sustained. The QA Committee will be responsible for implementing new policies and procedures and/or systems if current policies and procedures and/or systems are identified as insufficient to maintain corrective action and sustain solutions. The QA Committee meets weekly, monthly, and quarterly.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279	• **F279** **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 resident #3 on 08-26-13 when a therapy referral for the incontinence program was completed and a plan of treatment was initiated by Occupational Therapy to begin incontinence program on 08-28-13. On 08-26-13 resident #3 care plan was updated to reflect changes in incontinent episodes with measurable objective and timetable to meet the residents medical, nursing, and mental and psychosocial as identified in subsequent assessments.	09-05-13

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F 279	Continued From page 11 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a care plan to maintain or prevent decline of urinary incontinent episodes for 1 of 3 sampled residents who experienced an increase of incontinent episodes (Resident #3). The findings are: Resident #3 was readmitted to the facility on 03/21/13 with diagnoses which included dementia. Review of a bowel and bladder comprehensive assessment dated 03/21/13 revealed Resident #3 was able to follow instructions and willing to participate in a toileting program. Review of Resident #3's admission Minimum Data Set (MDS) dated 03/27/13 revealed an assessment of intact cognition. The MDS indicated Resident #3 was occasionally incontinent of urine and required extensive assistance with toileting. Review of the Care Area Assessment (CAA) dated 03/27/13 revealed Resident #3 was occasionally incontinent of bladder, required extensive assistance with toileting, had a history of urinary tract infections and poor oral intake. The problem area of urinary incontinence would	F 279	**ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** On 08-26-13 a revised system was initiated to ensure all new admits and current residents are properly assessed to ensure that appropriate treatment and services to prevent urinary tract infection and to restore as much normal bladder function as possible are accomplished. The revised system was developed by the Administrator, DON, MDS Assessment Nurse. For each resident the bladder baseline function will be established using 7 days of data from MDSMax which tracks ADL and bowel and bladder activity. The baseline data will be used to complete a Bowel and Bladder Comprehensive Assessment for each resident by assessing Nurse. The Nurse completing the Bowel And Bladder Comprehensive will initiate an appropriate individualized intervention if necessary to help maintain established baseline and help prevent functional decline. In-service training for revised system will be completed by 09-05-13 for all nursing personal (CNA, LPN, and RN). In-services will be conducted by ADON/DON. **ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:** On 08-26-13 a new system was put into place to track and monitor urinary continence for every resident to ensure proper documentation of urinary continence episodes which could result in a urinary continence decline. A new Continence Tracking Form was put into place to record urinary continence.	

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F 279	Continued From page 12 proceed to care plan. Review of Resident #3's quarterly MDS dated 06/13/13 revealed an assessment of severely impaired cognition. The MDS indicated Resident #3 was frequently incontinent of urine and required extensive assistance with toileting with no toileting program. Review of Resident #3's care plan dated 06/13/13 revealed an identified problem of frequent incontinency of urine, history of urinary tract infections and poor oral intake. Resident #3's goal was to exhibit no complications related to incontinence and signs and symptoms of a urinary tract infection. Interventions included monitoring for signs and symptoms of an infection, use of pull ups/briefs to maintain dryness, document continent/incontinent each shift and assess skin. Interview with Minimum Data Set (MDS) Nurse #1 on 08/07/13 at 3:18 PM revealed Resident #3's care plan did not require an evaluation of change due to the increase in incontinent episodes and his diagnosis of dementia. MDS Nurse #1 explained the care plan would be evaluated and revised if Resident #3 became incontinent 100% of the time. Interview with the Director of Nursing (DON) on 08/07/13 at 3:33 PM revealed she expected staff to develop a plan of care specific to the resident in order to achieve as many continent episodes as possible.	F 279	Recorded on the Continence Tracking Form is the urinary continence assessment per MDS Comprehensive assessment category. In addition each subsequent MDS assessment urinary continence and function will be compared to prior comprehensive urinary continence category. If change is noted in urinary continent category the MDS Nurse will notify the interdisciplinary team for appropriate intervention and action. A update to resident care plan to reflect new interventions and actions will be completed. The MDS Nurse is responsible to initiate the Continence Tracking Form on all new and current residents. All Continence Tracking Forms will be maintained in an alphabetical notebook in the MDS office. The MDS Nurse completing an MDS assessment will review and update each Continence Tracking Form in conjunction with an assessment. A Continence Tracking Form on all residents will be completed by 09-05-13. The DON is conjunction with the QA committee will review on a weekly basis at the weekly QA the notebook which contains the Continence Tracking Forms for each resident that is maintained by the MDS Nurse's to ensure that any changes in continence status is noted and appropriate interventions are put into place. **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:**	

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			Utilizing the Continence Tracking Form the MDS Nurse will monitor and log all urinary continent category declines. The logs will be taken to the QA Committee Meeting for review. The Continence Tracking Form will be reviewed monthly at QA Committee meetings for trends and tracking of urinary continence decline. The QA Committee will be responsible for implementing new policies and procedures and/or systems if current policies and procedures and/or systems are identified as insufficient to maintain corrective action and sustain solution.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER The findings are: Resident #3 was readmitted to the facility on 03/21/13 with diagnoses which included dementia. Review of a bowel and bladder comprehensive assessment dated 03/21/13 revealed Resident #3 was able to follow instructions and willing to participate in a toileting program. Review of Resident #3's admission Minimum Data Set (MDS) dated 03/27/13 revealed an assessment of intact cognition. The MDS indicated Resident #3 was occasionally incontinent of urine and required extensive assistance with toileting.	F 315	• **F315** **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 resident #3 on 08-26-13 when a therapy referral for the incontinence program was completed and a plan of treatment was initiated by Occupational Therapy to begin incontinence program on 08-28-13. On 08-26-13 resident #3 care plan was updated to reflect changes in incontinent episodes with measurable objective and timetable to meet the residents medical, nursing, and mental and psychosocial as identified in subsequent assessments.	09-05-13

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F 315	Continued From page 14 Review of the Care Area Assessment (CAA) dated 03/27/13 revealed Resident #3 was occasionally incontinent of bladder, required extensive assistance with toileting, had a history of urinary tract infections and poor oral intake. The problem area of urinary incontinence would proceed to care plan. Review of Resident #3's quarterly MDS dated 06/13/13 revealed an assessment of severely impaired cognition. The MDS indicated Resident #3 was frequently incontinent of urine and required extensive assistance with toileting with no toileting program. Review of Resident #3's care plan dated 06/13/13 revealed an identified problem of frequent incontinency of urine, history of urinary tract infections and poor oral intake. Resident #3's goal was to exhibit no complications related to incontinence and signs and symptoms of a urinary tract infection. Interventions included monitoring for signs and symptoms of an infection, use of pull ups/briefs to maintain dryness, document continent/incontinent each shift and assess skin. Interview with Nurse Aide (NA) #1 on 08/07/13 at 2:30 PM revealed Resident #3 did not have a specific toileting schedule. NA #1 explained she checked Resident #3 every 2 hours to see if incontinence care was required. NA #1 reported it was the facility's policy to check all incontinent residents every 2 hours.	F 315	**ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** On 08-26-13 a revised system was initiated to ensure all new admits and current residents are properly assessed to ensure that appropriate treatment and services to prevent urinary tract infection and to restore as much normal bladder function as possible are accomplished. The revised system was developed by the Administrator, DON, MDS Assessment Nurse. For each resident the bladder baseline function will be established using 7 days of data from MDSMax which tracks ADL and bowel and bladder activity. The baseline data will be used to complete a Bowel and Bladder Comprehensive Assessment for each resident by assessing Nurse. The Nurse completing the Bowel And Bladder Comprehensive will initiate an appropriate individualized intervention if necessary to help maintain established baseline and help prevent functional decline. In-service training for revised system will be completed by 09-05-13 for all nursing personal (CNA, LPN, and RN). In-services will be conducted by ADON/DON. **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 315	Continued From page 15 Interview with Nurse #1 on 08/07/13 at 2:41 PM revealed Resident #3 received incontinence care every 2 hours if needed and there was no specific toileting schedule. Interview with NA #2 on 08/07/13 at 2:48 PM revealed Resident #3 was checked every 2 hours in order to receive incontinent care. Interview with Nurse #2, unit manager, on 08/07/13 at 2:53 PM revealed Resident #3 was a possible candidate for a prompted toileting schedule but a consistent nurse aide was not assigned to Resident # 3. Nurse #2 explained Resident #3 was incontinent of urine and was on the facility's regular 2 hour check. Interview with Nurse #3 on 08/07/13 at 3:01 PM revealed Resident #3 was "usually continent" during the day shift upon his readmission. Nurse #3 explained Resident #3 required prompting to void. Nurse #3 reported Resident #3 would vary in his cooperation with a prompted toileting. Interview with the Director of Nursing on 08/07/13 at 3:33 PM revealed she expected staff to assess and document incontinent episodes in order to develop a toileting schedule specific to the resident.	F 315	On 08-26-13 a new system was put into place to track and monitor urinary continence for every resident to ensure proper documentation of urinary continence episodes which could result in a urinary continence decline. A new Continence Tracking Form was put into place to record urinary continence. Recorded on the Continence Tracking Form is the urinary continence assessment per MDS Comprehensive assessment category. In addition each subsequent MDS assessment urinary continence and function will be compared to prior comprehensive urinary continence category. If change is noted in urinary continent category the MDS Nurse will notify the interdisciplinary team for appropriate intervention and action. A update to resident care plan to reflect new interventions and actions will be completed. The MDS Nurse is responsible to initiate the Continence Tracking Form on all new and current residents. All Continence Tracking Forms will be maintained in an alphabetical notebook in the MDS office. The MDS Nurse completing an MDS assessment will review and update each Continence Tracking Form in conjunction with an assessment. A Continence Tracking Form on all residents will be completed by 09-05-13. The DON is conjunction with the QA committee will review on a weekly basis at the weekly QA the notebook which contains the Continence Tracking Forms for each resident that is maintained by the MDS Nurse's to ensure that any changes in continence status is noted and appropriate interventions are put into place.	

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F 315	Continued From page 16	F 315	**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:** Utilizing the Continence Tracking Form the MDS Nurse will monitor and log all urinary continent category declines. The logs will be taken to the QA Committee Meeting for review. The Continence Tracking Form will be reviewed monthly at QA Committee meetings for trends and tracking of urinary continence decline. The QA Committee will be responsible for implementing new policies and procedures and/or systems if current policies and procedures and/or systems are identified as insufficient to maintain corrective action and sustain solution.	