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 03/10/2015

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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to conduct a complete assessment at the time of a fall to determine if it was safe to transfer the resident and the resident had a left distal femur fracture for 1 of 3 residents reviewed for falls (Resident #1). The findings included: Resident #1 was admitted to the facility on 04/12/12 with diagnoses that included history of a fall with fracture, anxiety, Alzheimer's disease and others. The Minimum Data Set (MDS) dated 12/04/14 specified the resident had severely impaired cognition, required extensive assistance with activities of daily living (ADL) including transfers, but had not fallen since the last review. Review of Resident #1's medical record revealed a nurse's entry dated 02/18/15 made by Nurse #1 that she responded to the Nurse Supervisor's call for help around 9:15 PM to assist with moving Resident #1 off the floor. Nurse #1 documented that it appeared Resident #1 fell out of her wheelchair and that her left leg was twisted at the knee and the lower leg was turned outward.	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 309	Continued From page 1	F 309		

Nurse #1's entry specified that the Nurse Supervisor instructed move Resident #1 using a mechanical lift to transfer Resident #1 back to bed. The entry added that after Resident #1 was transferred back to bed, the resident's clothes were removed and a "lump" on the left thigh area was observed. Nurse #2 documented that the Nurse Supervisor left the room to contact the on-call physician and an order was obtained to send the resident to the Emergency Department.

Further review of the medical record did not reveal any additional documentation surrounding Residnet #1's fall on 02/18/15.

On 03/10/15 at 10:25 AM the Nurse Supervisor was interviewed and reported she was working the night of 02/18/15 and heard Resident #1 yelling from inside the room. The Nurse Supervsior stated Resident #1 sounded like she was in distress. The Nurse Supervisor opened Resident #1's door and found the resident in the floor and called for help. She exaplined that she immediately called for help and Nurse #1 entered the room. The Nurse Supervisor reported that Resident #1 was in the floor and appeared to have fallen out of the wheelchair and that the resident's torso was twisted and her leg left leg was turned outward. The Nurse Supervisor added that Resident #1 was unable to report what happended and was crying. The Nurse Supervisor stated that she "looked" at the resident and performed a "quick" assessment, did not check the resident's range of motion and determined it was safe to move the resident using a mechanical lift from the floor to the bed for so that she could perform a complete assessment. The Nurse Supervisor explained that Nurse #1, nurse aide #1 and herself transferred Resident #1

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F 309	Continued From page 2 back to bed using the mechaincal lift. The Nurse Supervisor added that she removed Resident #1's clothing and observed a large raised area on the left thigh and the resident began complaining of pain. The Nurse Supervisor stated she then notified the on-call physician and obtained orders to send the resident to the Emergency Department. The Nurse Supervisor confirmed that she did not document the fall or the assessment in the medical record because she forgot. On 03/10/15 at 11:45 AM the Director of Nursing (DON) was interviewed and reported that she had investigated Resident #1's fall on 02/18/15. The DON stated that she expected the nurses to conduct an immediate head to toe assessment when a resident fell that would include range of motion, vital signs and evidence of an injury before moving a resident. On 03/10/15 at 2:10 PM the Physician was interviewed and stated that when a fall occurred he expected the nurse to perform a complete assessment to determine if it was safe to move a resident. The Physician added that a complete assessment would include range of motion.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 3	F 323		

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review the facility failed to implement fall precautions for a resident at risk for falls that fell and sustained a fractured femur for 1 of 3 sampled residents (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 04/12/12 with diagnoses that included history of a fall with fracture, anxiety, Alzheimer's disease and others. Resident #1's fall care plan updated on 11/11/14 specified the resident was at risk for falls related to history of falls with a fracture and poor safety awareness due to dementia. The care plan specified interventions to prevent a major injury included:

- monitor resident for attempts to get out of bed or wheelchair unassisted
- bed and chair alarms in place to alert staff of unassisted transfers

The Minimum Data Set (MDS) dated 12/04/14 specified the resident had severely impaired cognition, required extensive assistance with activities of daily living (ADL) including transfers, but had not fallen since the last review.

A fall risk assessment dated 01/24/15 specified the resident was a high risk for falls.

Review of Resident #1's medical record revealed a nurse's entry dated 02/18/15 made by Nurse #1 that she responded to the Nurse Supervisor's call for help around 9:15 PM that Resident #1 fell.

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Nurse #1 documented that it appeared Resident #1 fell out of her wheelchair and that her left leg was twisted at the knee and the lower leg was turned outward. The entry specified that Resident #1's personal alarm was not sounding at the time of the fall.

Further review of Resident #1's medical record revealed that on 02/18/15 she was transported to the Emergency Department and diagnosed with a left distal femur fracture as a result of the fall in the facility.

On 03/10/15 at 10:10 AM nurse aide (NA) #1 was interviewed and reported she was assigned to care for Resident #1 on 02/18/15. She explained that she did not routinely care for the resident but was aware that the resident at times resisted care, was at risk for falls and required a personal alarm at all times. NA #1 reported that she had placed Resident #1's personal alarm on the resident's wheelchair prior to the evening meal. The NA could not recall if she checked that the alarm was functioning. The NA explained that on 02/18/15 she attempted to put Resident #1 to bed but the resident was combative. NA #1 added that she left the resident alone in her room to calm down and proceeded to go on break. The NA stated that she notified her peers that she was leaving for break but did not report to them that Resident #1 was still up. The NA added that she assumed the other nurse aides knew to monitor her residents while she was on break. The NA explained that when she returned from break she was told Resident #1 fell and was injured.

On 03/10/15 at 11:15 AM the Nurse Supervisor was interviewed and reported she was working the night of 02/18/15 and heard Resident #1

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F 323	Continued From page 5 yelling from inside the room. The Nurse Supervsior stated Resident #1 sounded like she was in distress. The Nurse Supervisor opened Resident #1's door and found the resident in the floor and called for help. The Nurse Supervisor added that Resident #1 was unable to report what happended and was crying. The Nurse Supervisor reported that Resident #1's personal alarm was not sounding. She explained that she did not investigate to determine why the alarm was not sounding because her priority was the injured resident. The Nurse Supervisor added that Resident #1's door was closed and that the door to the resident's room should not have been closed because the resident was at risk for falls and required frequent monitoring. On 03/10/15 at 1:15 PM Nurse #1 was interviewed and reported that NA #1 did not report Resident #1 had been combative with care and was still up when the nurse aide left for break. Nurse #1 added that she would expect nurse aides to report incidents of residents being combative and/or resisting care.	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514		

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preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility nurse that discovered a resident in the floor failed to document finding the resident in the floor and failed to document that the resident was assessed injuries after the fall occurred for 1 of 3 residents reviewed for falls (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 04/12/12 with diagnoses that included history of falls, anxiety, Alzheimer's disease and others. The Minimum Data Set (MDS) dated 12/04/14 specified the resident had severely impaired cognition.

Review of Resident #1's medical record revealed that Nurse #1 made an entry dated 02/18/15 that she responded to the Nurse Supervisor's call for help to get Resident #1 out of the floor. Nurse #1 documented that it appeared Resident #1 fell out of her wheelchair.

Further review of the medical record did not reveal any additional documentation surrounding Residnet #1's fall on 02/18/15.

On 03/10/15 at 10:25 AM the Nurse Supervisor was interviewed and reported that when Resident #1 fell, she was responsible for documenting in the medical record the circumstrnaces surrounding the fall including vital information such as injuires and her assessment of Resident

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F 514	Continued From page 7 #1. The Nurse Supervisor explained that she was working the night of 02/18/15 and heard Resident #1 yelling from inside the room. The Nurse Supervsior added that she was the first staff member to respond to the yell, opened Resident #1's door and found the resident in the floor. The Nurse Supervisor confirmed that she did not document the fall in the medical record because she forgot. She also stated that she performed a "quick" assessment of the resident but also failed to document the assessment in the medical record. On 03/10/15 at 11:45 AM the Director of Nursing (DON) was interviewed and reported that she expected nurses to document falls in the medical record. The DON stated that the Nurse Supervisor should have documented Resident #1's fall in the medical record and her assessment of the resident.	F 514		