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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		4/13/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/06/2018

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.

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record interview and staff interviews, the facility failed to develop a comprehensive care plan to address oxygen use for 1 of 16 residents sampled. (Resident #15). The Findings Included: Resident #15 was admitted to the facility on 1/26/2017. Resident #15's documented diagnoses on admission were hypertension, shortness of breath, epilepsy and unspecified dementia without behavioral disturbance. Review of the most recent comprehensive Minimum Data Set (MDS) dated 1/24/2018 and coded as an annual assessment revealed that the Resident #15 was receiving respiratory treatments of oxygen therapy. The assessment further revealed Resident #15 was severely cognitively impaired and required assistance from the staff for completing activities of daily living. Review of the physicians' orders dated 10/11/17 revealed "oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath". This order was discontinued on 2/19/18 and a new order was received on this date that stated, "Continuous oxygen at via nasal cannula at 2 liters a minute for hypoxemia." Review of the active care plan dated 3/13/2018 revealed that Resident #15 did not have any person centered measurable objectives with timeframes to evaluate the progress toward goals of oxygen therapy.	F 656	MEASURES THAT WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: When the resident is admitted in preparation to complete the MDS Assessment, the MDS Nurse completes a worksheet that assists them in obtaining pertinent information in completing the MDS. After the MDS is complete, traditionally the MDS Nurse has used the CAA's in determining what needs to be care planned. Not all medications or treatments have a specific CAA. This worksheet asks the question does the resident have oxygen (as well as other questions that may be useful). Once the assessment and the CAA'S are complete this worksheet will be used to ensure that each resident has person centered measurable objectives with timeframes to evaluate the progress towards the identified goals on the Care Plan. When there is no CAA for a specific order this will assist the MDS Nurse in making sure the Care Plan is correct and complete with all areas identified on the worksheet. During the morning clinical meeting the MDS nurse will review the physician telephone orders, the Incident Reports and any other documentation brought to the meeting to determine if there is a change in the resident that would warrant an update or change to the resident's care plan. The MDS Nurse would then update	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 656	Continued From page 2 An interview conducted on 3/16/18 at 8:45 am with the MDS Coordinator revealed that the care area assessment did not trigger for oxygen therapy. The MDS staff revealed that she "would normally " develop and implement a care plan for residents with oxygen therapy, even if the care area assessment did not trigger. She reported that she failed to create a care plan for Resident #15's oxygen therapy. During an interview on 3/16/18 at 1:10 pm with the Director of Nursing she revealed that she expected the MDS Coordinator to develop a care plan for all residents with oxygen.	F 656	the care plan to reflect the change in the resident. All current residents have been reviewed by the MDS Nurse to determine if oxygen has been care planned if the resident has an order for it to be administered. If it was determined the care plan did not include oxygen therapy it was added to the resident's individualized care plan. MEASURES THAT WILL BE PUT IN TO PLACE TO PREVENT THE ISSUE FROM OCCURRING AGAIN: The facility will ensure that each resident has a person centered Care Plan with measurable objectives with timeframes to evaluate the progress towards the identified goals. The facility will accomplish this by ensuring the MDS Nurse 1. Completes the worksheet that assists them in doing the MDS, CAA, and Care Plan; 2. Review the physician telephone orders, Incident Reports, etc. each day in the Clinical Meeting; 3. Updates the Care Plan on a daily basis if needed to reflect current changes in the resident. The facility has two (2) MDS Nurses who will be responsible to review the Care Plan for the other person along with the Worksheet and CAA's to ensure that each resident's needs have been identified along with goals and approaches. WHO WILL MONITOR THE SITUATION TO ENSURE IT DOES NOT OCCUR AGAIN AND FREQUENCY OF MONITORING: The facility has two (2) MDS Nurses who	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 656	Continued From page 3	F 656	will be responsible to review the Care Plan for the other person along with the Worksheet and CAA's to ensure that each resident's needs have been identified along with goals and approaches. They will complete this process daily for one (1) week; and then review 10 percent of the care plans weekly for three (3) weeks. The Director of Nursing will be responsible to review a 10 percent sampling of the care plans for three (3) months to ensure the systems put into place are being maintained. This will be presented to the QAPI Committee on a Monthly basis.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to prevent a resident from falling out of bed during incontinent care for one of 1 of 3 residents reviewed for falls. (Resident #56). The findings included: Resident #56 was admitted to the facility on 3/16/16 with diagnoses including a neurological	F 689	MEASURES THAT WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: A "Resident Profile" has been implemented for each resident based upon the MDS and Care Plan. The profile will be placed in the resident's room (in a secure location) that will instruct any staff member who needs to assist a resident;	4/13/18

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 689	Continued From page 4 condition, epilepsy unspecified not intractable without status epilepticus, and abnormal posture. Resident #56 Readmission Minimum Data Set (MDS) dated 1/24/18 specified the resident was cognitively intact with no memory problems. The assessment further revealed Resident #56 was totally dependent on 2 or more staff assistance for bed mobility, transfers and toilet use. The resident was assessed as not steady, only able to stabilize with staff assistance, impairment on both sides for upper extremity and lower extremity and was always incontinent of bowel and bladder. Resident #56 weight during the MDS assessment was 241 pounds. A review of the care plan dated 1/24/18 noted resident had no recent history of falls, was non-ambulatory due to neurological condition, had contracture's to bilateral knees, hands and feet. The care plan further noted he was always incontinent of bladder and bowel had muscle spasms and was taking baclofen as well as had a baclofen pump. Additionally, it noted Resident #56 was alert and able to make needs known. A review of a nurse's note dated 2/15/18 read in part: resident rolled out of bed while being changed by Nursing Assistant (NA). The note read that NA glided resident to the floor. Resident did not sustain any injuries. Resident #56 was observed on 3/13/18 at 10:05 AM lying in his bed with no visible signs of pain or agitation. Bilateral side rails were observed in the up position along the top quarter length of the bed. The resident was alert, oriented and eating his breakfast.	F 689	what the resident needs are exactly. It will include the following but not all inclusive: 1. Resident transfer status (Hoyer Lift, Sit-to-Stand, 2+ Assist, etc.) 2. Bed Mobility Assistance (1 or 2 assist) 3. Toileting Assistance Required (Independent, 1 or 2 assist) 4. Bed Rails needed for transfer or mobility status. Again this is not all that will be on the profile but as it pertains to the deficient practice. The Charge Nurses will be responsible to add or delete changes to the profile and to let the Certified Nursing Assistants know of any changes. In the morning clinical meeting the Incident Reports are reviewed to ensure interventions are put into place timely. The Clinical Team led by the Director of Nursing/Designee in the DON's absence will also review the Incident Reports to make sure the report is complete, to include witness statements from the staff. The Director of Nursing or Designee will be responsible to interview the alert and oriented residents to ensure the resident's version of the incident is obtained and correlates to the incident report. Further interventions will be put into place based upon the Incident Report, Resident Interview and Witness Statements. MEASURES THAT WILL BE PUT IN TO PLACE TO PREVENT THE ISSUE FROM OCCURRING AGAIN: In the morning clinical meeting the	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 689	Continued From page 5 A phone interview was conducted with the NA, who worked with Resident #56 on the night of the fall, on 3/15/18 at 12:55 PM. The NA reported resident was fully bed bound and needed total care. She stated she rolled the resident towards her while performing incontinent care. The NA stated resident usually holds the bedrail to hold himself while she performed incontinent care. She stated she may have not locked bedrail and bedrail fell when resident grabbed the bedrail. The NA stated the resident's upper body slid off the bed, she assisted him to the floor and stated she went to get nurse for an assessment, and resident was assessed with no injury. The NA further stated another Nurse Aide assisted her with lifting resident back to the bed with a mechanical lift. In an interview on 3/15/18 at 02:57 PM with the Director of Nursing (DON), she reported nurse aides would need to look at the care plan to determine how many staff are required to complete ADLs, specifically incontinent care. The DON read care plan dated 1/24/18 and stated Resident #56 required total assistance. In an additional interview on 3/15/18 at 03:24 PM with the DON, she stated she had no documentation from the facility's fall committee related to the investigation of incident/fall on 2/15/18. She reported no new interventions were put in place following the fall. The DON stated incident was thought to be an isolated event and no new interventions were put in place. She further stated that the resident was heavier than the NA assisting him and that it would have been difficult for the NA to stop the resident from falling out of the bed due to her size compared to the resident's size. She stated that two staff to assist	F 689	Director of Nursing and Nurse Managers review the falls, new physician orders, and any acute conditions. If there is a change that is needed to the Resident Profile the DON or her designee will check to make sure the Charge Nurse updated the profile. If not they will be responsible to make the changes. In addition the Incident Reports are reviewed to ensure interventions are put into place timely. The Clinical Team led by the Director of Nursing will also review the Incident Reports to make sure the report is complete, to include witness statements from the staff. The Director of Nursing or Designee will be responsible to interview the alert and oriented residents to ensure the resident's version of the incident is obtained and correlates to the incident report. Further interventions will be put into place based upon the Incident Report, Resident Interview and Witness Statements. The MDS Nurse will ensure that the changes and interventions are care planned for the resident. The Director of Nursing/Staff Development Nurse will conduct an In-service with the Nurses and CNA's on April 8th-13th, 2018 on 1. "Resident Profile" – to include location of the profile and how it will be updated and the importance of reporting any changes to the Charge Nurse or the Nurse Manager so the profile can remain updated. 2. Incident Report Management – To include completion, interventions and witness statements. The Nurses will have to ensure that anyone assigned to or	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 689	Continued From page 6	F 689		

would have been the best option.

An interview on 3/15/18 at 6:09 PM with the MDS Coordinator, she reported no interventions were put in place for Resident #56 following the fall on 2/15/18. She stated she assumed there would be 2 persons in the room when providing care for Resident #56. She reported that 2 nurse aides should be assisting Resident #56 with incontinent care, and that her assessments indicated that he needed 2 people for assistance.

In an additional interview with MDS Coordinator on 3/16/18 at 09:00 AM, She reported based on her MDS assessment Resident #56 required 2 persons assistance for hygiene. She stated, "by looking at the diagnosis of muscle spasms" assistance for 2 persons would be required.

An interview on 3/16/18 at 09:18 AM, Resident #56 reported the bedrail was down when the NA left the room on the night of the fall. The resident further stated that the NA left the room during incontinent care, the bed rails were not up on his bed and he rolled out of the bed onto the floor. He stated that no staff interviewed him about the fall after it occurred to determine how it happened. He stated he was lifted back into the bed with a mechanical lift by 2 persons.

In an interview on 3/16/18 at 09:24 AM with the DON and Administrator, the DON stated staff stated staff "make judgement calls" with how many staff are needed when toileting Resident #56. The Administrator stated staff are taught in orientation to get assistance as needed for safety. The DON stated 2 persons could have been used for providing incontinent care for Resident #56, and further stated they should have required

involved in the incident has to complete a witness statement.

WHO WILL MONITOR THE SITUATION TO ENSURE IT DOES NOT OCCUR AGAIN AND FREQUENCY OF MONITORING:

In the morning clinical meeting the Director of Nursing and Nurse Managers review the falls, new physician orders, and any acute conditions. If there is a change that is needed to the Resident Profile the DON or her designee will check to make sure the Charge Nurse updated the profile. If not they will be responsible to make the changes.
In addition at the Morning Clinical Meeting the Incident Reports are reviewed to ensure interventions is put into place timely. The Clinical Team led by the Director of Nursing will also review the Incident Reports to make sure the report is complete, to include witness statements from the staff. The Director of Nursing or Designee will be responsible to interview the alert and oriented residents to ensure the resident's version of the incident is obtained and correlates to the incident report. Further interventions will be put into place based upon the Incident Report, Resident Interview and Witness Statements. The MDS Nurse will ensure that the changes and interventions are care planned for the resident.
The Director of Nursing will conduct Quality Assurance Rounds of the Resident Profiles to ensure they are being updated timely. The QA rounds will be done daily

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 689	Continued From page 7 2-person assistance for toileting as an intervention after the 2/15/18 fall. The DON and the Administrator stated they were not aware of the discrepancies between the NA and Resident #56's statements of how the fall occurred. They were unable to provide any information into the facility's investigation of the fall with Resident #56. The Administrator agreed with the DON by stating Resident #56 should have 2 persons assistance for toileting.	F 689	(Monday-Friday) for two (2) weeks, three (3) times weekly for two (2) weeks, weekly for three (3) months. If during this time the Resident Profiles are not updated and accurate then the Director of Nursing/Designee will be responsible to In-service the staff again and if compliance is not reached then the employees involved will receive disciplinary action. The QAPI checklist will be presented to the QAPI Committee on a monthly basis.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		4/13/18

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 761	Continued From page 8 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, manufacturer's storage guidelines, and facility policy, the facility failed to dispose of expired medications, failed to label opened medications, and failed to discard a single use injection after use in 2 of 5 medication carts (100 hall med cart and 700 hall med cart) and 1 of 2 medication rooms (700 hall med room). Findings included: The review of manufacturer's storage specifications revealed that the insulin injection vial should be discarded 28 days after opening and that the Fluticasone and Salmeterol Dry Powder Inhaler (DPI) should be discarded thirty days after opening. The facility's undated policy that was provided by the Director of Nursing (DON) on 3/15/18 stated that no discontinued, outdated, or deteriorated drugs or biological are available for use in this facility. 1. a. An observation on 3/15/18 at 2:30 PM of 700 hall medication cart revealed an opened, undated single dose vial of Methotrexate (a medication to treat cancer) with remaining content that was not discarded. A single dose vial is intended for a single (one time) injection use in an individual patient. During an interview with Nurse A on 3/15/18 at 2:35 pm he stated that single dose vials of Methotrexate should be discarded after use.	F 761	MEASURES THAT WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: The Director of Nursing will in-service the nurses from April 8th–13th, 2018 concerning the policy and procedure for labeling, dating and destroying medications to include medications that are in single dose administration forms, in the appropriate time frame. The procedure will be as follows: 1. When a medication (such as eye drops, insulin, inhalers) that have a shelf life that requires an expiration date once opened by the Nurse he/she will be responsible to label the bottle/package with the open date and expiration date. 2. A Medication Reference Guide will be placed upon each medication cart that lists all medications that have specific time frames for usage. Based upon this information the nurse will calculate the number of days in order to list the expiration date of the medication. 3. Each Nurse is responsible when administering medications to note if the medication has been labeled with an open date. If it is not labeled the medication will be dated based upon the fill date of the medication on the label. 4. The Nurses on the 11pm-7am shift will be responsible to check the carts on a weekly basis to ensure labeling of these medications are being done.	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 761	Continued From page 9 b. An observation on 3/15/18 at 3:01 PM of 100 hall medication cart revealed an insulin injection vial with a label of opening dated 2/1/18, a Fluticasone and Salmeterol Dry Powder Inhaler (a respiratory medication) was opened on 2/7/18, and an open an undated vial of Lidocaine (an anesthetic). During an interview on 3/15/18 at 3:10 PM Nurse B reported that the medication cart is checked for expired medications monthly. During an interview with Nurse C on 3/15/18 at 3:15 PM she stated that all medications should be dated when opened. She added that all opened medications should be discarded if they do not have an opening date identified. 2. An observation on 3/15/18 at 2:24 PM of 700 hall medication room revealed 2 bottles of Daily-Vite (a multivitamin) with an expiration date of 12/17 and a can of formula for feeding with an expiration date of 7/1/17. The refrigerator in medication room A contained antibiotic intravenous solution with an expiration date of 2/27/18. During an interview with Nurse Supervisor on 3/15/18 at 2:32 pm she stated that a pharmacy staff member comes to the facility each day. She reported that the expired medications should have been sent to the pharmacy for disposal. During an interview with the DON on 3/16/18 at 10:40 am she stated that it is her expectation that staff will check medication rooms and medication carts for expired medications on a routine basis. She indicated her expectation is that expired medications would be returned to the pharmacy for disposal.	F 761	5. The Nurses on the 11pm-7am shift will also be responsible to check the Medication Rooms to include Stock Medications and Refrigerated medications to ensure that all medications that have been discontinued or are out of date will be placed in the tote to send back to the pharmacy to be destroyed on the next scheduled pick up date. MEASURES THAT WILL BE PUT IN TO PLACE TO PREVENT THE ISSUE FROM OCCURRING AGAIN: The Nurse Managers will be responsible to complete a Quality Assurance Round of the Medication Carts and Rooms on a weekly basis for four (4) weeks, then bi-monthly basis for three (3) months. After this process is complete the Nurse Managers will conduct a periodic (monthly) QAA of the Medication Carts and Rooms to ensure the Nurses are labeling, dating and destroying medications as per the protocol. If at any time it is noted the policy and procedure is not being followed it will be reported to the Director of Nursing who will then be responsible to ensure that re-training is completed. The Director of Nursing will be responsible to review the reports and take necessary steps to include re-training up to include disciplinary action. WHO WILL MONITOR THE SITUATION TO ENSURE IT DOES NOT OCCUR AGAIN AND FREQUENCY OF MONITORING:	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 761	Continued From page 10	F 761	The Pharmacy Representative/Pharmacist Consultant comes to the facility on a monthly basis and while here conducts an audit of medication carts and the Medications Rooms. In their report to the Director of Nursing they will list the deficient practices that were noted. The Director of Nursing will be responsible to review the report and take necessary steps to include re-training up to include disciplinary action. The QAPI checklist will be presented to the QAPI Committee on a monthly basis.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		4/13/18

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 812	Continued From page 11 by: Based on observations and staff interviews, the facility failed to cover, label and date foods, failed to discard expired food items, failed to maintain a system of receipt for the stored dry food items, failed to prepare and serve cold food items at the acceptable temperature of 41 degrees Fahrenheit or below for 1 of 2 dining tray line service observations, failed to maintain a clean working space and failed to protect food from possible contamination as evidenced by the failure of dietary staff not properly securing hair while in the kitchen. Findings included: 1. Initial observation of the kitchen on 3/12/2018 at 11:15 am revealed: A. The walk-in freezer contained one box of open and exposed peppers with no date or label and one box of mixed vegetables opened and exposed with no date or label. Six oval shaped frozen items were observed covered within brown paper, secured with clear plastic wrap, with no date or label. Further observation revealed an opened and undated box of apple pie. B. The refrigerator contained one sealed and one open half full bag of shredded cabbage. The "use by date" on both bags of cabbage was 3/8/2018. C. The dry food storage area contained a 24-ounce bottle of chocolate syrup, open and not dated (label instructed to refrigerate after opening). Further observation revealed one 4 pound sweet and sour sauces, five 1-gallon mayonnaise sauce containers, eleven boxes of	F 812	MEASURES THAT WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: The food items in the freezer, refrigerator, store room and kitchen have been checked to ensure they were covered, labeled, dated and if necessary discarded. All the dry food items in stock and received from delivery; before being placed on the shelf has dated with the date of receipt and policy is being followed for discarding. The food temperatures are being done at each meal and documented on a log. The entire kitchen has been cleaned on March 17, 2018 to ensure a clean work space. All the staff has been instructed to not allow anyone to enter the kitchen food preparation areas without using the appropriate hair protection garment. The Dietary Manager will conduct an In-service on April 10th-13th, 2018 to include the following: 1. Cover, labeling, dating and discarding; out of date foods; 2. System for receiving of the stored dry food items; 3. Maintaining the proper temperature of foods when serving; 4. Maintaining a clean work space; 5. Preventing contamination of food by properly security hair while in the kitchen. All staff will be required to attend one of the in-services on these dates. If an employee does not attend one of the	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 812	Continued From page 12 kosher salt (with one box showing damage), thirteen table salt containers, two 4 pounds stir fry sauce containers, an open poultry seasoning bottle, one glass jar of grape jelly, five 14-ounce containers of artichokes and one-gallon tub of pickle relish with no date of receipt or expiration date. Interview with dietary manager (DM) on 3/12/2018 at 11:25 am revealed that the dietary staff failed to secure and close the open peppers and mixed vegetables. She also reported the dietary staff failed to label and date the six oval shaped frozen items, that she identified as hash browns. The DM revealed that the cabbage should not be in the refrigerator and she expected all dietary staff to cover, label, date and discard all foods before the use by date. She further revealed that the chocolate syrup should not be in the dry storage area. She stated that the salt box appeared to be "water damaged". She reported that she did not have a system for the receipt of dry goods. Her expectation of the staff was that opened items requiring refrigeration are not stored in the dry storage area. The DM stated that the water damaged salt box "probably shouldn't be" on the shelf. During an interview with the DM on 3/14/18 at 10:35 am she revealed that she expected all dietary staff to date, label and discard all foods per the policy. 2. Observation of food temperatures conducted on 03/14/18 at 11:25 am revealed: A. Certified dietary manager conducted temperatures of the lunch meal from the steam table in the kitchen. Lunch meal consisted of a	F 812	in-services they will not be allowed to work until they completed the training. MEASURES THAT WILL BE PUT IN TO PLACE TO PREVENT THE ISSUE FROM OCCURRING AGAIN: 1. The Dietary Manager has implemented a labeling system for the staff to use to label the food items in the freezer, refrigerator, kitchen and store room to ensure food is covered, labeled, dated and discarding appropriately. 2. The Dietary Manager has implemented new Procedure for receiving of dry food item will be as follows: a) When the dry food items are received from delivery prior to being placed on the shelf the staff will be responsible to date the item with the date of receipt. b) If after a year and the item is still in stock, it will be discarded. c) The staff will be responsible to rotate the stock upon receipt with the oldest to the newest on the shelves. 3. Dietary Manager has implemented a Procedure for maintaining proper temperatures will be as follows: a. All food will be checked for proper temperature prior to being served to the residents. b. The Cook will be responsible to check the temperatures and record them on a log. c. If at any time a food does not meet the temperature guidelines for serving, the	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 812	Continued From page 13 cold plate with peaches, pineapples, pears, cottage cheese and tomatoes. The following were the temperatures of the food items in degrees: peaches 46.0, pineapples at 46.5, pears 45.1 and cottage cheese at 40.2. The temperature of the pureed cold plate was: peaches 50.9, pineapples 54.5, pears 53.0 and cottage cheese at 49.4. Interview on 3/14/18 at 11:39 am with the DM and staff revealed the expected cold temperatures. The certified dietary manager stated the cold food temperatures should be "about forty-five or below" degrees Fahrenheit. The DM revealed that cold items should be 40 or below degrees Fahrenheit. Dietary staff #1 further revealed that cold food item temperatures should be 40 degrees Fahrenheit or below. B. On 3/14/18 at 11: 45 am observed 5 of 5 residents eating the cold plate in the main dining area. Interview with kitchen staff #1 on 3/14/18 at 11:50 am revealed that the food being served in the main dining room, that the 5 residents were eating, came from the kitchen and had not been temped prior to distribution. She further stated that she was in the main kitchen completing temperatures of the food, and did not complete temperatures on the food the 5 residents were eating prior to them being served. Interview with kitchen staff #2 serving on the dining room steam table on 3/14/18 at 11:52 am revealed that the cold food items came from the "cooler" in the kitchen. She reported that the residents eating the cold plate in the dining area had been served from the dining room steam table and that she did not temp the food prior to	F 812	food will be removed from service until such time it does meet the required temperature for hot or cold foods. d. If the temperature cannot be met in order for the meal delivery to take place on time, a substitution will be made by the Dietary Manager/Designee. e. This procedure is applicable to both tray line services. 4. Dietary Manager has implemented a Procedure for maintaining a clean work space. a. The entire kitchen has been cleaned on March 17, 2018 to ensure a clean work space. b. A cleaning schedule has been implemented to ensure that sanitation is maintained. 5. Dietary Manager has implemented a Procedure to prevent contamination of food; a. All staff is required to secure hair properly while in the food preparation area of the kitchen. b. The staff must use a hair net or a hat as long as all hair is covered; c. If facial hair is present they will be required to wear a protective mask that covers the facial hair. WHO WILL MONITOR THE SITUATION TO ENSURE IT DOES NOT OCCUR AGAIN AND FREQUENCY OF MONITORING: The Dietary Manager will conduct Quality Assurance checks of the Dietary	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 812	Continued From page 14 serving residents the cold plate. Kitchen Staff #2 reported that she did not know what the temperatures were for the cold plate items that were served to the 5 residents in the main dining room. 3. Tours of the kitchen observations revealed: A. On 3/12/18 at 11:45 am a thin layer of dark gray and black matter on lower lip of the door seal was observed on the ice machine. Further observations revealed dust on the vents of the ice machine. B. On 3/14/18 at 10:33 am dust on the vents and dark gray and black matter to the lower lip of the door seal was observed on the ice machine. C. On 3/15/18 at 9:45 am black matter was observed to the working space above the sink, over the designated dish washing area. Observed kitchen staff #1 report to the certified dietary manager that there was "black mold at the sink". On 3/15/18 at 9:47 am, an interview with kitchen staff #1 revealed that the black matter was "black mold". Interview with the certified dietary manager revealed that she expected staff to submit work orders to maintenance. The certified dietary manager revealed that the mold had not been reported. 4. Observations of the staff in the kitchen revealed: A. On 3/13/18 at 8:47 am the certified dietary manager in the kitchen without a hair net.	F 812	Department as follows: 1. The Dietary Manager will conduct a QA check of the freezer, refrigerator, kitchen and store room to ensure the food is covered, labeled, dated and out of date foods are being discarded appropriately. This will be done two (2) times daily (Monday-Friday), for two (2) weeks and then daily for two (2) weeks; weekly thereafter. If at any time the Dietary Manager determines through her QA's that the policy and procedure is not being followed then she/he will be required to conduct an In-service with her staff to reiterate the requirement to follow policy. If the employees continue to not follow the policy and procedure then disciplinary action up to termination will be required. 2. The Dietary Manager will conduct a QA check of the dry food items; two (2) times weekly for one (1) month; one (1) time weekly, monthly thereafter to ensure the dry food received from delivery; prior to being placed on the shelf, the staff has dated the item with the date of receipt and that stock has been rotated. If at any time the Dietary Manager determines through her QA's that the policy and procedure is not being followed then she/he will be required to conduct an In-service with her staff to reiterate the requirement to follow policy. If the employees continue to not follow the policy and procedure then disciplinary action up to termination will be required. 3. Dietary Manager will conduct a QA check of the food temperatures,	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 812	Continued From page 15 B. On 3/13/18 at 8:50 am staff member #1 came out the kitchen with a plate of uncovered toast and no hair net. This staff member had on a hat with shoulder length hair that was not in a hair net. C. On 3/15/18 at 8:20 am the certified dietary manager standing at the right end of the steam serving table in the kitchen. She came out the kitchen with meal tickets in hand and returned to the kitchen's steam table. She did not have on a hair net. Interview of the staff member #1 on 3/13/18 at 8:52 am revealed that every manager rotated helping in the kitchen. He revealed that a resident wanted toast and he went to get it. Staff member #1 reported that whenever a resident wanted anything he just goes in the kitchen and tells the kitchen staff. He stated that he should have worn a hair net in the kitchen. Interview with DM on 3/13/18 at 9:00 am revealed that the DM expected all staff to do as dietary staff and place a hair net over their hair while in the kitchen. Interview with the certified dietary manager on 3/15/18 at 10:00 am revealed that she expected all dietary staff to wear hair nets and aprons while in the kitchen. She revealed that she knew where she "could and couldn't go without out a hair net" while in the kitchen and acknowledged she was not wearing a hair net on the observations on 3/13/18 and 3/15/18. The certified dietary manager further revealed that she expected all dietary staff to date everything coming in the kitchen and discard after	F 812	(Monday-Friday), one (1) time daily for two (2) weeks; then for one (1) meal, monthly thereafter. She/he will then conduct a QA check of the Temperature Log one (1) times daily for one (1) month, then one (1) time daily, monthly thereafter. 4. The Dietary Manager will be responsible to use the Dietary Quality Assurance Checklist, Form 10, to inspect the kitchen on a weekly basis for one month and then monthly thereafter to ensure the facility is maintaining a clean work space. 5. All of the Dietary staff will be trained and instructed to not allow anyone to enter the kitchen food preparation areas without using the appropriate hair protection garment. If the Dietary Manager determines this to be an issue she/he will be responsible to report to the Administrator. The Administrator will be responsible to counsel with the staff member to ensure no one that enters the food preparation has the proper attire to prevent contamination of the food. If problems continue then the employee will be disciplined up to include termination of employment. The QAPI Checklist will be presented to the QAPI Committee on a monthly basis	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 812	Continued From page 16 one year if not used. She also revealed that she expected the dietary cook to temp all the foods in the kitchen, then divide and distribute to the kitchen and dining room steam tables. An interview with the administrator and the DON on 3/16/18 at 2:00 pm was conducted. The administrator revealed that she expected all dietary staff to label and date food items. She reported that an audit, in February 2018, of the kitchen revealed that there were no expiration dates on the dry storage food items. She revealed that she was aware of the issue and had not constructed a plan of correction. The DON revealed that she expected all staff to always wear hair net while in the kitchen. The DON and the administrator revealed that foods should be maintained and served at the required temperatures. The DON reported that the kitchen should be clean and free from any black substances.	F 812		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865		4/13/18

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 865	Continued From page 17 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, facility record reviews, and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions placed mandating the facility to follow sanitary food handling and storage. This deficiency was cited on February 27, 2017 following a recertification and complaint survey and subsequently recited on March 16, 2018 on the current recertification survey. The repeat deficiency was in failure of foods covered, dated and stored, and dishware properly stored. This deficiency was recited during the facility's current recertification survey. The continued failure of the facility during two Federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross-referenced to: 483.60 F812 Food and Nutrition Service. Based on observations and staff interviews, the facility failed to cover, label and date foods, failed to discard expired food items, failed to maintain a system of receipt for the stored dry food items, failed to prepare and serve cold food items at the acceptable temperature of 41 degrees Fahrenheit or below for 1 of 2 dining tray line service observations, failed to maintain a clean working space and failed to protect food from possible	F 865	MEASURES THAT WILL BE PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE: All QAPI Check Sheets that were identified from our QAPI meetings and previous surveys have been checked by the Administrator to ensure they are being completed as directed. If any were found to be deficient in practice; was corrected and now in compliance. The Dietary Manager has been trained by the Administrator on the QAPI Check Sheet that was noted from the previous survey. She/he is now responsible to complete this check sheet as directed which is two (2) times weekly. The Dietary Manager will follow this until the QAPI Committee directs her differently. MEASURES THAT WILL BE PUT IN TO PLACE TO PREVENT THE ISSUE FROM OCCURRING AGAIN: Any new Department Manager will be trained as to any QAPI Check Sheets that must be completed as part of a prior Plan of Correction (POC) or directed by the QAPI Committee. This training will be conducted immediately following their employee orientation and prior to	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 865	Continued From page 18 contamination as evidenced by the failure of dietary staff not properly securing hair while in the kitchen. During the previous recertification survey of 2/27/17 this regulation was cited for failure to ensure foods were dated and covered when stored, dishware was dry when stored, and a container of expired sour cream in 1 of 2 nourishment room refrigerators was discarded (500/600/700 hall nourishment room). A review of the facility's Quality Assurance (QA) Program revealed the QA Committee met monthly and included the Administrator, Director of Nursing (DON), Medical Director (MD), and all the department heads. Concerns noted during audits and reports from staff or family members were brought to the committee meetings and from there they would be incorporated into the facility's Quality Assurance Program. On 3/16/18 at 11:05 AM, an interview was conducted with the Administrator and DON. The Administrator revealed that she started at the facility in June 2017. The DON stated that she started on 2/27/18 and has been doing clinical QAs. The administrator was aware of the previous citation (formerly cited as F0371) in February 2017. The administrator reviewed the previous plan of correction (POC) and QA Logs, and stated that they were supposed to be done 3 times a day for 4 weeks, then 4 times a week for 4 weeks, then twice weekly thereafter. The Administrator stated that there had been a turnover in staff, including the Dietary Manager. She, also, stated that the current Dietary Manager started 1/31/18.	F 865	assuming the role they were hired for. The training will include the found deficiency, the sited F-tag, the POC and the QAPI Check Sheets involved. The Administrator has implemented a form identified as “Master QAPI Departmental Checklist” for each discipline that is required to complete a QAPI checklist. On the form it will be a running list of the area(s) identified, the frequency of the checks, the date the checks are completed and the signature of the discipline. This will assist the Department Managers with organization of all checklists that are required. The Department Manager will be responsible to present this to the QAPI Committee on a Monthly basis. At that time the Administrator will be responsible to review and to sign off on the form to indicate the facility is in compliance with the QAPI Plan. If at any time the QAPI Committee determines that a Department Manager is not completing their QAPI Checklist, the Administrator will be responsible to re-train the Department Manager. If problems continue then the Administrator will be responsible to discipline the Department Manager who is deficient in practice. WHO WILL MONITOR THE SITUATION TO ENSURE IT DOES NOT OCCUR AGAIN AND FREQUENCY OF MONITORING: The Department Manager will be responsible to present the QAPI Checklist	

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 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 865	Continued From page 19 A review of copies of QAs submitted by the Administrator was completed. The Administrator stated that "it probably stopped when I terminated the previous Dietary Manager." The Administrator was unable to locate the QAs for December 2017, January 2018 and February 2018.	F 865	to the QAPI Committee on a Monthly basis. At that time the Administrator will be responsible to review and to sign off on the form to indicate the facility is in compliance with the QAPI Plan. The QAPI Committee will maintain a complete list of all required QAPI Check Sheets as mandated by the Committee. The QAPI Committee will be responsible to ensure that each discipline follows the directives given by the committee.	