

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MAY 08 2013

PRINTED: 04/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345000	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF BISCOE			STREET ADDRESS, CITY, STATE, ZIP CODE 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209	
(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 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>Preparation and submission of the plan of correction is in response to DHR 2567 for the survey and does not constitute an agreement or admission by Autumn Care of Biscoe of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Autumn Care of Biscoe contends that it was in substantial compliance with the requirements 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, Autumn Care of Biscoe submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of 4/17/2013.</p>	4/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Christina Stenson

TITLE

Adm. 4/18/13 revised 3/3/2012

(X6) DATE

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

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F 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by	F 156	F 156: This facility has and will continue to post the names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State Ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility and non-compliance with the advance directives requirements. Steps taken in regards to the issue found to have been cited during the survey findings: The bulletin board was updated with the correct information on 4/3/13 by the Admission's Coordinator. Steps taken in regards to residents having the potential to be affected by the survey findings: On 4/4/13 during the activity program, the Activity Assistant and Social Worker informed those residents present regarding DHHS, DHSR and the location of the survey results. The Resident Council president was present during this activity program.	4/17/13	

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F 156	Continued From page 2 such benefits. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to post current information to contact the state nursing homes regulatory agency. The findings included: On 4/1/13 at 10:45 am, during the initial tour of the facility, it was noted that on the bulletin board, near the 100 and 300 halls, the state agency was identified as Division of Facility Services with an outdated address and phone number listed. On 4/1/13 at 5:00 pm, the Resident Council president was interviewed. She stated that she attended the monthly meetings and couldn't recall any discussion on how to contact the state agency. She pointed to a flyer on her wall, which listed resident rights and how to contact the local Ombudsman, but stated that she didn't have any other information on the state agency. On 4/2/13 at 2:30 pm, the state contact information remained the same on the bulletin board. On 4/3/13 the Resident Council Minutes from 1/23/13, 1/23/13, 2/13/13 and 3/26/13 were reviewed. None of the documents contained discussion on informing the residents in attendance, how to contact the state nursing homes regulatory agency. Reminders on how to	F 156	The Activity Department, Social Worker and Admission's Coordinator completed informing all alert and oriented residents on 4/16/13 regarding the DHHS, DHSR and the location of the survey results. Systemic Changes: During monthly resident's council meeting, the residents will be informed regarding the DHHS, DHSR, and the location of the survey results by the Activity Director and/or Social Worker. QA Monitoring to prevent reoccurrence: The information boards in the facility will be reviewed monthly by the Administrator, Admission's Coordinator and Social Worker to ensure that the information is accurate as it relates to the DHHS, DHSR and Ombudsman along with the location of the survey results. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.	4/17/13	

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F 156	<p>Continued From page 3</p> <p>contact the Ombudsman were reviewed each month.</p> <p>The Administrative Staff # 7 was interviewed on 4/3/13 at 10:00 am. She stated that she participated in attending some of the monthly Resident Council meetings but couldn ' t recall any discussion about informing the residents in attendance about the state nursing homes regulatory agency contact information. She thought that it was posted on the a sign that hung in the Activities Room, but the sign only contained information about how to contact the Ombudsman.</p> <p>The Administrative Staff #5 was interviewed on 4/3/13 at 10:11 am. She stated that she was one of the two staff members that facilitated the monthly Resident Council meetings. She discussed resident rights however; she stated that she did not cover how to contact the state nursing homes regulatory agency. She commented that she kept the contact number to the state in her office. If anyone needed additional information, she would suggest that it be researched on the internet. When asked, the name of the state nursing homes regulatory agency that she would direct them to, she stated, North Carolina Regulatory Commission.</p> <p>The Administrative Staff #5 stated that she wasn ' t aware that the state changed the name of the nursing home division in 2007. She also expressed that she was not aware that the information posted on their bulletin board was outdated.</p> <p>The Administrative Staff # 4 was interviewed on</p>	F 156			

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F 156	Continued From page 4 4/3/13 at 12:10 pm. She shared that in 2007 she was on an extended medical leave and might had been absent when the state sent the notice that the name of the nursing homes regulatory agency and the mailing address had changed.	F 156			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F 157: This facility has and will continue to inform the resident; consult the resident's physician and notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form or treatment); or a decision to transfer or discharge the resident from the facility as specified in § 483.12(a).	4/17/13	

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F 157	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the responsible party (RP) of the change in the treatment and condition of the pressure ulcer for 1 (Resident #22) of 3 sampled residents with pressure ulcer. The findings included: Resident #22 was admitted to the facility on 3/2/09 with multiple diagnoses including Alzheimer's disease, Diabetes Mellitus, Anemia and Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 2/7/13 indicated that Resident #22 had memory and decision making problems and had a stage II pressure ulcer. Review of the wound assessment form revealed that on 1/21/13, Resident #22 had developed a stage II pressure ulcer on the left heel. The ulcer was treated with Comfeel (hydrocolloid wound dressing) and kerlix. On 1/30/13, the wound assessment form indicated that the ulcer on the left heel had a white/grey non viable tissue and/or non adherent yellow slough, less than 25 % of wound bed covered. A new form of treatment was ordered to clean with seacens and to apply hydrogel, cover with gauze and wrap with kerlix. Review of the nurse's notes and progress notes of the unit manager/supervisor revealed that the RP was not informed of the change in condition and the new treatment to the pressure ulcer on the left heel.	F 157	Steps taken in regards to Resident # 22 found to have been cited in the survey findings: Licensed Nurse left message for Resident # 22 family to contact facility regarding wound on 4/5/13. Family member for Resident # 22 was informed during facility visit on 4/7/13 regarding wound by Licensed Nurse. Steps taken in regards to residents having the potential to be affected by the survey findings: All current residents with wounds were audited for documentation of notification of wounds with all documentation completed as of 4/12/13. All licensed nurses received re-instruction regarding notifying residents, RP & MD of changes in resident condition which included wounds and treatments which began on 4/3/13 and completed on 4/16/13. Systemic Changes: A licensed nurse will complete weekly rounds with MD and complete documentation with resident/family notification. New admissions will be reviewed by QA Nurse or D.O.N. for appropriate documentation. All licensed nurses upon hire will receive instruction during orientation regarding notifying and documenting	4/17/13	

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F 157	<p>Continued From page 6</p> <p>The wound assessment form dated 2/20/13 revealed that the pressure ulcer on the left heel had a hard and black eschar, more than 50% and less than 75% of wound covered. A new form of treatment was ordered to apply Proderm (non prescription topical wound spray) twice a day. Review of the nurse's notes and progress notes of unit manager/supervisor revealed that the RP was not informed of the change in condition and the new treatment to the pressure ulcer on the left heel.</p> <p>On 3/11/13, Resident #22 was seen by the wound doctor. The pressure ulcer on the left heel was assessed as unstageable due to necrosis (100%). A new form of treatment was ordered on 3/12/13 to apply silver hydrogel and calcium alginate once daily to the left heel. Review of the nurse's notes and progress notes of unit manager/supervisor revealed that the RP was not notified of the change in condition and the new treatment to the pressure ulcer on the left heel.</p> <p>On 3/18/13, there was a new order to apply Santyl and Dakins solution to the pressure ulcer on the left heel. The notes did not indicate that the RP was informed of the new treatment to the left heel.</p> <p>On 4/3/13 at 2:55 PM, Nurse #6 was interviewed. She stated that the RP should be notified when there was a new form of treatment. After reviewing the records, she stated that she did not see that the RP was informed of the change in condition and the new form of treatment to the left heel pressure ulcer. She acknowledged that she was the nurse who assessed the pressure ulcer on 1/30/13 but did not notify the RP.</p>	F 157	<p>changes in resident condition by the SDC. QA Monitoring to prevent reoccurrence: QA Nurse or D.O.N./RN Supervisor will review all new admissions for appropriate documentation regarding resident/family notification of wounds. Resident's with wounds will continue to be reviewed weekly for appropriate documentation by QA Nurse or D.O.N. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.</p>	4/17/13	

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F 157	Continued From page 7	F 157	<p>F 162: This facility will not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts).</p> <p>Steps taken in regards to Resident # 13, 19 & 47 found to have been cited during the survey findings: The Administrator discussed with Resident # 13 & 47 regarding haircut services on 4/16/13. The responsible party for Resident # 19 was contacted regarding haircut services on 4/16/13 by Administrator. Facility haircut policy was updated on 4/16/13. Steps taken in regards to residents having the potential to be affected by the survey findings: A list of Medicaid Residents will be obtained monthly by the Activity Director or Social Worker and residents will be monitored for need for simple haircut. Beautician was updated regarding policy regarding haircuts for Medicaid Recipients on 4/16/13 by Administrator. Systemic Changes: Medicaid Residents upon admission will receive information regarding facility policy for haircuts by the Admission's Coordinator and in</p>	4/17/13	
F 162 SS=B	<p>483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS</p> <p>The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter.</p> <p>(This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)</p> <p>During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: Nursing services as required at §483.30 of this subpart. Dietary services as required at §483.35 of this subpart.</p>	F 162			

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F 162	Continued From page 8 An activities program as required at §483.15(f) of this subpart. Room/bed maintenance services. Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. Medically-related social services as required at §483.15(g) of this subpart. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: Telephone. Television/radio for personal use. Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. Personal clothing. Personal reading matter. Gifts purchased on behalf of a resident. Flowers and plants. Social events and entertainment offered outside	F 162	addition residents that become eligible by the Business Office Manager or Social Worker. QA Monitoring to prevent reoccurrence: Administrator or Business Office Manager will review Beautician charges monthly x 4 months for accuracy regarding Medicaid Residents to ensure there is no charge for a simple haircut. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.	4/17/13	

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F 162	<p>Continued From page 9</p> <p>the scope of the activities program, provided under §483.15(f) of this subpart. Noncovered special care services such as privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.</p> <p>The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide monthly haircuts, at no cost, to 3 of 3 residents (Residents # 13, # 19 and # 47) receiving Medicaid benefits.</p> <p>The findings included:</p> <p>The facility ' s Resident Handbook was reviewed. Under information for Medicaid residents it read that " The resident and/or legal representative will be responsible for the following charges, which Medicaid will not pay: Barber/Beautician charges. "</p>	F 162			

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F 162	<p>Continued From page 10</p> <p>Beauty shop price listings included haircuts for \$6.50.</p> <p>In an undated Policy on Beauty Shop and Barber Services, it read that " It is the policy of the facility to provide hair care services for residents. These are our prices listed below. Hair care provided to the resident as part of routine daily hygiene by a nursing staff member will be done at no charge. This includes a shampoo, routine styling, and/or shave only. Hair care provided by a licensed professional, at the request of the resident/family will be charged to the resident ' s account. "</p> <p>On 4/8/13, the facility provided an additional beauty service policy, dated 11/2004 that read: " It is the policy of this facility to provide the services of a beautician for the convenience of the patient. "</p> <ul style="list-style-type: none"> · Routine shampoo/drying of hair, trims/simple haircuts, combs, brushes will be provided by nursing staff as part of routine grooming care . · Upon request and written authorization of patient or responsible party, the services of a licensed beautician will be made available. Patient will be billed for the services requested. Listing of charges is given when authorization is obtained. <p>1. Resident #13 was admitted to the facility on 9/6/2010 and received Medicaid benefits. On 4/3/13 at 11:00 am, a copy of his financial statement was reviewed and indicated on 10/4/12 and 11/28/12 he received a haircut and was</p>	F 162			

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F 162	<p>Continued From page 11 charged \$6.00 for each service.</p> <p>On 1/3/13 and 3/1/13, he received a haircut and was charged \$6.50 for each service.</p> <p>The Administrative Staff # 4 was interviewed on 4/3/13 at 11:45 am. She stated that in her role, over the last twenty years, she has never had nurse aides cut the hair of residents. She explained that the aides, shampoo and style hair only. She commented that she permitted residents ' personal stylists to use the salon at no cost to do their hair, however, if they receive any service from the contracted hair stylist at the facility, there was a charge involved, even for Medicaid residents, needing a haircut. She further stated that she has never known haircuts to be free for Medicaid residents.</p> <p>The Administrative Staff # 6 was interviewed on 4/3/12 at 12:10 pm and explained that she formerly worked in the business office and handled financial transactions. She commented that she was not aware that simple haircuts and trims were covered in the monthly expenses for Medicaid recipients.</p> <p>2. Resident #19 was admitted to the facility on 5/16/12 and received Medicaid benefits. On 4/3/13 at 11:00 am, a copy of his financial statement was reviewed and indicated on 11/24/12 he received a haircut and was charged \$6.00 for the service.</p> <p>On 3/2/13, Resident #19 received a haircut and was charged \$6.50 for the service.</p> <p>The Administrative Staff # 4 was interviewed on</p>	F 162			

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F 162	<p>Continued From page 12</p> <p>4/3/13 at 11:45 am. She stated that in her role, over the last twenty years, she has never had nurse aides cut the hair of residents. She explained that the aides, shampoo and style hair only. She commented that she permitted residents' personal stylists to use the salon at no cost to do their hair, however, if they receive any service from the contracted hair stylist at the facility, there was a charge involved, even for Medicaid residents, needing a haircut. She further stated that she has never known haircuts to be free for Medicaid residents.</p> <p>The Administrative Staff # 6 was interviewed on 4/3/13 at 12:10 pm and explained that she formerly worked in the business office and handled financial transactions. She commented that she was not aware that simple haircuts and trims were covered in the monthly expenses for Medicaid recipients.</p> <p>3. Resident # 47 was admitted to the facility on 8/31/2010 and then re-entered on 10/6/12. She received Medicaid benefits. On 4/3/13 at 11:00 am, a copy of her financial statement was reviewed and indicated on 10/6/12 and 11/10/12, she was charged \$9.00 for a shampoo and cut. On 12/8/12 and 1/5/13, she was charged \$9.50 for each shampoo and cut. On 2/2/13 she was charged \$15.50 for a shampoo/set/cut and on 3/2/13; she was charged \$9.50 for a shampoo and cut.</p> <p>The Administrative Staff # 4 was interviewed on 4/3/13 at 11:45 am. She stated that in her role, over the last twenty years, she has never had nurse aides cut the hair of residents. She explained that the aides, shampoo and style hair</p>	F 162			

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F 162	Continued From page 13 only. She commented that she permitted residents ' personal stylists to use the salon at no cost to do their hair, however, if they receive any service from the contracted hair stylist at the facility, there was a charge involved, even for Medicaid residents, needing a haircut. She further stated that she has never known haircuts to be free for Medicaid residents. The Administrative Staff # 6 was interviewed on 4/3/13 at 12:10 pm and explained that she formerly worked in the business office and handled financial transactions. She commented that she was not aware that simple haircuts and trims were covered in the monthly expenses for Medicaid recipients.	F 162		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to discuss the Survey Results Book location with alert and oriented residents.	F 167	F 167: This facility has and will continue to ensure that each resident can examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility will also continue to make sure the results of the survey are available for examination and notice is posted. Steps taken in regards to the issue found to have been cited during the survey findings: On 4/4/13 the facility's resident council president was informed of the location of the survey results by Administrator.	4/17/13

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F 167	Continued From page 15 residents in attendance. 3. On 4/3/13 at 9:50 am, the resident council secretary was interviewed. She shared that she did not know what was contained in the Survey Results book but thought that it could possibly be kept in the solarium (activities room) where the other books were located. On 4/3/13 at 10:10 am, the Administrative Staff #5 was interviewed. She mentioned that she was one of the facilitators for the monthly council meetings but couldn't recall the last time she discussed the Survey Results book with the residents in attendance.	F 167			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review the facility failed to provide a bed long enough to accommodate a resident's height and failed to provide a wheelchair leg rest long enough to accommodate a resident's leg for 1 of 1 resident (Resident # 39). The findings included:	F 246	F 246: This facility has and will continue to ensure that each resident resides and receives services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Steps taken in regards to Resident # 39 found to have been cited in the survey findings: On 4/4/13 Resident #39's bed was extended in length by Maintenance. The wheelchair legs were corrected on 4/3/13 by Therapy department and Nursing Staff. Steps taken in regards to residents having the potential to be affected by the survey findings: On 4/5/13, the RN Supervisor audited all	4/17/13	

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F 246	Continued From page 16 Resident #39 was admitted on 11/2/12 and readmitted on 2/20/13 with diagnoses including: right below knee amputation, Diabetes Mellitus, left toe amputation, pressure ulcer and anemia. The Significant Change Minimum Data Set (MDS) dated 2/27/13 revealed Resident #39 was cognitively impaired and was 76 inches (6 foot 4 inches) tall and required extensive assist of 2 people for bed mobility. On 4/1/13 at 4:45 PM Resident #39 was observed in his room sitting in his wheelchair. He had a right below knee amputation with a dressing on it. He also had a dressing on his right foot. His left leg was bent at a 90 degree angle and his left foot was resting on the floor. The leg/foot rest of his wheel chair was at approximately 25 degrees from the seat of the wheelchair. A Nursing Assistant (NA #2) entered the room and was observed to raise Resident #39 's left leg up to place it on the leg/foot rest. The foot rest of the wheelchair was at the resident 's mid calf with his leg fully extended. NA #2 helped Resident #39 bend his knee and placed his foot on the foot pedal with his toes resting on the edge of the foot pedal, his leg raised at a 25 degree angle from the seat of the wheelchair and his left knee was bent upwards above his hips. NA #2 then left the room and Resident #39 lowered his left leg to the floor. On 4/3/13 at 8:25 AM Resident #39 was observed in bed. The head of the bed was raised approximately 45 degrees and the resident 's hips were positioned at the point where the head of the bed bends to raise the head of the bed.	F 246	current residents wheelchairs for appropriate accommodation of needs with corrective action taken immediately. On 4/8/13, the Administrator audited all current residents for appropriate bed length/width and corrective action taken immediately. Beginning on 4/5/13 all licensed nurses were instructed regarding the importance of appropriate wheelchairs and beds to accommodate a resident by D.O.N. and SDC and completed on 4/16/13. Systemic Changes: All new admissions will be monitored by the licensed nurse at admission for appropriate accommodation of the resident's needs with corrective action taken immediately. All newly hired nursing staff employees will be instructed during orientation to monitor the resident to ensure the equipment being used is appropriate for them. Current facility residents will be assessed during medication pass by the licensed nurse to ensure appropriate equipment is in use with corrective action taken immediately for any issue noted. Findings will be documented on audit form located on medication cart. QA Monitoring to prevent reoccurrence: SDC or RN	4/17/13	

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F 246	<p>Continued From page 17</p> <p>Resident #39 ' s leg was bent approximately 45 degrees and the toes of his left foot were resting on the footboard of the bed. He did not have a dressing on his left foot.</p> <p>On 4/3/13 at 10:40 AM Resident #39 was observed lying in bed with his left leg bent and his toes resting on the headboard. He was asked if he thought he was too tall for the bed he was in and he said " yes, I need a longer bed. " He also revealed that he was 6 foot 4 inches tall (76 inches).</p> <p>On 4/3/13 at 11 AM Nurse #1 was observed doing the dressing changes for Resident #39. While she changed the dressings on his right below knee amputation stump his left leg was bent and the toes of his left foot were touching the footboard of the bed. Resident #39 ' s hips were positioned at the point where the head of the bed bends when raised. Nurse #1 was interviewed at this time and said that the facility did have some longer beds. She also indicated that she thought Resident#39 ' s foot was touching the footboard because he was too low in the bed and he just needed to be pulled up. Nurse #1 was asked to look at the Resident ' s wheelchair leg/foot at this time and acknowledged that it did not appear long enough to accommodate the resident ' s leg and foot.</p> <p>On 4/4/13 at 11:45 AM Resident #39 was observed up in his wheelchair. He had a shoe on over the dressing on his left foot and he was resting his foot on the floor. The leg/foot rest on his wheelchair was longer than the one that had previously been on his wheelchair. The footrest was in the down position and approximately 2</p>	F 246	<p>Supervisor will monitor all new admissions to ensure equipment is appropriate for the resident's needs. SDC or RN Supervisor will assess 10 current facility residents per week x 6 months to ensure equipment is appropriate for the resident's needs, any issues noted will be corrected immediately. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.</p>	4/17/13	

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F 246	<p>Continued From page 18</p> <p>inches above the floor such that if Resident #39 put his foot on the foot rest his knee could maintain a 90 degree angle. The frame of Resident #39 ' s bed had been extended approximately 6 inches, however the mattress was the same size as it had been. Pads the length and width of the extension were at the foot of the mattress to take up the extra space caused by the extension of the frame.</p> <p>On 4/4/13 at 1:50 PM Occupational Therapist #1 (OT #1) was interviewed. She stated that she evaluated Resident #39 for Occupational Therapy (OT) services previously on 1/28/13 and 3/7/13 but no goals for wheelchair positioning were identified. She also indicated that she did not recall observing any concerns about the proportions of his wheelchair leg rests in relation to his leg length. OT #1 added that sometimes when nursing staff clean the wheelchairs, the leg/foot rests get put on the wrong wheelchair and that could be why the leg/foot rests on Resident #39 ' s wheelchair had been too short for him. OT #1 said that she had not received a referral to assess Resident #39 for wheelchair positioning or proportion and that if there were concerns it was up to nursing staff to make the referral.</p> <p>On 4/4/13 at 4:30 PM Administrative Staff (Admin Staff) # 1 and 4 were interviewed. The Admin Staff #1 said that at admission nursing staff should assess to determine if a resident needed a longer bed. She said that if they did need a longer bed the nurse should contact housekeeping to find a longer bed in the facility and if one could not be located it could be ordered. Admin Staff #4 stated that most of the</p>	F 246			

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F 246	Continued From page 19 beds in the facility were 80 inches long and could be extended 6 inches to 86 inches but that there were a few hand crank beds in the facility that were only 76 inches and that could not be extended. She added that the pads at the end of Resident #39 's mattress were temporary and that a longer mattress was being ordered. Admin Staff #4 added that when a longer bed was needed nursing should contact the Maintenance department to have the bed extended. The Admin Staff #1 and 4 did not know why Resident#39 had a wheelchair leg/foot rest that had been too short for him but acknowledged that residents needed wheelchair equipment proportional to their body size.	F 246		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to follow the care plan for fluid restriction for 1 (Resident #118) of 1 sampled resident on dialysis. The finding included: Resident #118 was admitted to the facility on 9/16/11 with multiple diagnoses including end stage renal disease (ESRD). The quarterly Minimum Data Set (MDS) assessment dated 2/28/13 indicated that Resident #118 had no memory and decision making problem and was	F 282	F282: This facility has and will continue to provide services by qualified persons in accordance with each resident's written plan of care. Steps taken in regards to Resident # 118 found to have been cited in the survey findings: Dietary Manager spoke with Resident # 118 on 4/3/13 regarding fluid requests and MD orders with changes noted on dietary tray card for meals. On 4/4/13, MD was notified regarding Resident # 118 fluid intake. Resident # 118 received education regarding fluid intake and MD orders again on 4/4/13. Styrofoam cup was removed from Resident # 118 bedside on 4/3/13.	4/17/13

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F 282	<p>Continued From page 20 on dialysis.</p> <p>On 11/30/12, there was a doctor's order for " fluid restriction 1000 ml (milliliter) daily. "</p> <p>The care plan dated 2/28/13 for Resident #118 was reviewed. One of the care plan problems was " dialysis needs " and the goal was " will have no complications related to bleeding/infection at the shunt/dialysis site daily through next review. " The approaches included " adhere to fluid restriction as ordered. "</p> <p>The fluid intake documentation for the last 7 days was reviewed. The fluid documentation included breakfast, lunch, supper and bedtime snacks. The daily fluid intake on 4/2/13 was 1320 ml, 4/1/13 was 1440 ml, 3/31/13 was 1200 ml, 3/30/13 was 1560 ml, 3/29/13 was 1080 ml, 3/28/13 was 1080 ml and 3/27/13 was 1200 ml. The daily fluid intake did not include the fluid given during medication pass and the fluid provided at bedside.</p> <p>On 4/2/13 at 9:52 AM, Resident #118 was observed. There was a styro foam cup (437 ml) full of water at bedside.</p> <p>On 4/3/13 at 10:35 AM, Resident #118 was observed. The lunch tray was served early because he was scheduled for dialysis. The tray contained 1 glass of tea (240 ml) and 1 can of sprite (220 ml). There was also a styro foam cup (437 ml) full of water at bedside.</p> <p>On 4/4/13 at 8:30 AM, Resident #118 was observed during breakfast. The breakfast tray contained apple juice (118 ml) and a whole milk</p>	F 282	<p>Steps taken in regards to residents having the potential to be affected by the survey findings: All current residents charts were reviewed for fluid restriction on 4/3/13 with education provided to those residents regarding the importance of adhering to the MD order by Dietary Manager and D.O.N. All current facility nursing staff employees received education beginning on 4/3/13 regarding the importance of fluid restriction and completed on 4/16/13 by the D.O.N. and SDC. Systemic Changes: All nursing staff upon hire will receive instruction regarding fluid restriction and the importance of educating the resident and informing the MD when resident does not consume the ordered amount. QA Monitoring to prevent reoccurrence: MDS Nurse and Dietary Manager will monitor residents on fluid restriction weekly x 4 weeks, then monthly x 4 months then quarterly thereafter regarding adherence to fluid restriction orders. Room will be monitored by MDS Nurse, meal tray will be monitored by Dietary Manager and intake amounts will be monitored by MDS Nurse and Dietary Manager weekly. Issues noted will be</p>	4/17/13	

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F 282	Continued From page 21 (237 ml). On 4/3/13 at 4:50 PM, Nurse #7 (assigned to Resident #118) was interviewed. She stated that she did not know how much fluid each shift has to provide to Resident #118. She stated that she would ask the director of nursing (DON). On 4/3/13 at 4:59 PM, NA #1 (nursing assistant assigned to Resident #118) was interviewed. She stated that she provided Resident #118 with 360 ml of water on her shift at bedside in addition to the fluids that were provided by the kitchen. On 4/3/13 at 5:15 PM, Nurse #7 indicated that according to the DON, the kitchen should provide 360 ml of fluids for breakfast, 240 ml for lunch and supper and 160 ml for the nurses to use during the medication pass. These provided 1000 ml of fluids in 24 hours. She further stated that Resident #118 should not have water at bedside.	F 282	reported to the MD for further instructions as well as relayed to the RP and resident. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.	4/17/13	
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 record review, observation and staff interview, the facility failed to ensure that fluid restriction was followed as ordered and failed to	F 309	F 309: This facility has and will continue to ensure that each resident receives 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. Steps taken in regards to Resident # 118 found to have been cited during the survey findings: Dietary Manager spoke with Resident # 118 on 4/3/13 regarding fluid requests and MD orders with changes noted on dietary tray card for meals.	4/17/13	

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F 309	<p>Continued From page 22</p> <p>develop a dietary and nursing plan for managing the fluid restriction for 1 (Resident #118) of 1 sampled resident on dialysis. The finding included:</p> <p>Resident #118 was admitted to the facility on 9/16/11 with multiple diagnoses including end stage renal disease (ESRD). The quarterly Minimum Data Set (MDS) assessment dated 2/28/13 indicated that Resident #118 had no memory and decision making problem and was on dialysis.</p> <p>On 11/30/12, there was a doctor's order for " fluid restriction 1000 ml (milliliter) daily. "</p> <p>The care plan dated 2/28/13 for Resident #118 was reviewed. One of the care plan problems was " dialysis needs " and the goal was " will have no complications related to bleeding/infection at the shunt/dialysis site daily through next review. " The approaches included " adhere to fluid restriction as ordered. " The care plan did not specify how much fluid dietary and nursing would provide in 24 hours.</p> <p>The fluid intake documentation for the last 7 days was reviewed. The fluid documentation included breakfast, lunch, supper and bedtime snacks. The daily fluid intake on 4/2/13 was 1320 ml, 4/1/13 was 1440 ml, 3/31/13 was 1200 ml, 3/30/13 was 1560 ml, 3/29/13 was 1080 ml, 3/28/13 was 1080 ml and 3/27/13 was 1200 ml. The daily fluid intake did not include the fluid given during medication pass and the fluid provided at bedside.</p> <p>On 4/2/13 at 9:52 AM, Resident #118 was</p>	F 309	<p>On 4/4/13, MD was notified regarding Resident # 118 fluid intake. Resident # 118 received education regarding fluid intake and MD orders again on 4/4/13 by Licensed Nurse. Styrofoam cup was removed from Resident # 118 bedside on 4/3/13. Steps taken in regards to residents having the potential to be affected by the survey findings: All current residents charts were reviewed for fluid restriction on 4/3/13 with education provided to those residents regarding the importance of adhering to the MD order by D.O.N. and Dietary Manager. All current facility nursing staff employees received education beginning on 4/3/13 and completed on 4/16/13 regarding the importance of fluid restriction by the D.O.N. and SDC. Dietary Staff were in-serviced on 4/4/13 by the Dietary Manager regarding fluid restriction. Systemic Changes: All nursing staff upon hire will receive instruction regarding fluid restriction and the importance of educating the resident and informing the MD when resident does not consume the ordered amount. QA Monitoring to prevent reoccurrence:</p>	4/17/13	

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F 309	<p>Continued From page 23</p> <p>observed. There was a styro foam cup (437 ml) full of water at bedside.</p> <p>On 4/3/13 at 10:35 AM, Resident #118 was observed. The lunch tray was served early because he was scheduled for dialysis. The dietary card indicated 1000 ml fluid restriction but did not specify how much fluid to offer for breakfast, lunch and supper. The tray contained 1 glass of tea (240 ml) and 1 can of sprite (220 ml). There was also a styro foam cup (437 ml) full of water at bedside. Unsweetened tea and diet sprite were listed on the diet card for lunch.</p> <p>On 4/4/13 at 8:30 AM, Resident #118 was observed during breakfast. The breakfast tray contained apple juice (118 ml) and a whole milk (237 ml). Apple juice and whole milk were listed on the diet card for breakfast.</p> <p>On 4/3/13 at 4:50 PM, Nurse #7 was interviewed. She stated that she did not know how much fluid each shift has to be provided to Resident #118. She stated that she would ask the director of nursing.</p> <p>On 4/3/13 at 4:51 PM, Administrative staff # 2 was interviewed. She stated that nobody had been monitoring the fluid intake to make sure that the resident was provided 1000 ml in 24 hours as ordered.</p> <p>On 4/3/13 at 4:59 PM, NA #1 (nursing assistant assigned to Resident #118) was interviewed. She stated that she provided Resident #118 with 360 ml of water on her shift at bedside in addition to the fluids that were provided by the kitchen.</p>	F 309	<p>MDS Nurse and Dietary Manager will monitor residents on fluid restriction weekly x 4 weeks, then monthly x 4 months then quarterly thereafter regarding adherence to fluid restriction orders. Room will be monitored by MDS Nurse, meal tray will be monitored by Dietary Manager and intake amounts will be monitored by MDS Nurse and Dietary Manager weekly. reported to the RP and MD for further instructions.</p> <p>Issues noted will be reported to the MD for further instructions as well as resident and RP. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, inservicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.</p>	4/17/13	

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F 309	Continued From page 24 On 4/3/13 at 5:15 PM, Nurse #7 indicated that the kitchen should provide 360 ml of fluids for breakfast, 240 ml for lunch and supper and 160 ml for the nurses to use during the medication pass. These provided 1000 ml of fluids in 24 hours. She further stated that Resident #118 should not have water at bedside. On 4/4/13 at 3:05 PM, administrative staff #3 was interviewed. She stated that Resident #118 should received 840 ml of fluids from the kitchen, 360 ml for breakfast and 240 ml for lunch and supper. She further stated that nurses should provide 160 ml for medication pass and Resident #118 should not have water at bedside. She also indicated that she was made aware today (4/4/13) that Resident #118 was getting more than 1000 ml of fluids in 24 hours. The doctor was notified and the diet card was corrected to reflect the 360 ml for breakfast and 240 ml for lunch and supper.	F 309		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation record review and staff and physician interview, the facility failed to	F 314	F 314: This facility has and will continue to ensure that any resident that enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Steps taken in regards to Resident # 170: Admitting Nurse indicated the presence of the ulcer requesting orders from MD and kept heels floated as well as keeping the foot in the boot ordered by discharging hospital	4/17/13

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F 314	<p>Continued From page 25</p> <p>assess and treat a pressure ulcer for 1 of 3 residents (Resident #170) reviewed for pressure ulcers; failed to prevent possible contamination when changing a pressure ulcer dressing for 1 of 3 residents (Resident #39) reviewed for pressure ulcers; and failed to dress pressure ulcers as ordered for 1 of 3 residents (Resident #39) reviewed for pressure ulcers.</p> <p>The findings included:</p> <p>1. Resident #170 was admitted to the facility on 3/25/13. Diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, acute and chronic respiratory failure, chronic kidney disease stage 3, diabetes mellitus, diabetic peripheral neuropathy and peripheral vascular disease with history of left below the knee amputation.</p> <p>The nursing admission assessment dated 3/25/13 included unstageable pressure ulcer to the right heel, heel boot on. Nurse 's notes dated 3/26/13 included " wearing boot to right foot and lower leg. "</p> <p>Admission orders did not address care or treatment for the pressure ulcer. The record did not reveal documentation that the wound had been assessed or measured.</p> <p>Physical Therapy assessment dated 3/26/13 included " unstageable area of right heel that is painful. " Treatment plan included diathermy to right foot to decrease pain and increase circulation to promote healing.</p> <p>Dietary notes dated 3/28/13 mentioned the resident had an unstageable pressure ulcer and</p>	F 314	<p>physician. Resident # 170 was transferred to hospital on 4/2/13. Steps taken in regards to residents having the potential to be affected by the survey findings: All current facility residents with wounds are being followed by a Wound Physician in-house on a weekly basis which began on 3/11/13. All licensed nurses were re-instructed on 4/3/13 regarding wound assessment and documentation by the QA Nurse which included (measurements, appearance, treatments, staging, updating care plan). Systemic Changes: All licensed nurses upon hire will be instructed regarding wound assessment and documentation by the SDC. QA Monitoring to prevent reoccurrence: QA Nurse will review all admissions for presence of a wound and ensure documentation and treatment is appropriate. QA Nurse or D.O.N. will review all residents with wounds weekly for appropriate documentation as it pertains to notification of MD and RP, orders and wound appearance. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for</p>	4/17/13	

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F 314	<p>Continued From page 26</p> <p>Prostat was started for wound healing.</p> <p>Nurse ' s notes dated 4/2/13 at 10:52AM revealed Resident #170 was transferred to the emergency room via emergency medical services due to a change in mental status, low oxygen levels and elevated serum potassium, and was admitted to the hospital. Resident #170 did not return to the facility during the survey.</p> <p>On 4/4/13 at 12:30 PM, Administrative Staff #2 provided a facility form used to fax information to the physician. The form indicated on 3/26/13 at 12:22 AM, the admitting nurse (Nurse #5) wrote that Resident #170 was admitted on 3/25/13 and had an unstageable pressure ulcer to his right heel. " Can we apply Proderm (a topical spray used in prevention/treatment of pressure ulcers) b.i.d. (twice a day)? " The form was signed by the physician on 3/29/13 with a " yes " response. The medical record (100% electronic) revealed no order for Proderm. Administrative Staff #2 stated that the order had not yet been entered into the computer. Administrative Staff #2 acknowledged there was no documentation that the pressure ulcer was being assessed regularly, nor was any treatment actually implemented. She added that the resident wore a Podus boot to keep pressure off heel or they floated his heel if the boot was off. Administrative Staff #2 acknowledged there should have been documentation of ongoing assessments of the pressure ulcer.</p> <p>On 4/4/13 at 2:25 PM a telephone interview was conducted with Nurse #5. The nurse stated that Resident #170 had an area of eschar on his heel approximately 4 centimeters by 1 centimeter.</p>	F 314	further action plans during morning meeting.	4/17/13	

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F 314	<p>Continued From page 27</p> <p>There was no drainage or odor present. The nurse indicated she notified the physician via fax.</p> <p>During an interview on 4/4/13 at 3:51 PM, the physician stated he would expect the nurses to assess the pressure ulcer daily for appearance, drainage, signs of infection and notify him if there were any changes.</p> <p>2a. Resident #39 was admitted on 11/2/12 and readmitted on 2/20/13 with diagnoses including: right below knee amputation, Diabetes Mellitus, left toe amputation, pressure ulcer and anemia.</p> <p>The Significant Change Minimum Data Set dated 2/27/13 (MDS) revealed Resident #39 was cognitively impaired and had a stage 1 or greater pressure ulcer on readmission.</p> <p>Review of the care plan dated 2/1/13 revealed a care plan focus area for wound care needs. The interventions included: protein supplement, alternating air mattress, wound measurements and wound care as ordered.</p> <p>On 4/1/13 at 4:45 PM Resident #39 was observed in his room sitting in his wheelchair. He had a right below knee amputation with a dressing on it. He also had a dressing on his left foot and knee and his left foot was resting on the floor. He had no foot covering over the dressing on his left foot.</p> <p>On 4/3/13 at 8:25 AM Resident #3 was observed in bed. Resident #39's leg was bent approximately 45 degrees and the toes of his left foot were resting on the footboard of the bed. He</p>	F 314	<p>Steps taken in regards to Resident # 39: On 4/3/13, Nurse # 1 received instruction on how to complete a dressing change appropriately. Resident # 39's bed was extended on 4/3/13. Steps taken in regards to residents having the potential to be affected by the survey findings: All licensed nurses were re-instructed on how to complete dressing changes and follow infection control policy (Included when to wash hands/change gloves, how to apply ointments/medications according to facility policy) on 4/3/13 by SDC, D.O.N and QA Nurse. Systemic Changes: All licensed nurses upon hire will be instructed regarding infection control and treatment/dressing changing policy by the SDC. QA Monitoring to prevent reoccurrence: SDC or RN Supervisor will audit each licensed nurse when completing a dressing change ensuring appropriate technique and infection control is followed according to facility policy each month for 6 months. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return</p>	4/17/13	

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F 314	<p>Continued From page 28</p> <p>did not have a dressing on his left foot.</p> <p>On 4/3/13 at 8:30 AM Nurse #1 was interviewed. She stated that Resident #39 ' s dressing change was due on second shift (3 PM - 11 PM) but indicated that if there was a problem with his dressings on her shift she would do the dressing change. When she was informed that Resident #39 ' s dressing was not on his left foot she said that she would change his dressings after she completed her medication pass.</p> <p>On 4/3/13 at 10:30 AM Nurse #1 stated she was ready to do the dressing change for Resident # 39. When she went in the resident ' s room to do the dressing, the dressing on his right below knee amputation was observed to have brown matter on it. Nurse #1 removed this dressing and wounds were observed at this time: the wound to the resident ' s right anterior knee (not specified as either arterial or pressure) and the pressure ulcer to his right lateral knee. No outward signs or symptoms of infection were present. Nurse #1 cleansed the anterior wound with wound cleansing solution on a 4x4 gauze, she then cleansed the lateral pressure ulcer with the same 4 x 4 gauze and used to cleanse the anterior wound. Nurse #1 kept the gloves she was wearing while cleansing the wounds on and brought an opened tube of Santyl (an ointment used in treating wounds) up to the resident ' s knee and squeezed some Santyl onto the anterior and then the lateral wound. She used her gloved finger to tap the Santyl into place over both of the wounds. Nurse #1 then removed her gloves, washed her hands and applied a clean pair of gloves. Nurse #1 then applied hydrogel gauze to each of the wounds and covered the areas with a</p>	F 314	demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.	4/17/13	

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F 314	<p>Continued From page 29 dry protective dressing.</p> <p>On 4/3/13 Nurse #1 was interviewed she acknowledged that she cleansed both wounds with the same wound cleanser and 4x4 gauze. She also indicated that she should have cleansed each of the wounds individually with fresh cleanser, gauze and gloves. She did not recall using the same her gloved finger to tap the Santyl over each of the wounds.</p> <p>On 4/4/13 at 4:30 PM Administrative Staff (Admin Staff) # 1 and 4 were interviewed. Admin Staff #1 acknowledged that Nurse #1 should have cleansed and Resident #39 ' s right anterior knee wound and right lateral knee pressure ulcer separately with clean supplies. She added that she had already started re-educating staff on proper dressing change technique to prevent cross contamination.</p> <p>2b. Resident #39 was admitted on 11/2/12 and readmitted on 2/20/13 with diagnoses including: right below knee amputation, Diabetes Mellitus, left toe amputation, pressure ulcer and anemia.</p> <p>The Significant Change Minimum Data Set dated 2/27/13 (MDS) revealed Resident #39 was cognitively impaired and had a stage 1 or greater pressure ulcer on readmission.</p> <p>Review of the care plan dated 2/1/13 revealed a care plan focus area for wound care needs. The interventions included: protein supplement, alternating air mattress, wound measurements and wound care as ordered.</p> <p>Review of the Physician ' s Order and Treatment</p>	F 314			

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F 314	<p>Continued From page 30 Record March 1 - April 3rd revealed:</p> <p>3/11/13 physician ' s order - wound on right anterior (front) knee, silvasorb hydrogel and dry dressing daily and as needed.</p> <p>3/11/13 physician ' s order - wound on right medial knee (middle or inner side of knee), santyl and hydrogel gauze with mepilex border cover dressing daily and as needed.</p> <p>3/28/13 physician ' s order - wound on right lateral knee (outer side of knee), santyl and hydrogel gauze with dry protective dressing.</p> <p>Review of the Wound care Specialist Evaluation from 3/11/13 - 4/3/13 revealed:</p> <p>Right Anterior Knee Wound 3/11/13 initial evaluation -not specified as either an arterial or pressure ulcer. The wound was described as " dry scab covers wound " and 100 percent granulation tissue (present in healing wounds). The wound measurements were: 0.3 x 1.4 x 0.1 cm (centimeters - length, times width, times depth) for a total of 0.15 squared cm.</p> <p>3/25/13 -was not specified as either an arterial or pressure ulcer. The wound was described as " dry scab covers wound " and 100 percent granulation tissue. The wound measurements were: 1.2 x 0.9 x0.1 for a total of 1.08 squared cm. The wound progress was " stable. "</p> <p>Right Medial Knee Wound 3/11/13 initial evaluation - unstageable pressure ulcer with 100 percent necrotic tissue (dry hard</p>	F 314			

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F 314	<p>Continued From page 31 black dead tissue that impairs healing). The wound measurements were: 2.5 x 4.3 x not measurable cm for a total of 10.75 squared cm.</p> <p>3/25/13 - unstageable pressure ulcer with 100 percent necrotic tissue but improved. The wound measurements were: 4.0 x 2.9 x not measurable for a total of 11.60 squared cm.</p> <p>Right Lateral Knee Wound 3/25/13 initial evaluation - unstageable pressure ulcer with 100 percent necrotic tissue. The wound measurements were: 2.0 x 2.6 x not measurable for a total of 5.20 squared cm.</p> <p>On 4/3/13 at 10:30 AM Nurse #1 was observed doing the dressing changes to Resident # 39 ' s right knee. She dressed the anterior knee wound with santyl (a deriding agent used to help remove necrotic tissue), hydrogel gauze and a dry dressing. The order for this wound dressing dated 3/11/13 was for silvasorb (an antimicrobial agent) hydrogel and dry dressing. Nurse #1 also dressed the right lateral knee pressure ulcer with santyl, hydrogel gauze and a dry dressing as ordered. After Nurse #1 had wrapped the resident ' s right knee with a gauze wrap dressing she reviewed the resident ' s treatments listed in the electronic medical record and determined she missed one knee dressing. She unwrapped the dry dressing and dressed the right medial pressure ulcer with silvergel and hydrogel gauze. The order for this wound dressing dated 3/11/13 was for santyl and hydrogel gauze with mepilex border cover dressing. Nurse #1 then reapplied a</p>	F 314			

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F 314	Continued From page 32 dry dressing to all three wounds and wrapped the resident ' s right knee with a gauze wrap. Nurse #1 was interviewed at this time and indicated she was unfamiliar with Resident #39 ' s dressing changes because she just started working on the hall on 4/1/13. She added that the nurses scheduled assignment was rotated every 3 months. On 4/4/13 at 4:30 PM Administrative Staff (Admin Staff) # 1 and 4 were interviewed. Admin Staff #1 satated that she had already started re-educating staff on proper dressing change technique.	F 314			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure a medication error rate less than 5% as evidenced by 2 errors out of 27 opportunities for error, resulting in an error rate of 7.41% for 1 of 6 residents observed during medication pass (Resident #69). The findings included: 1a. Resident #69 was admitted to the facility on 9/27/12. Diagnoses included anemia, chronic obstructive pulmonary disease and Alzheimer ' s disease.	F 332	F 332: This facility will continue to ensure that it is free of medication error rates of five percent or greater. Steps taken in regards to Resident # 69 found to have been cited during the survey findings: Nurse # 1 received instruction on 4/3/13 regarding the importance of accurate medication administration by D.O.N. Resident # 69 had orders to receive the Multivitamin and Ferrous Sulfate on a daily basis. Both medications were administered by Nurse # 1 on 4/3/13. Steps taken in regards to resident having the potential to be affected by the survey findings: All licensed nurses were re-instructed on 4/16/13 following on Medication Administration by D.O.N. & SDC. Systemic Changes: All Licensed Nurses upon hire will receive instruction regarding Medication Administration. All Licensed Nurses will have a Medication Pass Observation completed by the SDC or RN Supervisor monthly. QA Monitoring to prevent reoccurrence: SDC or RN Supervisor will complete a Medication Pass Observation on each	4/17/13	

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F 332	Continued From page 33 Review of Resident #69 ' s April physician orders revealed an order for daily multiple vitamin with minerals, 1 tablet. The Medication Administration Record (MAR) revealed the multiple vitamin was scheduled to be given at 8AM. On 4/3/13 at 9:15 AM, Nurse #1 was observed administering scheduled medications to Resident #69. Eight oral medications were given but did not include the multivitamin. During an interview on 4/3/13 at 2:20 PM Nurse #1 indicated she had ordered multiple vitamins from the pharmacy that morning so the multiple vitamin was not available at the time of the medication pass. The nurse added that she inadvertently charted it as given when she was charting the other medications. 2b. Review of Resident #69 ' s April physician orders revealed an order for ferrous (iron) sulfate 325 milligrams daily. The Medication Administration Record (MAR) revealed the ferrous sulfate was scheduled to be given at 8AM. On 4/3/13 at 9:15 AM, Nurse #1 was observed administering scheduled medications to Resident #69. Eight oral medications were given but did not include the ferrous sulfate. During an interview on 4/3/13 at 2:20 PM Nurse #1 indicated she had overlooked the ferrous sulfate on the MAR during the medication pass but inadvertently charted it as given when charting the other medications. The nurse added she could give it now.	F 332	licensed nurse by 4/17/13. The SDC or RN Supervisor will monthly review each licensed nurse during Medication Pass to ensure MD orders are followed for 6 months. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.	4/17/13	
F 333	483.25(m)(2) RESIDENTS FREE OF	F 333			

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F 333 SS=D	<p>Continued From page 34</p> <p>SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility records, hospital records and staff interviews, the facility failed to prevent a significant medication error by administering 2 doses of Coumadin in one evening for 1 of 10 residents (Resident#170) reviewed for unnecessary medications.</p> <p>The findings included:</p> <p>Resident #170 was admitted to the facility on 3/25/13. Diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, acute and chronic respiratory failure, chronic kidney disease stage 3 and pneumonia.</p> <p>Physician orders dated 3/29/13 included Coumadin (an anticoagulant drug) 3.5 milligrams (mg) daily to decrease the risk of stroke associated with atrial fibrillation. INR (international normalized ratio, a blood test that measures the blood 's ability to clot) was 1.6 on 3/29/13 (therapeutic range is 2.0-3.0). Review of the Medication Administration Record (MAR) revealed Coumadin 3.5 mg was scheduled for administration at 8PM and had been checked off as given on 3/29/13 - 4/1/13.</p> <p>INR on 4/1/13 was 1.4. Physician orders dated 4/1/13 at 8:24PM included discontinue Coumadin 3.5 mg and start Coumadin 4 mg daily. Review of</p>	F 333	<p>F 333: The facility will continue to ensure that each resident is free of significant medication errors. Steps taken in regards to Resident # 170 found to have been cited during the survey findings: Nurse # 4 was instructed regarding remaining with new orientee during each step of training to ensure physicians orders are followed accurately on 4/2/13 by D.O.N. and SDC. Steps taken in regards to resident having the potential to be affected by the survey findings: All residents with orders for Coumadin were audited to ensure orders and medications were accurate by QA Nurse. All current licensed nurses were in-serviced beginning on 4/8/13 and completed on 4/16/13 regarding remaining with nurses in orientation at all times. Nurses were also instructed regarding communicating changes to other licensed nurses when assisting with orders. In-services were completed by the D.O.N. and SDC. Systemic Changes: All nurses in training will have a licensed nurse present at all times while in training. Newly hired licensed nurses will be instructed by the SDC to not complete any task unless their trainer is present during</p>	4/17/13	

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F 333	<p>Continued From page 35</p> <p>the MAR revealed the Coumadin 4 mg was scheduled for administration at 9PM daily and had been checked off as given on 4/1/13.</p> <p>Nurse ' s notes dated 4/2/13 at 10:52AM revealed Resident #170 was transferred to the emergency room via emergency medical services due to a change in mental status, low oxygen levels and elevated serum potassium.</p> <p>Hospital records revealed an INR dated 4/2/13 at 12:23PM was 1.53.</p> <p>During an interview on 4/2/13 at 7:15 PM, Nurse #4 acknowledged entering the Coumadin orders into the computer on 4/1/13, and did not tell Nurse #2 that the order had been changed.</p> <p>During an interview on 4/3/13 at 11:58 AM, Nurse #2 acknowledged that he had administered medications to Resident #170 on 4/1/13. He stated he was a new employee, still in orientation and learning the residents, medication cart and computer system. He said he did not specifically recall giving both doses of Coumadin to the resident, but said that if he charted any medication as given, he gave it. Nurse #2 added he did recall that Resident #170 had several cards of Coumadin in different doses on the med cart. He stated that the nurse who was orienting him was at the desk while he gave the medications.</p> <p>During an interview on 4/4/13 at 8:50 AM, Administrative Staff #1 indicated that when a nurse is orienting a new nurse, she expected the nurse to stay with the orientee at the medication cart. Administrative Staff #1 added that Resident</p>	F 333	<p>orientation. QA Monitoring to prevent reoccurrence: SDC or RN Supervisor will complete a medication pass audit with each newly hired licensed nurse during orientation to ensure medications are administered accurately once weekly while in orientation and monitor to make sure the trainer is present. SDC or RN Supervisor will complete a medication pass audit with each licensed nurse monthly for 6 months. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.</p>	4/17/13	

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F 333	Continued From page 36 #170 should not have had both doses of Coumadin in one evening.	F 333	<p>F 412: This facility has and will continue to provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Steps taken in regards to Resident # 14 found to have been cited during the survey findings: Resident # 14 had dental appointment on 4/15/13. Steps taken in regards to residents having the potential to be affected by the survey findings: The IDT interviewed all current alert & oriented residents on 4/8/13 & 4/9/13 regarding dental needs with information given to the Social Worker to coordinate appointments. Nursing staff was questioned for residents with dental issues on 4/8/13 & 4/9/13 with information give to SW to coordinate appointments. Systemic Changes: All residents will be reviewed quarterly with MDS assessment for dental needs by IDT and issues noted given to the Social Worker. Nursing staff will be instructed annually by</p>	4/17/13	
F 412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, the facility failed to schedule a dental appointment for replacement dentures for 1 of 3 Medicaid residents (Resident #14) seeking assistance.</p> <p>The findings included:</p> <p>Resident #14 was admitted to the facility on 6/21/11 and then re-admitted on 12/11/11 with the following cumulative diagnoses: Dementia and dysphagia. On her annual Minimum Data Set (MDS), dated 3/27/13, she was assessed as having moderate cognitive impairments. Under dental appliances, she was noted to have none.</p> <p>Resident #14 ' s chart was reviewed and revealed two dental consultations from 2012. On 6/7/12, the Dental History and Record form documented</p>	F 412			

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F 412	<p>Continued From page 37</p> <p>that she was seen by the dentist, wearing a full set of dentures in acceptable condition.</p> <p>On a return visit on 12/11/12, it was noted on the Dental History and Record form, that Resident #14 was only wearing her top dentures.</p> <p>During an interview with Resident #14 on 4/1/13 at 4:30 pm, she mentioned that she stopped wearing her bottom denture because it fit poorly. It could not be determined when this took place.</p> <p>A Progress Note, dated 1/23/13 that was recorded during a Care Conference meeting, indicated that Administrative Staff #5 spoke with Resident #14 and her RP (responsible party) at the meeting; and was informed that Resident #14 lost her bottom dentures and wanted to see if the dentist could replace them. The Grievance Log was reviewed, and there were no reports of lost dentures for Resident #14.</p> <p>Administrative Staff #5 was interviewed on 4/4/12 at 12:00 pm. She recalled that when the dentures were discussed at the care conference meeting in January, the RP indicated that Resident #14 's mouth was hard to fit for dentures; however, she still wanted to be seen by a dentist. She commented that even though Resident #14 reported that her bottom denture was lost, she couldn ' t establish when they became lost. Administrative Staff #5 stated that she planned to make arrangements to schedule the dental appointment, but " dropped the ball. " At 12:15 pm, she indicated that she had spoken to the van driver, who was informed that she needed to schedule a dental consult for Resident #14. She stated that she wasn ' t able to establish when the</p>	F 412	<p>IDT to monitor and communicate dental needs to licensed nurse and Social Worker. QA Monitoring to prevent reoccurrence: Any resident within their MDS assessment window will be audited weekly x 4 weeks then 5 residents will be reviewed monthly x 4 months by the IDT for dental needs with issues documented in the resident's chart and steps taken to correct. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.</p>	4/17/13	

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F 412	Continued From page 38 denture became lost.	F 412	<p>F 431: This facility has and continues to ensure that drugs and biologicals are labeled in accordance with currently accepted professional principles, and includes the appropriate accessory and cautionary instructions, and the expiration date when applicable. Steps taken in regards to items found to have been cited during the survey findings: Stock medications were audited for expiration date with date placed on cap on 4/4/13 by Licensed Nurse and RN Supervisor. Any expired medication found was discarded on 4/4/13 by Licensed Nurse and RN Supervisor. Any opened medication without a date was discarded by Licensed Nurse on 4/4/13. Steps taken in regards to residents having the potential to be affected by the survey findings: All licensed nurses were instructed regarding the facility policy for labeling and storage of drugs and biologicals beginning on 4/4/13 by the D.O.N. and SDC and completed which also included <u>auditing for expiration dates and discarding</u> on 4/16/13. SDC or RN Supervisor will complete a Medication Pass Audit with each licensed nurse by 4/17/13. Systemic Changes: All</p>	4/17/13	
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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 quantity stored is minimal and a missing dose can be readily detected.</p>	F 431			

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F 431	<p>Continued From page 39</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and staff interviews, the facility failed to discard expired medications in 2 (600 and 100 hall medication carts) of 4 medication carts and failed to date advair (treatment for chronic obstructive pulmonary disease) and prostat (protein supplement) when opened on 3 (600, 500/200 and 100 medication carts) of 4 medication carts observed. The findings included:</p> <p>On 4/4/13 at 10:40 AM, the medication cart on the 600 hall was observed. There was 1 opened Advair discus that was undated and a bottle of Oscal 500 mgs (milligrams) with D with expiration date of 7/11. When brought to the attention of Nurse # 3 at 10:48 AM, she stated that Advair should have been dated when opened. She also stated that the bottle of Oscal with D was brought in by a family member and the nurse who received it should have checked the expiration date prior to putting it in the cart.</p> <p>On 4/4/13 at 10:50 AM, the medication cart on 500/200 hall was observed. There was a bottle of Prostat that was opened and undated. The instruction on the bottle read in part " discard 3 months after opening, record date opened on the bottom of container. " At 11:00 AM, Nurse #8 was interviewed. She stated that she was not instructed to date the Prostat when opening. After reading the instruction on the bottle, Nurse #8 stated that it should have been dated when opened and added that she had already discarded the bottle.</p>	F 431	<p>licensed nurses upon hire will be instructed regarding labeling and storage of drugs and biologicals by the SDC during orientation. Licensed Nurses will be instructed that expired medications must be discarded as well as a medication that is open without a date must be discarded. QA Monitoring to prevent reoccurrence: SDC or RN Supervisor will complete a Medication Pass Audit with each Licensed Nurse monthly. D.O.N., SDC, QA Nurse and RN Supervisor will weekly review each medication cart for appropriate labeling of medications x 4 weeks then twice monthly x 3 months then once monthly x 3 months for medications that have expired, expired medications will be discarded immediately. Any opened medication without a date will be discarded. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) in Quality Assurance meeting for further action plans during morning meeting.</p>	4/17/13	

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F 431	<p>Continued From page 40</p> <p>On 4/4/13 at 11:10 AM, the medication cart on 100 hall was observed. There was a bottle of Prostat that was opened and undated and a bottle of Colace liquid with expiration date of 3/13. At 11:20 AM, Nurse #1 was interviewed. She stated that Prostat should have been dated when opened and she acknowledged that the Colace liquid was already expired. She further stated that nurses should be checking for expiration dates daily.</p> <p>On 4/4/13 at 11:25 AM, administrative staff #1 was interviewed. She stated that nurses should be checking their medication carts for expired medications daily and the unit managers should be checking the medication carts weekly but could not find their medication cart inspection reports. She also indicated that pharmacy consultant was also checking the medication carts monthly. Administrative staff #1 revealed that the policy was to date Advair when opened and to discard it 30 days after opening. She also stated that Prostat should be dated when opened.</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF BISCOE			STREET ADDRESS, CITY, STATE, ZIP CODE 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209	
(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
K 000	INITIAL COMMENTS	K 000	Preparation and submission of the plan of correction is in response to HCFA 2567 for the survey and does not constitute an agreement or admission by Autumn Care of Biscoe of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Autumn Care of Biscoe contends that it was in substantial compliance with the requirements 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, Autumn Care of Biscoe submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of 6/21/13. K062 Our sprinkler system will have an obstruction investigation conducted by 6/21/13. If any corrective action is needed we will also have that accomplished by 6/21/13. Our sprinkler system has two (2) riser's	6/21/13
K 062 SS=E	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations, document review and staff interviews on 5/9/2013 the following Life Safety item was observed as noncompliant, specific findings include: The sprinkler contractor's documentation dated 4/29/2013 did not note that the sprinkler five year obstruction investigation had been conducted. CFR#: 42 CFR 483.70 (a)	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Cristine Stenson* TITLE *Administrata* DATE *5/23/13*

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345000	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF BISCOE			STREET ADDRESS, CITY, STATE, ZIP CODE 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system.</p> <p>CFR#: 42 CFR 483.70 (a)</p> <p>NOTE: There were no Life Safety Code Deficiencies noted during the survey.</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Christine Henson Administrator *W/H* TITLE *5/23/13* (X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345000	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 3 B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF BISCOE			STREET ADDRESS, CITY, STATE, ZIP CODE 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209	
(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
K 000	<p>INITIAL COMMENTS</p> <p>This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system.</p> <p>CFR#: 42 CFR 483.70 (a)</p> <p>NOTE: There were no Life Safety Code Deficiencies noted during the survey.</p>	K 000	<p>One was installed in 1992 the other in 2007. Both will have the obstruction investigation done. Viking Sprinkler Company has put our facility in their computer system for quarterly and annual inspections. We will ask them to put our five year obstruction investigation into the system also. We will make a sign and place it above our weekly sprinkler log in the riser room with dates of when our last obstruction investigation was done and when our next one is due.</p>	4/21/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Christine Henon* TITLE *Administrative* DATE *5/23/13*

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.