PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING ______ B. WING ______	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	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 000	INITIAL COMMENTS The facility was notified of Immediate Jeopardy on 02/14/12 at 483.25 for failure to ensure a safe transport for Resident #135 by not securing the resident in the facility's van which resulted in the resident falling forward from the wheelchair and sustaining hematomas and contusion to the head and Injury of the hand. The Immediate Jeopardy began on 02/10/12 (when the incident happened) and was identified on 02/13/12. The Immediate Jeopardy was removed on 02/16/12 when the facility provided the credible allegation of compliance. The facility remained out of compliance at the lower scope and severity "D".	F 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 2/24/2012.	2/24/12
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure a safe transport for 1 (Resident #135) of 4 sampled residents by not securing the resident in the facility's van which resulted in the resident falling forward from the wheelchair sustaining hematomas and contusion to the head and injury of the hand. Immediate Jeopardy began on 02/10/12 and was	F 323	F 323: This facility has and will continue to ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Admin (X6) DATE: 2/29/12

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

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F 323	Continued From page 1 identified on 02/13/12 at 2:10 PM. Immediate jeopardy was removed on 02/16/12 at 11:00 AM when the facility provided a credible allegation of compliance. The facility remained out of compliance at the lower scope and severity level, an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (D). The facility was in the process of implementing their corrective actions on training and monitoring. The findings include: The facility's policy on " Fleet Safety Program Guidelines " dated 02/23/04 was reviewed. The policy under operation of organization vehicles read in part " the driver and any passenger must wear seatbelts at all times when traveling in an organization vehicle or their own vehicle on organization business " . Resident #135 was admitted to the facility on 11/07/11 with multiple diagnoses including Glaucoma, Senile Cataract and Dementia. The admission Minimum Data Set (MDS) assessment dated 11/16/11 indicated that Resident #135 had moderate cognitive impairment and had no falls since admission. The assessment further indicated that Resident #135 had impaired vision and needed extensive assistance with 2 plus (+) persons with transfer. Review of Resident #135's care plan dated 11/18/11 included fall risk and safety needs related to cognitive impairment as problems. The goals were for the resident to have no falls and no injury requiring hospitalization through next review.	F 323	**F 323:** Steps taken in regards to Resident #135 being transported to an appointment on 2/10/12 via facility van. Resident #135 was transported to hospital for evaluation from scene of the incident. Van Driver #1 responsible for the incident received disciplinary action on 2/10/12. Van Driver #1 received instruction from Maintenance on 2/10/12 with return demonstration on how to safely secure wheelchair and resident prior to transport. Van Driver #1 responsible for the incident was audited by Maintenance on 2/13/12 to ensure that resident seat belt and wheelchair straps were being appropriately secured prior to transport. Van Drivers were randomly audited daily by Maintenance and the Administrator for one week following the incident with no issues noted (see attached audits). Steps taken in regards to residents having the potential to be affected by the survey findings: All current facility van drivers (full-time and part-time) were re-instructed on 2/10/12 on how to safely secure residents and the wheelchair for transport with return demonstration by Maintenance.	2/24/12

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F 323	Continued From page 2 The nurse's notes were reviewed. The notes dated 02/10/12 at 12:59 PM and written by Nurse #1 revealed that the resident was on leave of absence (LOA) via facility transport at 12:15 PM for an appointment with an eye clinic. Van driver #1 had called the nurse at 12:45 PM and stated that the resident had flipped out of the wheelchair, bumped her head and had bruises on her head. The resident was alert and verbal. Nurse #1 had consulted with the administrator and the Director of Nursing (DON) and advised van driver #1 to call 911. The resident was transported to the hospital emergency room for evaluation. Nurse #1 was on vacation and could not be reached for an interview. The nurse's notes dated 02/10/12 at 10:53 PM were written by Nurse #2. The notes revealed that Resident #135 returned from the emergency room and eye clinic accompanied by a family member. She had 2 hematomas on her forehead and a bruise in her right hand. She had complained of pain in her hand and Tylenol was given. Nurse #2 was interviewed on 02/15/12 at 3:25 PM. She stated that the family member had picked up the resident from the emergency room and took her to the eye clinic for her appointment. Nurse #2 further stated that Resident #135 was assessed when she returned to the facility. She was noted to have bruises on her forehead and right hand, swelling on her left eye brow and she was complaining of pain in her hand. She indicated that she had given the resident Tylenol for the pain. Nurse #2 also indicated that administrative staff #1 had assessed the resident when she returned from the eye clinic. The administrative staff #1 was interviewed on	F 323	A Transportation Review Checklist, a form used to monitor vehicle inspection and safety measures and comfort of the resident for transports were completed on 2/15/12 with current van drivers by Maintenance (see attached form). All van drivers were re-instructed on 2/15/12 explaining to contact 911 first in the event of an emergency then contact the facility. Van Driver #1 received supervised transport on 2/15/12. A transportation review checklist that monitors vehicle safety and resident safety/comfort was completed with full-time van drivers on 2/15/12 by Maintenance (see attached). Systemic Changes: During the orientation period, all new hires for the van driver position will satisfactorily pass the transportation review checklist, Driver Road Test (which audits the driver's ability to follow vehicle safety as well as driving safety) and the Safety Program Guidelines (Driver and Vehicle Safety as it relates to compliance with all pertinent state and federal laws). In the event of an incident during resident transport, all new hires for the van driver position	2/24/12

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F 323	Continued From page 3 02/15/12 at 3:40 PM. She stated that she had assessed Resident #135 when she returned from the eye clinic. The resident had two hematomas on her forehead, an abrasion above the left eyebrow and bruises in her right hand. On 02/14/12 at 2:25 PM, Resident #135 was observed up in wheelchair in her room. She had bruises on her right forehead and a scar on her left forehead. She had also bruises in her right hand. When asked, she stated that she fell but did not remember when and how. On 02/14/12 at 2:30 PM, administrative staff #2 was interviewed. She stated that Resident #135 had fallen out of the wheelchair in the facility's van due to van driver #1 did not secure her with the seatbelt during transport. She also indicated that she had investigated the incident and retrained the van drivers including van driver #1 on properly securing residents for wheelchair transports in the van. The van drivers also had a return demonstration on 02/10/12 on securing residents for transport to and from appointments. Each van driver was able to demonstrate proper placement of wheelchair in the van for transport, securely fastening the wheelchair to the van and securely fastening the resident to the wheelchair using the seatbelt. The investigation report was reviewed. The report revealed that Nurse #1 had paged the DON around 12:45 PM to inform her that van driver #1 had called to inform that Resident #135 had fallen out of the wheelchair on their way to an eye appointment. Van driver #1 wanted to know what to do as Resident #135 had a bump on her head. The DON had informed Nurse #1 to tell van	F 323	will be instructed to notify 911 first then to contact the facility. Random audits will be done on an on-going monthly basis by Maintenance or Administrator to ensure all straps are properly fastened. A log will be kept within the Maintenance Department with each van driver. Administrator or D.O.N. will monitor to ensure compliance monthly. Each Friday the upcoming week's transportation appointments will be reviewed by the D.O.N. or SDC for appropriate scheduling and time frames. In the event of a scheduling conflict, rescheduling of an appointment or outside transport assistance will be utilized i.e. local professional transport service or EMS. If an adjustment in scheduling needs to be done, the van driver is to contact the D.O.N. or SDC for approval. QA Monitoring to prevent reoccurrence: Van Driver #1 and all other van drivers will be randomly audited daily x 1 week then weekly x 4 weeks the monthly x 4 months by Maintenance or Designee to ensure that all straps are securely fastened with corrective action taken as needed beginning 2/15/12 (see attached).	2/24/12

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F 323	Continued From page 4 driver #1 to call 911. The report further indicated that the DON had informed the administrator, who then sent the maintenance staff member to the scene to assess the situation with the van and to assess how the incident occurred. Upon return of van driver #1 to the facility, she met with the administrator and DON. She stated that she realized her mistake and that the situation was her fault. She stated that she was in a hurry and did not strap the seat belt around the resident before transporting to the appointment. She stated that she did strap the wheelchair down, however did not strap the resident. She stated that she was in a hurry because she was running behind after dropping off a resident at dialysis. She also stated that she had backed the resident into the van which would not allow a seat belt to strap around the resident. Van driver #1 was informed that no matter what the situation, the resident must always have a seat belt in use as well as the wheelchair being tied down. She was also informed to make sure that appointments were not placed close together in order to prevent the issue of being in a hurry. She had expressed understanding. The report also revealed that the maintenance staff member had met with each van driver and each van driver had a return demonstration on proper safety measures when transporting residents in the van. Van driver #1 had received a written warning for failing to strap the seat belt around the resident's body when transporting to an appointment in the van. A written report by van driver #1 was reviewed. The report indicated that she picked up Resident #135, backed her up in the van and tied her down in the wheelchair. She did not put the seat belt strap around the resident. She turned off on road	F 323	Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) will be addressed in Quality Assurance meeting for further action plans during morning meeting.	2/24/12

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F 323	Continued From page 5 220 onto 211 when she heard the resident falling out of wheelchair. She stopped under the bypass to check the resident and to call the facility. She then called 911 as instructed and the resident was transported by the EMS (emergency medical service) to the emergency room. She added that she had backed the resident in facing the back door. This position would not allow her to put the seat belt around the resident. On 02/14/12 at 2:37 PM, van driver #1 was interviewed. She stated that she has been working at the facility as a nursing assistant and a restorative aide since 2009. She had driven the facility's van for almost a year now. She was trained by the maintenance staff member on how to secure the resident and the wheelchair prior to transport. She stated that she did not have any incident/accident involving the van until 02/10/12. She indicated that Resident #135 had an appointment at the eye clinic on 02/10/12. She was in a hurry because she was running late and the resident's family member was waiting for her at the clinic. She loaded the resident in the van facing the back door, secured the wheelchair but did not secure the resident. She also stated that she positioned the wheelchair facing the back door instead of facing forward which made her not able to use the strap to the resident. She stated that when she turned, she heard the resident fall out of the wheelchair and hit the door. She pulled over and checked the resident. Resident #135 was on the floor facing down with bruises on her forehead and knuckles. She called the facility and she was advised to call 911. She then called 911 and the resident was brought to the hospital emergency room. She revealed	F 323		

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F 323	Continued From page 6	F 323		

that the maintenance staff member went to the scene to inspect the harness. He also explained to her the importance of securing the resident with the seatbelt during transport. She again stated that she knew that she had to secure the wheelchair and the resident prior to transport but she just did not do it because she was in a hurry. Van driver #1 added that most of the doctor's offices will cancel the appointment if you were late for 15-20 minutes and she did not want that to happen. She revealed that on Saturday (02/11/12), she continued on driving the facility's van. Van driver #1 revealed that on 02/13/12, she had a return demonstration with the maintenance staff member on securing the wheelchair and the resident in the van.

On 02/14/12 at 3:19 PM, the maintenance staff member was interviewed. He stated that he was told to go to the scene on 02/10/12 to check the harness in the van. He stated that the harness for the wheelchair and the resident were intact and were in good working condition. He indicated that he had trained van driver #1 on properly securing the resident during transport prior to her driving the van. He also stated on 02/10/12, he reinstructed van driver #1 the importance of securing the resident in the van and on 02/13/12, he had a return demonstration with van driver #1 on how to properly secure the wheelchair and the resident in the van.

On 02/14/12 at 3:58 PM, van driver #1 was re interviewed. She stated that she did not have any problems with the workload for transports. She indicated that the facility had 2 vans and 4 drivers. She stated that she kept up with the daily

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F 323	Continued From page 7 appointments and communicated with the driver of van #2. She stated that normally van #2 had to take the residents to the dialysis clinic and van #1 had to take the rest of the appointments. On 02/10/12, there was a resident that needed to be picked up from the hospital and van #2 had to pick this resident up. Van #1 was left to transport the 3 residents to the dialysis clinic and Resident #135 to the eye clinic. Van driver #1 (driver of van #1) further stated that she was running late for Resident #135 eye appointment so she was in a hurry. The hospital notes were reviewed. The report of the CT (computerized tomography) scan of the head dated 02/10/12 revealed a diagnosis of Contusion. On 02/14/12 at 4:17 PM, the administrator was informed of the immediate jeopardy. A credible allegation of compliance was provided on 2/16/12 at 11:00 AM. (A.) Steps taken in regards to Resident #135 being transported to an appointment on 2/10/12. While making a left hand turn, Van Driver # 1 heard resident fall out of wheelchair as per Van Driver #1's statement, she indicated she had not put seat belt strap around resident. Van Driver #1 contacted charge nurse at facility via cellular phone. Charge nurse informed D.O.N. and was informed to tell Van Driver #1 to contact 911 immediately. EMS took resident to hospital on 2/10/12 from facility van. ER report stated: 1. No acute intracranial abnormality. There is a small left frontal scalp hematoma. Administrator was made aware of situation and maintenance staff sent to facility van location to audit the situation	F 323		

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F 323	Continued From page 8 and equipment. Wheelchair straps were noted to be intact, resident seat belt not in use per Van Driver # 1's statement. Van Driver #1 responsible for the incident received disciplinary action on 2/10/12. Van Driver #1 received instruction from Maintenance on 2/10/12 with return demonstration on how to safely secure wheelchair and resident prior to transport. Van Driver #1 responsible for the incident was audited by Maintenance on 2/13/12 to ensure that resident seat belt and wheelchair straps were being appropriately secured prior to transport. Van Driver #1 responsible for the incident will be randomly audited daily x 1 week, then weekly x 4 weeks then monthly x 4 months by Maintenance to ensure all straps securely fastened prior to transports with corrective action taken as needed. (B.)Steps taken in regards to residents having the potential to be affected by the survey findings: All current facility van drivers (full-time and part-time) were re-instructed on 2/10/12 on how to safely secure residents and the wheelchair for transport with return demonstration by Maintenance. A Transportation Review Checklist, a form used to monitor vehicle inspection and safety measures and comfort of the resident for transports will be completed on 2/15/12 with current van drivers. This checklist will be completed by Maintenance. Checklist includes: Pre-trip/Post trip inspection, Flares/Triangles, Fire Extinguisher, First Aid Kit, Under the hood Inspection, Outside Van inspection, Vehicle breakdowns or emergencies, Location of automobile parts, Mirror adjustments, Driving in inclement weather, Accident reporting, Proper lift techniques, Securing wheel chair, Securing seated passenger, Transporting of extra supportive equipment, Postural security/comfort, No smoking/eating, No cell phone usage,	F 323		

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F 323	Continued From page 9 Cleaning vehicle, Transporting more than one resident at a time, Maneuvering wheelchair with passenger over thresholds, What to do when an emergency occurs with a resident, Demonstration of proper communication with passenger when driving, Demonstrates proper communication techniques with hearing impaired, Proper assistance for visually impaired, Be aware of resident's sensitivity to temperature changes/odors, Read and follow all manufacturer's instructions, Maximize the clear space around the passenger to reduce the possibility of contact with vehicle components and other passengers in a crash, and You are responsible for this vehicle. All van drivers were re-instructed on 2/15/12 explaining to contact 911 first in the event of an emergency then contact the facility. Van Driver #1 received supervised transport on 2/15/12. A transportation review checklist that monitors vehicle safety and resident safety/comfort was completed with full-time van drivers on 2/15/12 by Maintenance. (C.)Systemic Changes: During the orientation period, all new hires for the van driver position will satisfactorily pass the transportation review checklist, Driver Road Test (which audits the driver's ability to follow vehicle safety as well as driving safety) and the Safety Program Guidelines (Driver and Vehicle Safety as it relates to compliance with all pertinent state and federal laws). In the event of an incident during resident transport, all new hires for the van driver position will be instructed to notify 911 first then to contact the facility. Random audits will be done on an on-going monthly basis by Maintenance or Administrator to ensure all straps are properly fastened. A log will be kept within the Maintenance Department with each van driver.	F 323		

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F 323	Continued From page 10 Administrator or D.O.N. will monitor to ensure compliance monthly. Each Friday the upcoming week's transportation appointments will be reviewed by the D.O.N. or SDC for appropriate scheduling and time frames. In the event of a scheduling conflict, rescheduling of an appointment or outside transport assistance will be utilized i.e. local professional transport service or EMS. If an adjustment in scheduling needs to be done, the van driver is to contact the D.O.N. or SDC for approval. (D.)QA Monitoring to prevent reoccurrence: Van Driver #1 and all other van drivers will be randomly audited daily x 1 week then weekly x 4 weeks the monthly x 4 months by Maintenance or Designee to ensure that all straps are securely fastened with corrective action taken as needed. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) will be addressed in Quality Assurance meeting for further action plans during morning meeting. The allegation of compliance was verified on 2/16/12 starting at 9:25 AM. Three, including van driver #1, of 4 van drivers were interviewed. They stated that they had been reeducated on properly securing the wheelchair and the resident during transport and had a return demonstration on properly securing the resident and the wheelchair with the maintenance staff member. A road test and a transportation review checklist including securing seated passenger with seat belt were also completed. The van drivers also stated that they have to call 911 first when accident/incident happened in the van. When interviewed, the administrator stated that one of the 4 van drivers was on vacation and when she comes back she	F 323		

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AUTUMN CARE OF BISCOE	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 323	Continued From page 11 will be trained on properly securing the resident and the wheelchair in the van before letting her drive the van. Van driver #1 also stated during the interview, that she has to inform the administrator or the DON when there is a conflict in appointments/schedule. Review of the records also revealed that 3 van drivers had signed a completed driver road test, transportation review checklist and the transportation safety policy. On 02/14/12, the maintenance staff member was observed to have a road test with the three van drivers. Van drivers were observed by the maintenance staff member on properly securing the wheelchair and the resident prior to transport and how they were positioned in the van.	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING: 01 - MAIN BUILDING 01 B. WING ____	03/01/2012

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 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Thursday 3/1/2012 between 9:00 AM and 1:00 PM the following was noted: 1) Facility at the time of the inspection did not have documentation for monthly load tests conducted that with the recording percent rated load and/or temperature rise. A load bank test had not been completed within the past year. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust	K 144	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 4/15/2012. K144: A two hour load bank test will be done by Piedmont Generator on 3/20/2012. The same will be done for our other generator.	4/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristine Stenson | TITLE: Administrator | (X6) DATE: 3/15/12

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	401 LAMBERY 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 144	Continued From page 1 gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing) 42 CFR 483.70(a)	K 144	We will incorporate this load bank test into our annual service agreement. Our weekly run log will have a column for this test. Any repairs needed will be accomplished by 4/15/2012.	4/15/12
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by:	K 211		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	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 211	Continued From page 2 Based on observation on Thursday 3/1/2012 between 9:00 AM and 1:00 PM the following was noted: 1) Alcohol Based Hand Rub (ABHR)dispenser was noncompliant: specific findings include an alcohol based hand rub was located with six inches of the light switches throughout the facility. 42 CFR 483.70(a)	K 211	K 211: All Alcohol Based Hand Rub (ABHR) dispensers were relocated in Main Building 01 so as not to be within 6 inches of the light switches.	4/15/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING 02 - BUILDING 02 B. WING	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	401 LAMBERT ROAD P O BOX 705 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 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/1/2012 between 9:00 AM and 1:00 PM the following was noted; 1) The Supply storage room located at the nurse station was not self closing located at nurse station #2. 2) The corridor door to the facility storage closet located on 400 hall was not self closing. 3) The Corridor door to the storage room on 600 hall did not close, latch and seal. 42 CFR 483.70(a)	K 029	**K029:** The supply storage room at Nurse's Station # 2 the facility storage closet on 400 hall and the storage room on 600 hall will all be equipped with a self-closing device to ensure that it will close, latch and seal. We will look at all other corridor doors to see if others may fall into this same issue. Any room that purposes for which they are used might change will be assessed for this issue before any changes are done. We will incorporate a daily check of these doors into our morning building rounds. All doors will be equipped with a self-closing device by 4/15/2012.	4/15/12
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061	**K061:** The Gate valves for the backflow preventer for the sprinkler system will have tamper switches installed. This is our only supply which feeds both risers. These tamper switches will be tied into our fire alarm. They will be inspected quarterly by the sprinkler company and annually during our fire alarm inspection. This will be accomplished by 4/15/2012.	4/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 3/15/12

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING 02 - BUILDING 02 B. WING	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	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 061	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/1/2012 between 9:00 AM and 1:00 PM the following was noted: 1) The gate valves for backflow preventer for the sprinkler system located outside was not equipped with electronically supervised tamper alarms. 42 CFR 483.70(a)	K 061		
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Thursday 3/1/2012 between 9:00 AM and 1:00 PM the following was noted: 1) One of two smoke dampers located in the attic on 500 hall did not close upon activation of the fire alarm. 42 CFR 483.70(a)	K 104	K104: An inspection has been made by Delwood Mechanical HVAC of the smoke damper that did not close. This damper will be repaired if parts available or will be replaced if not to ensure proper operation. This is the only HVAC system that penetrates a smoke barrier in our facility. Damper will be checked for proper operation for three months during our monthly fire drill and checked annually during our fire alarm inspection. A weekly check will be done for three months and if the problem does not reoccur, a monthly check thereafter. Repairs or replacement will be done by 4/15/2012.	4/15/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING 03 - BUILDING 3 B. WING	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	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 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Thursday 3/1/2012 between 9:00 AM and 1:00 PM the following was noted: 1) There are two transfer switches located in the electrical room and at the time of the inspection both indicator panels were not operating properly. One did not show switch connected to normal power and the other did not show panel connected to emergency power. 2) Facility at the time of the inspection did not have documentation for monthly load tests conducted that with the recording percent rated load and/or temperature rise. A load bank test had not been completed within the past year. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:	K 144	K144: Piedmont generator will be here on 3/20/12 to address the light issues we have on both generator transfer cases located in the electrical room. Our other generator transfer case does not have digital board for light read out (It has bulbs which are easily replaced). Both maintenance workers will be instructed on how to read the panels and what breakers operate the panels. A column will be added to the weekly run log for this generator to ensure the panels are lighting up correctly. All work will be accomplished by 4/15/2012. K144: A two hour load bank test will be done by Piedmont Generator on 3/20/2012. The samo will be done for our other generator. We will incorporate this load bank test into our annual service agreement. Our weekly run log will have a column for this test. Any repairs needed will be accomplished by 4/15/2012.	4/15/12 4/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: 3/15/12

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING 03 - BUILDING 3 B. WING ________	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	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 144	Continued From page 1 (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing) 42 CFR 483.70(a)	K 144	K 211: All Alcohol Based Hand Rub (ABHR) dispensers were relocated in Building 03 so as not to be within 6 inches of the light switches.	3/15/12
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING 03 - BUILDING 3 B. WING ______	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	401 LAMBERT ROAD P O BOX 70B 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 211	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/1/2012 between 9:00 AM and 1:00 PM the following was noted; 1) Alcohol Based Hand Rub (ABHR)dispenser was noncompliant; specific findings include an alcohol based hand rub was located with six inches of the light switches throughout the facility. 42 CFR 483.70(a)	K 211		