PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0381

ANTUMN CARE OF BISCOE SIMMARY STATEMENT OF DEFICIENCES SIMMARY STATEMENT OF DEFICIENCY SIMMARY STATEMENT OF DEFICIENCY SIMMARY STATEMENT OF DEFICIENCY SIMMARY STATEMENT OF DEFICIENCY STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CUA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STREET ADDRESS, CITY, TATK, JP CODE 401 LAMPERT ROAD P O BIX 708 BISCOE, NC 27209 BISCOE, NC 27209 FOOD SUMMARY STATEMENT OF DEFICIENCIES (PAPID PRETIX RECOUNTORY OR U.S. IDENTIFYING INFORMATION) FOOD 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 was which resulted in the resident in the facility was middled separated and liquiry of the hand. The immediate Jeopardy began on 02/10/12 (when the incident happened) and was identified on 02/16/12 when the facility provided the recreitled allegation of compilance. The facility remained out of compilance. The lower scope and severity "D". F 323 483.25(h) FREE OF ACCIDENT SS=J HAZAROSISUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possibla; 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 falled to ensure a safe transport for 1 (Recident #135) of 4 sempled residents by not securiting the resident falling to the property of the property of the part of the part of the part of the property of the part of th			345000			02/16/2012
FOOD 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 residentialing forward from the wheelchair and sustaining harmstornas 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 began on 02/10/12 (when the facility provided the credible allegation of compliance at the lower acope and severity "D". F 323 SS=3 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possibla; 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 sempted residents by not securing the resident in the sedent in the crediting that the page of correction and as ficilly complete in all areas as of 2/24/2012. F 323: This facility has and will continue to ensure that the resident's environment remains as free of filter the continue to ensure that the resident's environment remains as free of filter the continue to ensure that the resident's environment remains as free of filter the continue to ensure that the resident's environment remains as free of filter the continue to ensure that the resident's environment remains as free of filter the continue to ensure that the resident's environment remains as free of filter the continue to ensure that the resident's environment remains as free of filter the continue to ensure that the resident's environment remains as free of filter the continue to ensure that the resident's environment remains as free of filter the continue to ensure that the resident's environment remains as free of filter the continue to ensure that the re			343000	4	Of LAMBERT ROAD P O BOX 708	
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 falling forward from the wheelchair and sustaining hamatomas 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 323 Mas 2.56th Free OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as frae 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 falled to ensure a sefe transport for 1 (Resident #135) of 4 sempled residents by not securing the exident falling 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 facts alleged or the correctness of the texts alleged or the correctness of the facts alleged or the correctness	PREFIX	/PACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	E APPROPRIATE DATE
by: Based on record review, observation and staff interview, the facility falled to ensure a safe transport for 1 (Resident #135) of 4 sampled residents by not securing the resident in the This complete in all atoms as 2/24/2012. F 323: This facility has and will continue to ensure that the resident's residents by not securing the resident falling environment remains as free of	F 323	The facility was not on 02/14/12 at 483.2 transport for Resider resident in the facility resident falling forward and Injury of the har began on 02/10/12 (and was identified of Jeopardy was remote facility provided the compliance. The factompliance at the kind 483,25(h) FREE OF HAZARDS/SUPER. The facility must enenylronment remains is possible; and adequate supervisity prevent accidents.	fied of Immediate Jeopardy 25 for failure to ensure a safe at #135 by not securing the y's van which resulted in the ard from the wheelchair and has and contusion to the head ad. The Immediate Jeopardy (when the incident happened) in 02/13/12. The Immediate ved on 02/16/12 when the credible allegation of culty remained out of ower scope and severity "D". ACCIDENT VISION/DEVICES Issure that the resident has as free of accident hazards each resident receives on and assistance devices to		of correction is in resp 2567 for the survey constitute an agreemen by Autumn Care of Bis of the facts alleged or of the conclusions statement of deficiencie correction is prepared because of the requirem and federal laws. A Biscoe contends the substantial complian requirements 42 Cf Subpart B throughout stated in the statement In accordance with s law, Autumn Care of this plan of correction statement of deficience as its allegation of con- pertinent requirements	and does not at or admission coe of the truth the correctness stated on the es. This plan of and submitted nents under state autumn Care of at it was in the extra truth truth the extra truth truth the extra truth tru
1 Tacking 8 vall within 100 diced in this 100 min.		by: Based on record r interview, the facili transport for 1 (Re residents by not se facility's van which	by: Based on record review, observation and staff interview, the facility falled to ensure a safe transport for 1 (Resident #135) of 4 sempled 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.		2/24/2012. F 323: This facili continue to ensure the environment remain	ty has and will hat the resident's as as free of
hematomas and contusion to the head and injury cach resident receives adequate	,	hematomas and o of the hand.			cach resident rec supervision and assi-	ceives adequate

Any deficiency statement ending with an extends (") denotes a deficiency which the instruction may be excused from connecting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossable 90 days following the data of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclossable 14 days following the data those documents are made available to the factive. If deficiencies are clied, an exproved plan of correction is requisite to continued program perfectpation.

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

345000

HAR 0 5 2012

PRINTED: 02/23/2012 FORM APPROVED

2/24/12

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

AUTUMN CARE OF BISCOE

STREET ADDRESS, CITY, STATE, ZIP CODE 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE)

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)

TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

TO ADDRESS PLAN OF CORRECTION (X5) COMPLETION DATE

F 323

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: 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

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 being wheelchair straps were appropriately secured prior to transport. Van Drivers were randomly audited daily by Maintenance and Administrator for one week following

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.

the incident with no issues noted (see

attached audits).

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA			(X2) MH	TIPLE CONSTRUCTION	(X3) DATE SU	RVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLET	
		345000	B. WING		02/1	6/2012
	COVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	dated 02/10/12 at 12: #1 revealed that the rabsence (LOA) via fa for an appointment w #1 had called the nur that the resident had wheelchair, bumped I her head. The reside Nurse #1 had consult and the Director of Ni van driver #1 to call 9 transported to the hose evaluation. Nurse #1 not be reached for an The nurse's notes dawere written by Nurse that Resident #135 re room and eye clinic a member. She had 2 and a bruise in her rig complained of pain in given. Nurse #2 was 3:25 PM. She stated picked up the resident and took her to the ey Nurse #2 further state assessed when she right hand, swelling o was complaining of pindicated that she had for the pain. Nurse # administrative staff #*	are reviewed. The notes 59 PM and written by Nurse resident was on leave of cility transport at 12:15 PM ith an eye clinic. Van driver se at 12:45 PM and stated flipped out of the ther head and had bruises on ant was alert and verbal. red with the administrator rursing (DON) and advised red out of the resident was repital emergency room for rwas on vacation and could red out interview. The notes revealed returned from the emergency recompanied by a family rematomas on her forehead red thand. She had red hand and Tylenol was red that Resident #135 was returned to the facility. She returned to the resident Tylenol red also indicated that red had assessed the resident red that Resident resident red that assessed the resident red that assessed the resident red that resident resident red that assessed the resident red that resident	F 3:	inspection and safety comfort of the resident were completed on current van drivers by (see attached form). A were re-instructed explaining to contact 91 event of an emergency the	titor vehicle measures and for transports 2/15/12 with Maintenance all van drivers on 2/15/12 I first in the men contact the #1 received 2/15/12. A checklist that and resident impleted with in 2/15/12 by d). Fing the whires for the atisfactorily view est (which to follow driving safety) Guidelines ty as it relates retinent state event of an ransport, all	

		VILDICAID SERVICES	(VOLMULTIDLE CONSTRUCTION /V		(VO) DATE CHIDNEY		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345000	B. WIN	WING			6/2012
	CARE OF BISCOE		STREET ADDRESS, CITY, STATE, ZIP CODE 401 LAMBERT ROAD P O BOX 708				
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F 323	assessed Resident # the eye clinic. The re on her forehead, an a eyebrow and bruises On 02/14/12 at 2:25 F observed up in wheel bruises on her right fo left forehead. She ha hand. When asked, s did not remember who On 02/14/12 at 2:30 F was interviewed. She had fallen out of the v van due to van driver the seatbelt during tra that she had investiga retrained the van driver on properly securing transports in the van. return demonstration residents for transpor Each van driver was a placement of wheelch securely fastening the securely fastening the securely fastening the using the seatbelt. The investigation repor report revealed that N DON around 12:45 Pl driver #1 had called to had fallen out of the v eye appointment. Va what to do as Residen	She stated that she had 135 when she returned from sident had two hematomas brasion above the left in her right hand. PM, Resident #135 was chair in her room. She had brehead and a scar on her ad also bruises in her right she stated that she fell but en and how. PM, administrative staff #2 be stated that Resident #135 wheelchair in the facility's #1 did not secure her with ansport. She also indicated	F	323	then to contact the facility, audits will be done on an monthly basis by Mainten Administrator to ensure all s properly fastened. A log will within the Maintenance Dewith each van driver. Admini D.O.N. will monitor to compliance monthly. Each F	Random on-going nance or straps are I be kept epartment strator or ensure riday the eportation of by the eportation of t	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	COVIDER OR SUPPLIER		-	40	EET ADDRESS, CITY, STATE, ZIP CODE 01 LAMBERT ROAD P O BOX 708 ISCOE, NC 27209			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 323	that the DON had inform who then sent the mathe scene to assess to assess how the incomposition of van driver #1 to the administrator and DO realized her mistake her fault. She stated did not strap the seat before transporting to stated that she did st however did not strap that she was in a hur behind after dropping. She also stated that sinto the van which wo strap around the resigniformed that no matter around the resigniformed to mak were not placed close the issue of being in understanding. The maintenance staff me van driver and each will demonstration on protransporting residents had received a writte the seat belt around it transporting to an application. She wheelchair.	The report further indicated ormed the administrator, sintenance staff member to he situation with the van and cident occurred. Upon return a facility, she met with the van. She stated that she and that the situation was that she was in a hurry and belt around the resident to the appointment. She rap the wheelchair down, of the resident at dialysis. She had backed the resident ould not allow a seat belt to dent. Van driver #1 was the what the situation, the have a seat belt in use as it being tied down. She was a sure that appointments a together in order to prevent a hurry. She had expressed report also revealed that the sember had met with each van driver had a return oper safety measures when is in the van. Van driver #1 in warning for failing to strap the resident's body when	F	323	Any area of identified concerr addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, returned demonstration, etc.) will be addin Quality Assurance meeting further action plans during meeting.	rn Idressed for	2/24/12	

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345000	B. WING			02/10	6/2012
	OVIDER OR SUPPLIER			40	EET ADDRESS, CITY, STATE, ZIP CODE 01 LAMBERT ROAD P O BOX 708 ISCOE, NC 27209		
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F 323	out of wheelchair. She to check the resident then called 911 as ins was transported by the service) to the emergishe had backed their door. This position we seat belt around their control of the facility restorative aide since facility's van for almost trained by the mainte to secure the resident transport. She stated incident/accident involute involute incident/accident involute involute incident/accident involute incident/accident involute involute involute involute incident/accident involute involut	the heard the resident falling the stopped under the bypass and to call the facility. She structed and the resident the EMS (emergency medical ency room. She added that esident in facing the back build not allow her to put the resident. PM, van driver #1 was ted that she has been as a nursing assistant and a 2009. She had driven the st a year now. She was nance staff member on how that she did not have any sliving the van until 02/10/12.	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	scene to inspect the hat to her the importance with the seatbelt during stated that she knew wheelchair and the reshe just did not do it to Van driver #1 added to offices will cancel the late for 15-20 minutes to happen. She revea (02/11/12), she continue. Van driver #1 revended a return demonst staff member on securesident in the van.	staff member went to the narness. He also explained of securing the resident ng transport. She again that she had to secure the sident prior to transport but because she was in a hurry, that most of the doctor's appointment if you were and she did not want that led that on Saturday nued on driving the facility's realed that on 02/13/12, she ration with the maintenance uring the wheelchair and the	F	323			
	member was interviewed told to go to the scene harness in the van. If for the wheelchair and and were in good wor that he had trained vasecuring the resident driving the van. He a reinstructed van drive securing the resident he had a return demo on how to properly se resident in the van. On 02/14/12 at 3:58 Finterviewed. She stat problems with the worindicated that the faci	PM, the maintenance staff wed. He stated that he was a on 02/10/12 to check the de stated that the harness of the resident were intact king condition. He indicated an driver #1 on properly during transport prior to her also stated on 02/10/12, he or #1 the importance of in the van and on 02/13/12, nstration with van driver #1 cure the wheelchair and the PM, van driver #1 was resed that she did not have any rkload for transports. She lity had 2 vans and 4 at she kept up with the daily					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345000	B. WING		02/16/2012	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF BISCOE			S	STREET ADDRESS, CITY, STATE, ZIP CODE 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209		
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F 323	of van #2. She stated take the residents to thad to take the rest of 02/10/12, there was a picked up from the hopick this resident up. It the 3 residents to the #135 to the eye clinic van #1) further stated for Resident #135 eye a hurry. The hospital notes we the CT (computerized head dated 02/10/12 Contusion. On 02/14/12 at 4:17 Finformed of the immedilegation of compliar at 11:00 AM. (A.) Steps taken in replaining transported to a While making a left had heard resident fall out Driver #1's statement put seat belt strap are #1 contacted charge informed to tell Van Dimmediately. EMS to 2/10/12 from facility vacute intracranial abnue the frontal scalp hemalmade aware of situation of the picket intracranial abnue the frontal scalp hemalmade aware of situation of the picket intracranial abnue the frontal scalp hemalmade aware of situation of the picket intracranial abnue the frontal scalp hemalmade aware of situation of the picket intracranial abnue th	mmunicated with the driver that normally van #2 had to he dialysis clinic and van #1 f the appointments. On resident that needed to be spital and van #2 had to Van #1 was left to transport dialysis clinic and Resident. Van driver #1 (driver of that she was running late appointment so she was in the revealed a diagnosis of PM, the administrator was diate jeopardy. A credible nee was provided on 2/16/12 gards to Resident #135 for appointment on 2/10/12. The report of the indicated she had not so whe indicated she had not so which is the indicated she had not so whe indicated she had not so w	F 32	23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345000	B. WING			02/16/2012	
	NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF BISCOE			401	ET ADDRESS, CITY, STATE, ZIP CODE 1 LAMBERT ROAD P O BOX 708 SCOE, NC 27209		
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F 323	to be intact, resident of Driver #1's statemen for the incident receive 2/10/12. Van Driver #1 Maintenance on 2/10, demonstration on how wheelchair and reside Driver #1 responsible by Maintenance on 2/ resident seat belt and being appropriately so Van Driver #1 respon randomly audited dail weeks then monthly at to ensure all straps so transports with correct (B.) Steps taken in reconstructed on secure residents and with return demonstration Transportation Review monitor vehicle inspectand comfort of the rescompleted on 2/15/12 This checklist includes: P Flares/Triangles, Fire Under the hood Inspecion, Vehicle by Location of automobil Driving in inclement we Proper lift techniques Securing seated pass	eelchair straps were noted seat belt not in use per Van t. Van Driver #1 responsible ed disciplinary action on the received instruction from 1/2 with return versafely secure ent prior to transport. Van for the incident was audited 1/3/12 to ensure that wheelchair straps were ecured prior to transport. Sible for the incident will be y x 1 week, then weekly x 4 to 4 months by Maintenance ecurely fastened prior to trive action taken as needed. Fards to residents having the distribution by Maintenance. It wheelchair for transport the wheelchair for transport will be with current van drivers. Completed by Maintenance. The trip inspection, Extinguisher, First Aid Kit, cition, Outside Van eakdowns or emergencies, e parts, Mirror adjustments, reather, Accident reporting, Securing wheel chair, enger, Transporting of extra, Postural security/comfort,	F3	23			

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		345000	B. WIN	IG_		02/16/2012	
	NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF BISCOE			4	REET ADDRESS, CITY, STATE, ZIP CODE 101 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209		
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F 323	resident at a time, Mapassenger over thresiemergency occurs with of proper communicated driving, Demonstrates techniques with heart assistance for visually resident's sensitivity to changes/odors, Read manufacturer's instruct space around the past possibility of contact wother passengers in a responsible for this vere-instructed on 2/15/first in the event of an the facility. Van Drive transport on 2/15/12. checklist that monitors safety/comfort was confivered on 2/15/12 by (C.)Systemic Change period, all new hires festisfactorily pass the checklist, Driver Road driver's ability to follow driving safety) and the (Driver and Vehicle Scompliance with all pelaws). In the event of transport, all new hire will be instructed to not the facility. Random a on-going monthly bas Administrator to ensurfastened. A log will be	nsporting more than one neuvering wheelchair with holds, What to do when an the a resident, Demonstration it ion with passenger when a proper communication and impaired, Proper impaired, Be aware of the temperature and follow all ctions, Maximize the clear senger to reduce the with vehicle components and crash, and You are whicle. All van drivers were 12 explaining to contact 911 emergency then contact or #1 received supervised. A transportation review as vehicle safety and resident empleted with full-time van Maintenance. Is: During the orientation or the van driver position will transportation review. Test (which audits the vehicle safety as well as a Safety Program Guidelines afety as it relates to entinent state and federal an incident during resident as for the van driver position of the	F	323			

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION			RVEY ED
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		345000	B. WIN	IG		02/16/2012	
	CARE OF BISCOE			4	REET ADDRESS, CITY, STATE, ZIP CODE IO1 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209		
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F 323	compliance monthly. week's transportation reviewed by the D.O.I scheduling and time f scheduling conflict, re appointment or outsid be utilized i.e. local prorements. If an adjustin be done, the van drive SDC for approval. (D.)QA Monitoring to Driver #1 and all other andomly audited dail weeks the monthly x 4 Designee to ensure the fastened with correcting Any area of identified at the time as indicated disciplinary, in-servicited.) will be addressed meeting. The allegation of com 2/16/12 starting at 9:2 driver #1, of 4 van driver #1, of 5 van driver #1, of 5 van driver #1, of 6 van driver #1, of 6 van driver #1, of 7 van driver #1, of 8 van driver #1, of 9	N. will monitor to ensure Each Friday the upcoming appointments will be N. or SDC for appropriate rames. In the event of a scheduling of an le transport assistance will rofessional transport service ment in scheduling needs to ler is to contact the D.O.N. or	F	323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLET	
		345000	B. WING	_	02/1	16/2012
	ROVIDER OR SUPPLIER		40	EET ADDRESS, CITY, STATE, ZIP CO 1 LAMBERT ROAD P O BOX 708 SCOE, NC 27209	ODE	
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F 323	and the wheelchair in drive the van. Van dri interview, that she ha or the DON when their appointments/schedu also revealed that 3 v completed driver road checklist and the trans 02/14/12, the mainten observed to have a rodrivers. Van drivers with maintenance staff me	perly securing the resident the van before letting her iver #1 also stated during the is to inform the administrator re is a conflict in ille. Review of the records ran drivers had signed a d test, transportation review sportation safety policy. On nance staff member was bad test with the three van vere observed by the imber on properly securing the resident prior to transport	F 323			
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						THE PROPERTY OF A SHARE AND A

EPARTMENT OF HEALTH AND HUMAN SERVICES PRINTEU: 03/05/2012 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTIO AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER; COMPLETED A BUILDING 01 - MAIN BUILDING 01 B. WING 345000 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 SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PŘEFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION YAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 SS=D Generators are inspected weekly and exercised Preparation and submission of the under load for 30 minutes per month in accordance with NFPA 99. 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 This STANDARD is not met as evidenced by: because of the requirements under Based on observation on Thursday 3/1/2012 between 9:00 AM and 1:00 PM the following was state and federal laws. Autumn Care noted: of Biscoe contends that it was in substantial compliance with the 1) Facility at the time of the inspection did not requirements 42 CFR, Part 483, have documentation for monthly load tests conducted that with the recording percent rated Subpart B throughout the time period load and/or temperature rise. A load bank test stated ín the statement had not been completed within the past year. deficiencies, In accordance with state and federal law, Autumn Care NFPA 99 3-4.4.2 Record keeping. A written of Biscoe submits this plan of record of inspection, performance, exercising period, and repairs shall be regularly maintained correction to address the statement of and available for inspection by the authority deficiencies and to serve as its having jurisdiction. allegation of compliance with the pertinent requirements as of the dates NFPA 110 6-4.2 (1999 edition) generator sets in stated in the plan of correction and as Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, fully complete in all areas as of using one of the following methods: 4/15/2012 (a) Under operating temperature conditions or at K144: A two hour load bank test not less than 30 percent of the EPS nameplate will be done by Piedmont Generator rating (b) Loading that maintains the minimum exhaust on 3/20/2012, The same will be done for our other generator.

LABORATORY DIRECTOR'S OR PROVIDER'S UPPLIER REPRESENTATIVE'S SIGNATURE

Amurshall

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

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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) MULTI A. BUILDIN	PLIE CONSTRUCTION G 01 - MAIN: BUILDING 01	(X3) DATE S		
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	PROVIDER OR SUPPLIER N CARE OF BISCOE		4	EET ADDRESS, CITY, STATE, ZIP CODE 01 LAMBERY ROAD P O BOX 708 ISCOE, NC 27209	1. 03/1	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (BACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ついこつ カド	COWNI'ELION
K 144	gas temperatures a manufacturer. NFPA 110 6-4.2.2 (EPS Installations the requirements of 6-4 with the available Eannually with supplementally with supplementally of nameplate rating for percent of namepla followed by 76 percents.	is recommended by the	^ K144	We will incorporate this letest into our annual agreement. Our weekly run log will column for this test. Any repairs needed accomplished by 4/15/2012.	service	4/5/12
K 211 SS=D	Where Alcohol Bass dispensers are install o The corridor is at o The maximum indicapacity shall be 1.2 rooms) o The dispensers have from each other o Not more than 10 smoke compartment o Dispensers are not an ignition source. o If the floor is carpe sprinklered, 19.3	ed Hand Rub (ABHR) alled in a corridor; least 6 feet wide lividual fluid dispenser 2 liters (2 liters in suites of ave a minimum spacing of 4 ft gallons are used in a single at outside a storage cabinet, of installed over or adjacent to leted, the building is fully 2.7, CFR 403.744, 418,100, 3.70, 483.623, 485,623	K 211			
	This STANDARD is	not met as evidenced by:				
18M CMS-256	7(02-99) Provious Versions (Observation Country and the Annual Country of the Annual Country o			<u></u>	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/05/2012 FORM APPROVED

OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING _ 345000 03/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE - 401 LAMBERT ROAD P O BOX 708 AUTUMN CARE OF BISCOE BISCOE, NC 27209 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) (D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE PREFIX (X5) GGMP),ETION PREFIX TAG TAG DATE DEFICIENCY K 211 Continued From page 2 K 211 Based on observation on Thursday 3/1/2012 between 9:00 AM and 1:00 PM the following was K 211: All Alcohol Based Hand noted: 1) Alcohol Based Hand Rub (ABHR)dispensér (ABHR) Rub dispensers was noncompliant: specific findings include an relocated in Main Building 01 so as alcohol based hand rub was located with six not to be within 6 inches of the light inches of the light switches throughout the facility. switches. 42 CFR 483,70(a)

FORM CMS-2567(02-99) Provious Versions Obsolete

Event (D: 831121

Facility ID: 922949

If continuation sheet Page 3 of 3

PRINTED: 03/05/2012 FORM APPROVED QMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ANO PLAN OF CORRECTION COMPLETED A BUILDING 02 - BUILDING 02 B. WING 345000 03/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE autumn gare of biscoe 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REPERENCED TO THE APPROPRIATE ID PREFIX COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 5S≈F One hour fire rated construction (with 1/4 hour K029: The supply storage room at fire-rated doors) or an approved automatic fire Nurse's Station # 2 the facility extinguishing system in accordance with 8.4.1 and/or 19,3,5,4 protects hazardous areas. When storage closet on 400 hall and the the approved automatic fire extinguishing system storage room on 600 hall will all be option is used, the areas are separated from equipped with a self-closing device other spaces by smoke resisting partitions and to ensure that it will close, latch and doors. Doors are self-closing and non-rated or We will look at all other field-applied protective plates that do not exceed corridor doors to see if others may 48 Inches from the bottom of the door are permitted. 19.3.2.1 fall into this same issue. Any room that purposes for which they are used might change will be assessed for this issue before any This STANDARD is not met as evidenced by: clanges are done. Based on observation on Thursday 3/1/2012: We will incorporate a daily check of between 9:00 AM and 1:00 PM the following was these doors into our morning noted: building rounds. 1) The Supply storage room located at the nurse All doors will be equipped with a station was not self closing located at nurse self-closing device by 4/15/2012. 2) The corridor door to the facility storage closet located on 400 hall was not self closing. K061: The Gate valves for the 3) The Corridor door to the storage room on 600 backflow preventer for the sprinkler hall did not close, latch and seal. system will have tamper switches 42 CFR 483,70(a) installed. This is our only supply K 061 NFPA 101 LIFE SAFETY CODE STANDARD K-061 which feeds both risers. SS=D These tamper switches will be tied Required automalic sprinkler systems have into our fire alann. valves supervised so that at least a local alarm They will be inspected quarterly by will sound when the valves are closed. NFPA 72, 9.7.2.1 the sprinkler company and annually during our fire alarm inspection. This will be accomplished 4/15/2012. LABORATORY DIRECTOR AOR PROVIDER/SURFILIER REPRESENTATIVES SIGNATURE STAC (QX

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 those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83821

Facility (D: 922949

If continuation sheet Page 1



AND PLAN OF CORRECTION AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG 02 - BUILDING 02	(X3) DATE SURVEY COMPLETED	
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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	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFIGIENCY)	ULD BE COM	gi Kuhon Vir
K 061	Continued From pa	age 1	K 061			
K 104 SS=E	Based on observatives between 9:00 AM a noted: 1) The gate valves sprinkler system to equipped with electronic alarms. 42 CFR 483,70(a) NFPA 101 LIFE SA Penetrations of sm protected in according to the content of t	is not met as evidenced by: tion on Thursday 3/1/2012 and 1:00 PM the following was for backflow preventer for the cated outside was not tronically supervised tamper AFETY CODE STANDARD oke barriers by ducts are fance with 8.3.6. Is not met as evidenced by: tion on Thursday 3/1/2012 and 1:00 PM the following was be dampers located in the attic close upon activation of the	K 104	K104: An inspection has be by Delwood Mechanical Ithe smoke damper that did a This damper will be repaire available or will be replaced ensure proper operation. This is the only HVAC system of the proper operation for three months our monthly fire drill and annually during our fire inspection. A weekly check will be defined months and if the problem to reoccur, a monthly thereafter. Repairs or replacement will be by 4/15/2012.	IVAC of not close. d if parts if not to elem that in our reproper during checked alarm one for em does check	1/2

PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 03 - BUILDING 3 B. WING 345000 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 S5=D Generators are inspected weekly and exercised K144: Piedmont generator will be under load for 30 minutes per month in here on 3/20/12 to address the light accordance with NFPA 99. 3.4.4.1. 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 This STANDARD is not met as evidenced by: casily replaced). Based on observation on Thursday 3/1/2012 Both maintenance workers will be between 9:00 AM and 1:00 PM the following was instructed on how to read the panels and what breakers operate the panels. 1) There are two transfer switches located in the Ar column will be added to the electrical room and at the time of the inspection both indicator panels were not operating properly. weekly run log for this generator to One did not show switch connected to normal ensure the panels are lighting up power and the other did not show panel correctly: connected to emergency power. All work will be accomplished by 2) Facility at the time of the inspection did not 4/15/2012. have documentation for monthly load tests conducted that with the recording percent rated K144: A two hour load bank test load and/or temperature rise. A load bank test will be done by Piedmont Generator had not been completed within the past year. on 3/20/2012. The same will be NFPA 99 3-4.4.2 Record keeping. A written done for our other generator. record of inspection, performance, exercising We will incorporate this load bank period, and repairs shall be regularly maintained test into our and available for inspection by the authority annual service having jurisdiction, agreement. Our weekly run log will have a NFPA 110 6-4.2 (1999 edition) generator sets in column for this test. Level 1 and Level 2 service shall be exercised at repairs nceded will least once monthly, for a minimum of 30 minutes, be accomplished by 4/15/2012. using one of the following methods: LABORATORY DIRECTOR'S OR PROVIDENSUMPLIER REPRESENTATIVE'S SIGNATURE TITLE (XO) DATE admentation you sterson

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 disclossible 90 days 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

PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	A MEDICALD SERVICES		CIVID IVID, Dago-099	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 3	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER		STREET ARRIBERS, SITY STATE TIP CORE		

AUTUMN CARE OF BISCOE

401 LAMBERT ROAD P O BOX 708

AUTUMN CARE OF BISCOE			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) COMPLETIO 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	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.	\$ 15 12	
K 211 SS=D	minutes, for a total of 2 continuous hours. (load bank testing) 42 CFR 483,70(a) 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)	K 211			
	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				

AUTUMN CARE

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

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AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING D3 - BUILDING 3		(X3) DATE SURVEY COMPLETED	
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	CARE OF BISCOE		. 5	TREET ADDRESS, CITY, STATE, ZIP CO 401 LAMBERT ROAD P O BOX 70B BISCOE, NC 27209	DE	
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K 211	This STANDARD Based on observa between 9:00 AM a noted; 1) Alcohol Based I was noncompliant; alcohol based hand	ls not met as evidenced by: tion on Thursday 3/1/2012 and 1:00 PM (he following was read Rub (ABHR) dispenser specific findings include an drub was located with six switches throughout the facility.	K 21			
<u>, </u>						
RM CMS-258	7(02-99) Previous Versions	Obsolete Event ID: 831121		chility (D: 922949	Splinusling ob an	