

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

PRINTED: 04/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON ST RAEFORD, NC 28376		
(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 found to be in compliance with the Medicare/Medicaid Long Term Care Regulations 42 CFR Part 483, Sub part B during a recertification and complaint investigation survey.	F 000		

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

TITLE

(X6) DATE

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

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

RECEIVED
JUN 06 2012
CONSTRUCTION SECTION
05/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____
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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON ST RAEFORD, NC 28376
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K 045 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8

This STANDARD is not met as evidenced by: 42 CFR 483.70(a).
By observation on 5/22/12 at approximately noon the following exit discharge illumination was observed as non-compliant: specific findings include no exit discharge lighting at the Alzheimer's porch exit beyond the gate. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.

K 067 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

This STANDARD is not met as evidenced by:

K 045 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. Preparation and submission of the Plan is in response to OMS-2567 and is not an admission by Autumn Care of Raeford that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law.

K 045 Installed new light on outside of the fence area and connected it to the emergency power source that will illuminate the area of egress so that it will not leave the area in darkness should current lighting fail to illuminate.

On a monthly basis for 3 months area will be monitored by the maintenance director to assure the lighting is working properly and is adequate.

The results of the monthly monitoring will be discussed monthly at a special Quality Assurance Meeting for three (3) months. If substantial compliance has been met and no further areas of concerns are identified or recommendations indicated by the Quality Assurance Committee, review of the monitoring of the lighting will be discontinued.

K 067 - Alarm company and HVAC company will review the current system

06/9/12

6/28/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jacqueline H. Ward</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/4/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined the other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 day 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 15 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: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2012
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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON ST RAEFORD, NC 28376
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K 067 Continued From page 1
42 CFR 483.70(a)
By observation on 5/22/12 at approximately noon the following Heating, Ventilating, and Air Conditioning system (HVAC) was non-compliant; specific findings include

A. The HVAC system did not shut down with fire alarm activation.

B. There was not an emergency shut down switch located at a readily observed station.

K 067 and provide an electrical connection to the fire alarm panel that will shut down with fire alarm activation. Manual switches will be analyzed by a HVAC contractor and if not operational, will be repaired so they can be activated manually.

Monthly, for three months, HVAC and switches will be monitored by the Maintenance Director for proper operation during a fire drill.

The results of the monthly monitoring will be discussed monthly at a special Quality Assurance Meeting for three (3) months. If substantial compliance has been met and no further areas of concerns are identified or recommendations indicated by the Quality Assurance Committee, review of the monitoring of the HVAC shutdown and emergency shutdown switch will be discontinued.