STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	**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 No deficiencies were cited as a result of the complaint investigation conducted on 4/10/14. Event ID # SPQG11. The 2567 was amended on 5/6/14 as follows: 1) The date of March 8, 2014 was changed to April 8, 2014 in the staff interview with Nurse #4 in F425, 2) Clinical Regional Director (CRD) was changed to Regional Director of Operations (RDO) throughout the deficiency for F258.	F 000		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide a comfortable and pleasant dinning experience for one (1) of two (2) dinning observations of a resident observed with continued yelling while being fed (Resident #169). This had the potential to affect all residents on the locked unit that were eating in the dinning room. Findings included: Resident #169's quarterly minimum data set completed on 3/18/14 indicated no cognitive pattern score. Diagnoses included dementia and anxiety. Inattention and disorganized thinking was indicated as continuously present. Behavioral symptoms not directed towards others were indicated as occurred daily which included	F 252	Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the conclusions stated on the Statement of Deficiencies. This Plan of Correction is prepared and submitted solely because of requirements under State and Federal Law. For the resident affected: According to the 2567, all residents were affected by the resident□'s yelling in the dining room on 4/7/2014. After learning of the disturbance caused by Resident #169, all residents who caused an unpleasant dining	4/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/05/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 252	Continued From page 1 "disruptive sounds." A review of the resident census for 4/7/14 revealed a census of thirty residents on the locked unit. 1. During a dinning observation on 4/7/14 at 12:09 pm, upon entering the locked unit, a resident could immediately be heard yelling loud. Upon entry into the dinning room, the room was occupied with 18 residents eating. Resident #169 was observed being fed by NA #1 yelling loudly, in the presence of the other residents that were eating. Observation on 4/7/14 at 12:10 pm Resident #169 continued prolonged yelling while been fed by NA #1 in the dinning room. Observation on 4/7/14 at 12:35 pm Resident #51 entered the dinning room and screamed out in an angry tone directed toward Resident #169 "what's the matter with you?" Resident #51 was then taken out of the dinning room to the activity room by Staff #1. Observation on 4/7/14 at 12:40 pm Resident #169 continued yelling while NA #1 continued to feed her in the dinning room. Observation on 4/7/14 at 12:48 pm Resident #119 who was sitting at the dinning room table stood up and stated "I'm tired of all that yelling" then sat back down. Observation on 4/7/14 at 12:55 pm upon completion of the meal, Resident #169 continued to scream. NA #1 transported Resident #169 via rolling chair from out of the dinning room to the	F 252	environment for the other residents were removed from the situation and taken to their room accompanied by a staff member. This directive to remove the resident from the dining room when they are causing an unpleasant environment has always been an expectation of Autumn Care of Raeford, as evidenced by NA #1 reply in the last sentence of the last paragraph of the 2567. For the residents with the potential to be affected: All residents in the facility have a potential to be affected by this kind of unpleasant dining environment. The Nurses and CNA□s on all of the halls were directed to remove residents from the dining room when they cause an unpleasant environment for the other residents dining in the room, not just on the locked unit. Measures put in place: All CNA□s and Licensed Nurses were re-educated and in-serviced, beginning on 04/10/2014 and completed on 04/18/2014, regarding the standard protocol for ensuring that all residents have a pleasant dining experience. All CNA□s and Licensed Nurses were re-educated that an environment free from disruptive yelling and screaming is essential to ensure a pleasant dining experience for all residents. CNA□s and Licensed Nurses were also re-educated that residents who caused disruptions during dining times should be removed from the situation and taken to their room accompanied by a staff member.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 252	Continued From page 2 activity room across the hallway. 2. During a second dinning observation on 4/8/14 at 12:30 pm, the dinning room on the locked unit was occupied with 17 residents eating. Resident #169 was not present in the dinning room. The dinning environment was observed to be calm and pleasant while residents ate lunch. At 12:45 pm, Resident #169 was observed in her room fed by NA #6 with no yelling. In an interview on 4/9/14 at 2:06 pm, NA #1 when questioned regarding Resident #169 stated that it was normal for the resident to yell in the dinning room while eating and throughout the day. NA #1 indicated that other residents become agitated as a result of Resident #169's yelling during meals such as "Resident #51, #99 and #100." NA #1 concluded to decrease the yelling around the other residents, Residents #169 is usually taken to her room. In an interview on 4/10/14 at 3:10 pm, accompanied by the administrator, the director of nursing stated that she expected Resident #169 to have been "removed from the dinning room from the presence of the other residents if the resident continued to yell out/scream."	F 252	Monitoring: Meals will be audited on all halls at all times to ensure a pleasant dining experience occurs. The DON, ADON, Staff Development Coordinator or Designee will observe one meal on the locked unit daily x 2 weeks. If substantial compliance is found with daily observation, the DON, ADON, Staff Development Coordinator or Designee will then observe one meal on the locked unit weekly x 4 weeks. If substantial compliance is found by weekly observation, the DON, ADON, Staff Development Coordinator, or Designee will then observe 1 meal a month in 1 of the 4 designated dining areas on-going to ensure substantial compliance in all dining areas throughout the facility. Any issues or violations of compliance will be discussed in the facilities Quarterly Quality Assurance Meeting.	
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 258		4/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 258	Continued From page 3 Based on observations, record review and staff interviews, the facility's locked unit had an alarm on the entry door that sounded multiple times throughout the day when staff or visitors entered and exited the unit, emitting a loud noise. One (1) of thirty (30) residents was observed to be reacting to the sound (Resident #153). Resident #153's quarterly minimum data set completed on 3/3/14 indicated a short and long term memory problem. Daily decision making was listed as severely impaired. Review of the resident census dated 4/8/14 and 4/9/14 revealed a census of thirty residents resided on the locked unit. A continuous observation on 4/8/14 revealed: Observation on 4/8/14 at 12:17 pm, an alarm sounded loud within the unit upon maintenance entry into the unit. Observation on 4/8/14 at 12:22 pm, an alarm sounded loud within the unit upon maintenance exit the unit. Observation on 4/8/14 at 12:26 pm, an alarm sounded loud within the unit upon house-keeping staff exit the unit. Observation on 4/8/14 at 12:27 pm, an alarm sounded loud within the unit upon house-keeping staff entry into the unit. Observation on 4/8/14 at 12:28 pm, an alarm sounded loud within the unit upon house-keeping staff exit the unit. Resident #153 was observed pacing back and forth anxiously in front of the	F 258	Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the conclusions stated on the Statement of Deficiencies. This Plan of Correction is prepared and submitted solely because of requirements under State and Federal Law. For the resident affected: Due to State Surveyor expressing concern about the alarm sounding when the door to the locked unit opened, the alarm was removed on 04/09/2014. According to the Statement of Deficiencies, Resident #153 was observed by the State Surveyor to be pacing back and forth in the hallway anxiously. As evidenced by Resident #153□s Medical Record, this behavior is a common occurrence for this resident and this behavior has continued to occur even since alarm was removed on 04/09/2014. For the residents with the potential to be affected: The alarm only rang at the nurse□s station at the center of the unit. No alarm sounded in resident rooms, dining room or day room. The behaviors of all Resident□s on the locked unit will be evaluated through observation to determine if the alarm being removed still allows the locked unit to remain safe and secure for all residents residing in the unit. Prior to the State Annual Survey that began on 04/07/2014, Autumn Care of Raeford had already eliminated all alarms in the facility except this alarm on the locked unit. All bed alarms, chair alarms	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 258	Continued From page 4 nurse's station while looking above the nurse's station on the wall where the alarm was sounding; he then proceeded to the door which was locked, looked back at the wall where the sound was coming from and proceeded down the hallway in a hurried manner. Observation on 4/8/14 at 12:31 pm, an alarm sounded loud within the unit upon a family member entry into the unit. The alarming sound continued until turned off by Nurse #1 at 12:33 pm. The family member stated "that alarm is very annoying." Observation on 4/8/14 at 12:34 pm, an alarm sounded loud within the unit upon activity staff exit the unit. Observation on 4/8/14 at 12:35 pm, an alarm sounded loud within the unit upon NA #2 entry into the unit. Observation on 4/8/14 at 12:36 pm, an alarm sounded loud within the unit upon NA #3 entry into the unit. Observation on 4/8/14 at 12:39 pm, an alarm sounded loud within the unit upon Nurse #2 entry into the unit. Observation on 4/8/14 at 12:40 pm, an alarm sounded loud within the unit upon NA #3 exit the unit. Observation on 4/8/14 at 12:41 pm, an alarm sounded loud within the unit upon family members exit the unit. A continuous observation on 4/9/14 revealed:	F 258	and personal alarms had already been eliminated through Autumn Care of Raeford□s Quality Assurance Performance Improvement Committee. The alarm to the locked unit was the only alarm in the facility and was the next alarm that would be assessed by the QAPI Committee. This alarm was the last alarm remaining due to it being a vital part of patient safety. Measures put in place: The alarm was removed on 04/09/2014. Monitoring: The locked unit will be observed daily on-going by the staff working on the locked unit to ensure no adverse consequences occur due to alarm□s absence. Any adverse consequences related to resident safety due to absence of alarm will be discussed in the Facility□s Quarterly Quality Assurance Meetings. Clarification: At the bottom of page one of F-Tag 258, State Surveyor states,"During an observation on 4/9/14 at 2:53 pm, accompanied by the administrator, director of nursing and the regional director of operations (RDO), upon entry into the locked unit an alarm sounded loud within the unit. When asked could they identify any concerns with the general environment, the alarm sound again loudly within the unit; the RDO turned in a quick manner toward the door and stated "what is that?" The administrator replied, "That is the door	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 258	Continued From page 5 Observation on 4/9/14 at 6:15 am, the alarm sounded loud within the unit upon entry into the unit. Observation on 4/9/14 at 6:25 am, an alarm sounded loud within the unit upon NA #4 exit the unit. Observation on 4/9/14 at 6:30 am, an alarm sounded loud within the unit upon NA #4 entry into the unit. Observation on 4/9/14 at 6:34 am, an alarm sounded loud within the unit upon NA #4 exit the unit. Observation on 4/9/14 at 6:35 am, an alarm sounded loud within the unit upon NA #5 exit the unit. Observation on 4/9/14 at 6:37 am, an alarm sounded loud within the unit upon Nurse #3 entry into the unit. Observation on 4/9/14 at 6:38 am, an alarm sounded loud within the unit upon Nurse #1 entry into the unit. Observation on 4/9/14 at 6:41 am, an alarm sounded loud within the unit upon Nurse #3 exit the unit. Observation on 4/9/14 at 6:45 am, an alarm sounded loud within the unit upon NA #4, NA #5 entry into the unit. Observation on 4/9/14 at 6:56 am, an alarm sounded loud within the unit upon NA #6 entry	F 258	alarm within the unit alarming." Upon entry in the locked unit, the State Surveyor stated, Tell me what you see wrong. The three Autumn Care Employees present stated they did not see anything wrong with the environment. The Regional Director of Operations asked that the State Surveyor be more specific as to what he wanted us to observe. The State Surveyor then asked, What do you hear? The Administrator then stated, I hear an alarm when someone enters or exits the locked unit. The State Surveyor then said, Okay, now let□s go back to the conference room to talk about this. At no time did any staff member ever ask "What is that?" The Regional Director of Operations has been the interim Administrator at Autumn Care of Raeford on two separate occasions and is fully aware that this alarm has sounded at the nurse□s station for over ten years.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 258	Continued From page 6	F 258		

into the unit.

Observation on 4/9/14 at 6:59 am, an alarm sounded loud within the unit upon NA #6 exit the unit.

Observation on 4/9/14 at 7:03 am, an alarm sounded loud within the unit upon maintenance entry into the unit.

Observation on 4/9/14 at 7:04 am, an alarm sounded loud within the unit upon NA #2 entry into the unit.

Observation on 4/9/14 at 7:05 am, an alarm sounded loud within the unit upon NA #8 entry into the unit.

Observation on 4/9/14 at 7:15 am, an alarm sounded loud within the unit upon maintenance exit the unit.

During an observation on 4/9/14 at 2:53 pm, accompanied by the administrator, director of nursing and the regional director of operations (RDO), upon entry into the locked unit an alarm sounded loud within the unit. When asked could they identify any concerns with the general environment, the alarm sound again loudly within the unit; the RDO turned in a quick manner toward the door and stated "what is that?" The administrator replied, "That is the door alarm within the unit alarming."

In an interview on 4/9/14 at 3:00 pm, the administrator accompanied by the director of nursing (DON) and RDO, the administrator stated "I see no concerns with the alarm sounding within the locked unit." The administrator indicated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 258	Continued From page 7 first became aware of the alarm sound within the locked unit when she became administrator on March 1, 2013. The DON concurred that she did not see a problem with the alarm sounding within the unit. The DON stated that the alarm sound within the unit "purpose" was to alert the staff that one was entering or exiting the unit and to ensure the safety of the residents. The administrator indicated that she was aware that the door alarm sounded within the unit each time the door was entered or exited by one. The administrator concluded that the "purpose" of the sounding alarm was for residents with high elopement risk - particularly residents that are ambulatory. In an interview on 4/10/14 at 3:15 pm, the maintenance director stated that the alarm had sounded within the locked unit for at least nine years since he'd been the maintenance director and that he did not know that the door alarm could be silenced or turned off.	F 258		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		4/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 425	Continued From page 8 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to store discontinued medications in a secure and separate area from the active medications per facility policy for two discharged residents (Resident #32, 120) from 2 (100/200 hall medication room and 100 hall medication cart) of 9 medication storage areas. The findings included: Review of the facility policy titled "Disposal of Medications and Medication-Related Supplies" dated June 2012 revealed "When medications are discontinued by the prescriber or the resident is discharged and medications are not sent with the resident, the medications are marked as discontinued and stored in a secure and separate area from the active medications." 1a.On 4/10/14 at 12:15 pm, an observation of the 100 hall medication cart revealed an opened bottle of Nitrostat tablets (used to treat chest pain) for Resident #120 comingled with medications of residents that were currently residing in the facility. A review of the medical record revealed Resident #120 was discharged from the facility on 4/4/14.	F 425	Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the conclusions stated on the Statement of Deficiencies. This Plan of Correction is prepared and submitted solely because of requirements under State and Federal Law. For the resident affected: Both residents affected had already expired before survey was completed. For the residents with the potential to be affected: While this deficiency does not directly affect residents, all medications of Residents who expire in the facility are to be sent back no more than three days after expiration. All medications of residents who discharge to the hospital are to be sent back to the pharmacy no more than 30 days after resident discharges to the hospital; given the resident does not return in the 30 day period. Also, all medications of residents who have either expired or discharged are to be taken out of the med carts (where the active residents medications are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 425	Continued From page 9 During an interview with Nurse #4 on 4/10/14 at 12:20 pm, she stated the medication carts should be cleaned daily and discontinued medications should be removed. The nurse further indicated Resident #120 passed away at the hospital on Tuesday, April 8, 2014. 1b.On 4/10/14 at 12:30 pm, an observation of the refrigerator in the 100/200 hall medication room revealed a bag of aspirin suppositories (30 count) for Resident #32 comingled with medications of residents that were currently residing in the facility. Review of the medical record revealed Resident #32 expired in the facility on 4/6/14. In an interview with Nurse #5 on 4/10/14 at 2:23 pm, she stated it was the responsibility of the nurses on the hall to remove the medications when the medications were discontinued or when the resident expired. During an interview on 4/10/14 at 3:05 pm, the Director of Nursing (DON) stated it was her expectation for the nurses to make sure they were following the policy and making sure discontinued medications were sent back accordingly. The DON further indicated the facility had three days to send back the medications of an expired resident. She further stated the facility could keep the medications for residents discharged to the hospital for up to 30 days.	F 425	stored) and kept in a separate place until the medications are either sent back to pharmacy or the resident re-admits to the facility. Measures put in place: All Licensed Nurses were re-educated and in-serviced, beginning on 04/10/2014 and completed on 04/18/2014, as it relates to sending medication back to pharmacy per policy. All Licensed Nurses were re-educated that it is the policy of Autumn Care of Raeford and Legacy Consultant Pharmacy to return medications of permanently discharged or expired residents within 3 days. They were educated that medications of Residents who discharge to the hospital are to be sent back within 30 days, given the Resident does not return to the facility in the 30-day period. In addition, the licensed nurses were re-educated to always remove medications of discharged or expired residents from the medication cart when active residents medications are stored. Monitoring: The DON, ADON, Staff Development Coordinator or Designee are both to check the med carts and the med rooms, including the refrigerator, for any medications that have not been returned in the time period allowed in the policy. The above named people will also check to ensure that any medications of discharged or expired residents have been removed from the medication carts where active residents medications are stored. This audit will be performed daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 425	Continued From page 10	F 425	to all med storage areas for one week. If substantial compliance is found during this audit, all medication storage rooms will be checked weekly x 3 weeks. If substantial compliance is found again, all medication storage areas will then be audited monthly on-going. Any issues or violations of compliance will also be discussed in the Facility□s Quarterly Quality Assurance Meetings.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		4/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 441	Continued From page 11 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to place a soiled brief and bed linen properly by continuing to allow the brief and linen to remain on the floor, while providing care to 1 of 1 resident observed for infection control (Resident #148). Findings included: The facility policy dated 11/1/13 in part read "personnel will handle, store and process and transport linens so as to prevent the spread of infection. Handling of linens: to reduce the risk of environmental contamination, personnel bag and/or contain contaminated linen at the point of use by placing in soiled hamper outside of resident's room." A review of the sixty-day minimum data set completed on 3/6/14 indicated that Resident #148 cognitive pattern was severely impaired. During an observation on 4/9/14 at 6:10 am, Resident #148 was heard yelling from outside the door "ouch, girl your hurting my leg." Upon announcement and entry into the room (name of	F 441	Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the conclusions stated on the Statement of Deficiencies. This Plan of Correction is prepared and submitted solely because of requirements under State and Federal Law. For the resident affected: As was explained to the State Surveyor by Nurse Aid #7, in order to keep the resident safe from harm, the Nurse Aid dropped the linen and the brief in order to stabilize the leg of Resident # 148 and keep Resident #148 from any harm. The DON, the Nursing Supervisor, the Staff Development Coordinator and Nurse Aid #7 all explained to State Surveyor that it is not the policy of Autumn Care of Raeford to place linen on the floor in a routine patient care situation. The DON also explained to State Surveyor that resident safety does come first. After linen had	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 441	Continued From page 12 room #) the resident was observed positioned on her right side facing the wall (bed was pushed completely against the wall). NA #7 was observed supporting the resident's top left leg while completing placement of a clean brief. NA #7 then turned the resident towards her, and pulled the clean fitted sheet in place at the top of the bed (against the wall). A soiled brief saturated with yellow matter, and soiled linen (sheet) with yellow matter was observed on the floor at the bottom of the bed. In an interview on 4/9/14 at 6:14 am, NA #7 when questioned why was there a soiled brief and linen observed on the floor upon entry into the room, throughout completion of a brief placement and placement of clean linen on the bed she stated "Resident #148 was about to fall before entering the room." She concluded that she normally did not place soiled linen or brief on the floor. In an interview on 4/9/14 at 6:40 am, the nursing supervisor stated that she expected the soiled brief and linen not to be placed on the floor. In an interview on 4/9/14 at 2:39 pm, the staff development coordinator stated that she expected the soiled linen and brief not to have been placed on the floor. In an interview on 4/9/14 at 3:19 pm, the director of nursing stated that she expected nursing staff to prioritize residents' care with safety being first. She concluded that she did not expect the soiled brief and linen to be placed on the floor.	F 441	been dropped on the floor to stabilize Resident #148, State Surveyor abruptly entered the closed door to the room without announcement and asked why the linen was on the floor. NA #7 explained the situation to the State Surveyor at that time. NA #7 then politely asked State Surveyor to close the door in order to give Resident #148 the right to privacy. NA #7 then proceeded to finish care on Resident #148. Once Resident #148 was dressed and able to be left alone in the bed again, NA #7 picked up dirty linen and carried it to the dirty linen basket in the hall way. For the Residents with the potential to be affected: It is the policy and practice of Autumn Care of Raeford that linen is not to be placed on the floor unless there is a situation where patient safety could be jeopardized. All CNA□s and Nurses are educated related to all infection control practices during orientation before ever working with residents in the facility. Measures put in place: All CNA□s and Licensed Nurses were re-educated and in-serviced regarding the procedure of disposing of dirty linen as it relates to infection control, beginning on 04/09/2014 and completed on 04/18/2014. Monitoring: The Administrator, DON, ADON, Staff Development Coordinator or designee will observe patient care and disposal of linen during rounds throughout the facility. One of the above named staff members will perform this observation twice a day x 1 week, ensuring that all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	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 441	Continued From page 13	F 441	shifts are audited each week. If substantial compliance is found, observations will be performed once a day x 2 weeks. If substantial compliance is found in these observations as well, one of the above named staff members will then observe patient care and the disposal of linen once a month on-going. Any issues or violations of compliance will be discussed in the Facility□s Quarterly Quality Assurance Meeting as well.	