STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MOCKSVILLE	**1007 HOWARD STREET MOCKSVILLE, NC 27028**

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide maintenance and housekeeping services necessary to maintain a safe and clean interior in three of three resident bathing rooms and failed to maintain two geriatric chairs in good condition on one of three hallways (200 hall). The findings included: 1. On 5/5/15 at 5:30PM, an observation of the bathing room on 100 hall was conducted. An area of peeling paint was noted above the sink with some of the paint missing. The area was approximately eight inches in length. Black material was noted on the grout on the floor of the shower and bathing room. Cobwebs were noted over the door of the entrance to the bathing room and cobwebs were noted on the wall over the sink. Dust was noted on the vent fan blades and on the vent fan cover. On 5/5/15 at 12:55PM, an observation of the bathing room on 400 hall was conducted and revealed the following: one ceiling light near the door of the bathing room was not working and the light cover was brown in color, one light cover over the tub was brown in color; one light near the tub had 22 bugs and white material noted in the light cover, one light cover in the shower area had 20 bugs and white material in the light cover. Black material was noted in the grout on the	F 253	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 correctness of the conclusion stated on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirements under states and federal laws. The wall in the bathroom on 100 hall has been painted. Cobwebs have been removed from the 100 hall bathing room. The black material in the grout in the bathing rooms on the 100, 200 and 400 halls have been removed. Dust has been removed from the fans and vents in the bathing rooms on the 100 and 200 halls. The lights fixtures in the 100 and 400 hall bathing room have been replaced. Geri chair arms are replaced and are inspected monthly by the Administrator or Maintenance Director to ensure that they remain in the appropriate condition. The Administrator or Maintenance Director inspects all bathing rooms weekly to ensure appropriateness of paint, dust, grout, and light fixtures for three months	6/4/15

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

Electronically Signed | 05/22/2015

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F 253	Continued From page 1 shower floor and on one wall of the shower stall. On 5/6/15 at 11:40AM, an observation of the bathing room on 100 hall revealed peeling paint approximately eight inches in length over the sink. The black material was noted on the grout on the floor of the shower and bathing room. Cobwebs over the door and sink were observed. Dust was noted on the vent fan blades and on the vent fan cover. On 5/6/15 at 1:05PM, an observation of the 200 hall bathing room was conducted and revealed black material on the grout of the bathing room floor. Dust was noted on the vent fan blades and on the vent fan cover. On 5/6/15 at 4:00PM, NA #1 stated she would write out a maintenance slip and put it in the maintenance director ' s box if she saw anything that needed to be repaired/ fixed. NA #1 stated she had not written out any requisitions for any problems noted in the 100 bathing room. On 5/6/15 at 4:30PM, a tour of the facility was conducted with Administrative staff #1 and Administrative staff #3. When the tour was conducted of the 100 hall bathing room, Administrative staff #3 stated he was aware of the peeling/ loose ceiling paint but it would take several days to do the repairs and he would have to shut down that shower. Administrative staff #1 stated they had done extensive changes/ improvements over the past year--removing carpet, replacing floors, painting, etc. and had prioritized improvements by doing resident rooms first. Administrative staff #3 stated it was housekeeping ' s responsibility to clean the bathing room, mop the floor in the bathing room	F 253	and then monthly for three additional months. Geri chairs are inspected weekly for three months and monthly for three additional months to ensure that they are kept in good repair. An audit form will be utilized to track compliance and areas that need to be addressed. The Administrator will audit these inspections weekly to ensure compliance. All staff members will be inserviced on the proper usage of Maintenance Request forms by 6/4/2015. The Administrator or Maintenance Director will report the weekly and monthly inspections to the Quality Assurance Committee monthly for six months.	

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F 253	Continued From page 2 and clean any cobwebs. He said he did not have the cleaning/ care of the bathroom fans on a schedule but it would be done. When the tour was conducted of the 400 hall bathing room, Administrative staff #3 stated it was the responsibility of the housekeeping staff to clean and mop the bathroom floor. He said he did not have the cleaning/ care of the bathroom fans on a schedule but it would be done. Administrative staff #3 said he did not have the cleaning of the light fixtures on a regular schedule and the light fixtures were cleaned when the bulbs needed to be changed. He said he was not aware that one of the lights was not working in the bathing room. Administrative staff #1 and Administrative staff #3 said they expected the bathing rooms to be clean and free of insects in the lights. When the tour of the 200 hall bathing room was conducted, Administrative staff #3 stated it was the responsibility of the housekeeping staff to clean and mop the bathroom floor. He said he did not have the cleaning/ care of the bathroom fans on a schedule but it would be done. 2. On 5/6/15 at 1:05PM, an observation of 200 hall was conducted. One geriatric chair in the hallway was noted to have both armrests cracked and in disrepair. A geriatric chair in room 202-2 was observed to have both arm rests cracked and in disrepair. On 5/6/15 at 3:25PM, Nurse #1 stated if staff saw anything that needed to be fixed, they would fill out a maintenance form and place it on the maintenance director ' s door. She stated, if she	F 253		

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F 253	Continued From page 3 saw any cracked arm rests on the geriatric chairs or wheelchairs, she would report it to the maintenance director and/or the director of nursing. Nurse #1 stated she had not observed any geriatric chairs with cracked armrests. On 5/6/15 at 4:30PM, a tour of the 200 hall was conducted. The geriatric chair in the hallway and the geriatric chair in room 202-2 was observed. Administrative staff #3 stated he had not received any requisitions to repair and/or replace the geriatric arms and would have them repaired. On 5/6/15 at 4:45PM, Administrative staff #1 stated any staff member could write a maintenance requisition and put it in the maintenance director ' s box. He stated the maintenance requisitions were always available and were located on the maintenance director's door. Administrative staff #1 said the armrests would be repaired and/or replaced.	F 253		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	F 371	F 371 It is the practice of this facility to	6/4/15

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F 371	Continued From page 4 facility failed to discard expired milk, date liquid eggs when opened, maintain a clean storage area for bread products and to have all persons entering the food preparation areas of the kitchen wear hair coverings. The findings included: 1. On 5/4/15 at 11:15 AM a jug of milk with a use by date of 4/29/15 was observed in the walk in refrigerator. Interview with the Dietary Manager at this time revealed that she had expected the milk delivery person to check all the milk when making his delivery and to discard any out of date items. She stated that the milk delivery person had already been there that morning so she was surprised he had missed this out of date jug of milk. The Dietary Manager added that she would ensure the milk was discarded. On 5/4/15 at 11:20 AM an open carton of liquid eggs was observed in the reach in dairy refrigerator. The carton was not date with the date it was opened. The Dietary Manager was interviewed at this time and acknowledged the carton should have been dated when it was opened so staff would know when it needed to be discarded. 2. On 5/6/15 at 11:55 AM the trays in the bread storage cart were observed. They had extensive areas of black greasy/dusty grime imbedded in the plastic and the edges and corners of the trays had built up dusty debris. All of the trays were being used to store loaves of bread, rolls or buns that were contained in their packaging but placed directly on the trays. The Dietary Manager was interviewed at this time. She acknowledged that the trays appeared dirty and indicated that she was unsure if and when the trays had previously been cleaned. She removed the trays and stated	F 371	store, prepare, and distribute food under sanitary conditions. The unopened gallon of milk was labeled "do not use", and was picked up by the milk distributor on 5/6/15 for facility credit. No patients were harmed by the alleged practice, as the milk was not served. The dietary manager conducted an inservice for all dietary staff on 5/7/15 regarding food/beverage expiration dates. The dietary manager or cook will use an audit form to perform audits of food expiration dates twice weekly for 1 month, then once weekly for 6 months to monitor for food storage compliance. The Administrator will review these audits to ensure compliance. Findings of audits are reported at the facility QAPI meeting by the dietary manager, with corrective action taken as needed. F371 The open carton of pasteurized eggs was discarded on 5/4/15 when discovered in the dairy refrigerator. No patients were harmed by this alleged practice. The dietary manager conducted an inservice with all dietary staff on 5/7/15 regarding the facility policy on labeling and dating open food containers. The dietary manager or cook uses an audit form to perform audits of food storage, including monitoring for labeling and dating, in all refrigerators twice weekly for 1 month, then weekly for 6 months to assure food storage compliance. The Administrator will review these audits to ensure compliance. Findings of audits are reported at the facility QAPI meeting by the dietary manager, with corrective action	

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F 371	Continued From page 5 that she would have the Maintenance Director pressure wash them. On 5/7/15 at 9:45 AM the Dietary Manager was interviewed. She revealed that the bread cart trays had been washed but that the built up grime that was on the trays had not come off, although the loose debris was gone. At this time, the built up grime was observed to flake off when scraped. The Dietary Manager added that the trays would be replaced. 3. On 5/6/15 at 11:45 dietary staff were observed getting food items onto the steam table and observed getting other food and beverage service items ready for the lunch tray line. At this time Non-dietary Staff Member #1 walked into the kitchen without a hairnet on. She came into the kitchen about as far as the steam table before being redirected by the Dietary Manager that she was not supposed to be in the kitchen. On 5/6/15 at 11:50 Non-dietary Staff Member #2 came into the kitchen without a hair net on. She came into the kitchen about as far as the steam table before being redirected to wait at the entrance to ask for what she wanted. Non-dietary Staff Member #2 then said that she had just wanted to get herself a fork. The forks were observed on the far side of the steam table. On 5/7/15 at 9:45 AM the Dietary Manager was interviewed. She acknowledged that on 5/6/15 she had redirected 2 non-dietary staff members from the kitchen area and that neither of them were wearing hair nets. She said that non-dietary staff were not allowed in the kitchen but all she could do was redirect them. The Dietary Manager also acknowledged that the 2	F 371	taken as needed. F371 The bread racks were sanitized by facility employees on 5/6/15. No patients were harmed by this alleged practice. The dietary manager contacted the bread distributor to replace the bread rack with new ones. Routine cleaning of the bread rack is scheduled to be done monthly and as needed by the dietary cooks or aides. The dietary manager or cook audits the cleanliness of the bread rack twice a month for 3 months using an audit form. The Administrator will review the audits to ensure completion. Finding of audits are reported at the facility QA meeting by the Dietary Manager, with corrective action taken as needed. F371 It is facility policy that only dietary employees are allowed in the kitchen. Visitors and other employees are met at the door by dietary employees to respond to their requests. No patients were harmed by the alleged practice. The dietary manager inserviced all facility staff about the policy on traffic in the kitchen by 6-4-15. The dietary manager or cook audits the kitchen for unauthorized persons not wearing a hair net on a daily basis. Dietary Manager reports findings of the audits to the facility QA committee meeting, with corrective action taken as needed.	

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F 371	Continued From page 6 non-dietary staff members that entered the kitchen did not hesitate in doing so. The non-dietary staff were not interviewed.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interviews, the facility failed to act upon the pharmacist ' s recommendation for a gradual dose reduction of the antipsychotic medication Seroquel for one of five residents (resident #11) reviewed for unnecessary medications. The findings included: Resident #11 was admitted to the facility on 5/14/14 with multiple diagnoses including bipolar disorder, hallucinations, acute paranoid reaction, depression and anxiety. A review of the Annual Minimum Data (MDS) Set dated 4/21/15 revealed the resident was assessed with the use of an antipsychotic medication.	F 428	The gradual dose reduction for resident #11 was addressed by physician on 5/19/2015. The nurse practitioner will be re-educated on the gradual dose reduction regulations by 5/29/2015 by the Director of Nursing or Assistant Director of Nursing. An audit of all residents receiving anti-psychotics was performed by the Director of Nursing on 5/20/2015 to ensure that all recommendations were addressed. All recommendations had been addressed. Pharmacist recommendations for reductions of anti-psychotics will be reviewed monthly by the Director of	6/4/15

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F 428	Continued From page 7 A review of the physician ' s orders revealed an order dated 9/30/14 which stated " Seroquel 25 milligrams (mg) by mouth twice a day (bid): Hallucinations. " The pharmacy Note to Attending Physician/Prescriber dated 3/19/15 stated " This resident has taken antipsychotic-Seroquel 25 mg bid -since 9/30/14 with history of hallucinations. MDS of 1/15 indicates no hallucinations, delusions or behavioral symptoms. Would the resident be a candidate for a trial reduction to Seroquel 25 mg every night without significant risk? " The note was marked no and signed by the Nurse Practitioner (NP) on 3/19/15. There was no written explanation for the rejection of the trial reduction of Seroquel. An interview was conducted with Nurse Practitioner #1 on 5/6/15 at 3:22 PM. She stated when a resident was being treated by a psychiatric service, she would always decline a pharmacist ' s recommendation for a gradual dose reduction of an antipsychotic medication. She stated she would not adjust the dosage of an antipsychotic medication when the resident was being treated by a psychiatric service. An interview was conducted with Administrative Staff #2 on 5/6/15 at 3:50 PM. She stated that resident #11 was being treated by a psychiatric counselor. The resident ' s attending physician was responsible for managing her antipsychotic medications. She stated she was not aware that Nurse Practitioner #1 did not act upon the pharmacist ' s recommendation for a gradual dose reduction of an antipsychotic medication when the resident was being treated by a psychiatric service.	F 428	Nursing and will complete an audit form to ensure proper follow up of the pharmacist recommendations. The Director of Nursing or Assistant Director of Nursing will report the results of the audits to the QA Committee monthly for three months and then quarterly for two quarters for a total of three quarters to ensure compliance.	

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F 428	Continued From page 8 An interview was conducted with Physician #1 on 5/7/15 at 1:20 PM. The physician stated he was the resident ' s attending physician during March of 2015. He stated he was not made aware of the pharmacist ' s recommendation for the trial dose reduction of Seroquel for resident #11 on 3/19/15. He stated Nurse Practitioner #1 was within her scope of practice to accept or reject the recommendation for the trial dose reduction of Seroquel. Physician #1 stated Nurse Practitioner #1 failed to act upon the pharmacist ' s recommendation for a gradual dose reduction of Seroquel.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		6/4/15

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F 431	Continued From page 9 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on review of the manufacturer's specification, observation and staff interview, the facility failed to date the symbicort inhaler and the xopenex (levalbuterol) inhalation (drugs used to treat asthma and chronic obstructive pulmonary disease) on 3 (400 hall medication cart and 200 hall medication cart #1 and cart #2) of 5 medication carts observed. Findings included: The manufacturer's specification for symbicort read in part "expire three months after foil package opened. " The manufacturer's specification for xopenex read in part "store unused vials in the foil pouch and discard all unused vials in two weeks after the pouch is opened. " 1. On 5/7/15 at 10:10 AM, the 400 hall medication cart was observed. There was a used symbicort inhaler observed with no date of opening. On 5/7/15 at 10:15 AM, Nurse #2 was	F 431	The symbicort inhaler and xopenex nebulizer treatments were returned to the pharmacy and replaced. All medication carts were checked and a 100% audit of inhalers and nebulizers was completed on 5/8/2015 by the Director of Nursing and again on 5/21/2015 by the Director of Nursing and all are now in compliance. Nursing staff will be inserviced by the Director of Nursing by 5/28/2015 on proper medication storage. The Director of Nursing or her designee will audit 100% of inhalers and nebulizer treatments weekly for eight weeks and then monthly for three months to ensure compliance. The Direct of Nursing or her designee will be responsible for reporting these results to the Quality Assurance Committee.	

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F 431	Continued From page 10 interviewed. She acknowledged that the symbicort was already opened and was not dated. She indicated that it should have been dated when opened and she will discard it. On 5/7/15 at 11:05 AM, administrative staff #2 was interviewed. She stated that her expectation was for the nurses to date the symbicort when opened. 2. On 5/7/15 at 10:35 AM, the 200 hall medication cart #1 was observed. There was an opened foil pouch of xopenex with nine vials observed with no date of opening. On 5/7/15 at 10:40 AM, Nurse #3 was interviewed. She acknowledged that the xopenex foil pouch was opened and was not dated. She stated that it should have been dated when opened. On 5/7/15 at 11:05 AM, administrative staff #2 was interviewed. She stated that her expectation was for the nurses to date the xopenex when opened. 3. On 5/7/15 at 10:37 AM, the 200 hall medication cart #2 was observed. There was a used symbicort inhaler observed with no date of opening. On 5/7/15 at 10:40 AM, Nurse #3 was interviewed. She acknowledged that the symbicort inhaler was opened and was not dated. She stated that it should have been dated when	F 431		

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F 431	Continued From page 11 opened. On 5/7/15 at 11:05 AM, administrative staff #2 was interviewed. She stated that her expectation was for the nurses to date the symbicort when opened.	F 431		