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 02/22/2018

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AUTUMN CARE OF RAEFORD	1206 N FULTON STREET 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to place a call bell within reach during 4 observations for two days for 1 of 8 residents (Resident #94). Findings included: Resident #94 was admitted to the facility on 2/19/14. Diagnoses included, in part, dysphagia (difficulty speaking), cerebral palsy, epilepsy and scoliosis, lack of coordination, urinary incontinence, and pain. The Minimum Data Set (MDS) quarterly assessment dated 01/30/18 revealed the resident was cognitively aware. Resident #94 required total dependence with the assistance of one to two staff members with bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing. Resident #94 had no impairments, used a wheelchair, and was always incontinent of bladder and frequently incontinent of bowel. A review of the Care Area Assessment dated 10/31/17 revealed Resident #94 triggered for Activities of Daily Living (ADLs). A care plan dated 01/30/18 revealed a plan of care for self-care deficit for ADL care with an	F 558	The call bell for Resident #94 was double clipped to the mattress at an appropriately identified location on the bed to ensure that it would not fall out of reach. The corrective action plan as demonstrated and agreed upon by the resident. Nursing staff will be re-educated on ensuring resident #94's call bell is double clipped in an appropriate location to stay within reach as well as re-educated in keeping all call bells within reach. Education will be completed by the Staff Development Coordinator by 3/15/2018. Call Bell Placement audits will be conducted 5 days a week by the DON and/or designee(s) for 6 weeks, then 3 days a week for 6 weeks to ensure that call bells remain accessible to each resident. Immediate intervention will be make if call bell is found out of reach. The Director of Nursing will review the audits weekly and the results of the audits will be reviewed in QAPI each month for three months to ensure ongoing compliance.	3/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 03/12/2018

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

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F 558	Continued From page 1	F 558		

intervention to include to keep call bell within reach.

An observation of Resident #94 on 02/18/18 at 12:00 pm, revealed the resident's call bell was a flat disc shaped call bell. It was noted to be on the floor beside the bed. The resident was unable to extend her arms to pick things up off the floor and her hands were contracted due to her disease process of Cerebral Palsy. The resident was noted to have difficulty with speaking (dysphagia) and spoke in a soft and garbled voice.

An interview with Resident #94 on 02/18/18 at 12:00 pm, revealed the resident was unable to extend her arms to pick items up off the floor. The resident reported she had to wait for a staff member to come into her room if she needed any help.

An observation of Resident #94 on 02/18/18 at 1:45 pm, revealed the resident's call bell was tied to the bar of the left side rail on Resident #94's bed.

An interview with Resident #94 on 02/18/18 at 1:45 pm, revealed a staff member must have come in while she was sleeping and tied it to the bed. Resident #94 attempted to demonstrate reaching for the call bell on the side rail. Resident #94 was unable to reach the call bell.

An observation of Resident #94 on 02/19/18 at 9:00 am, revealed the call bell was clipped to the resident ' s left upper shoulder on her hospital gown.

An interview with Resident #94 on 02/19/18 at

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F 558	Continued From page 2 9:00 am was conducted. Resident #94 was asked to demonstrate if she could reach the call bell to her left shoulder. Resident #94 stated she was unable to and stated the call bell needed to be down by her side so she could reach it with her hand. Resident #94 stated she has told staff that she needed the call bell down by her side. An observation of Resident #94 on 02/19/18 at 11:45 am, revealed the call bell was placed under the resident's pillow at the head of the bed. An interview with Resident #94 was conducted on 02/18/18 at 11:45 am. Resident #94 demonstrated she was unable to reach the call bell behind her pillow. Resident #94 reported she was not able to get her call bell if it was on the floor, tied to the side of the bed, or under the pillow. The resident stated it needed to be down by her left side so she could use it. The resident stated it was often out of her reach or it would fall on the floor. Resident #94 stated she has told the staff the call light needed to be down by her side. An interview with Nurse #1 on 02/19/18 at 2:30 pm was conducted. Nurse #1 confirmed if the call bell was on the floor, tied to left side of the bed and hanging down, pinned to her shoulders or tucked under the pillow, the resident would be unable to reach her call light. Nurse #1 reported the resident needed her call bell within reach at all times in order to let her needs known to the staff. Nurse #1 stated the call bell should down by the side of her hand so that she could reach it all times. Nurse #1 observed the call bell behind Resident #94 ' s pillow and moved the call bell to her side at this time. An interview was conducted with the Director of	F 558		

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F 558	Continued From page 3 Nursing (DON) on 02/22/18 at 4:45 pm. The DON reported her expectation was that the call bell be within reach at all times.	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to revise a care plan for 1 of 3 residents (Resident #58) reviewed to	F 657	The MDS nurse along with the interdisciplinary team updated the care plan for resident #58 to reflect current,	3/15/18

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F 657	Continued From page 4 reflect the care of pressure ulcers which were facility acquired. Findings included: Resident #58 was admitted to the facility on 09/29/17. Diagnoses included, in part, Alzheimer's, anxiety and protein calorie malnutrition. The Minimum Data Set (MDS) dated 01/06/18 revealed the resident was severely cognitively impaired. Resident #58 had one or more unhealed pressure ulcers at stage 1 or higher, was at risk for developing pressure ulcers, and had 3 unstageable pressure ulcers. Resident #58 was not admitted with any pressure ulcers. A review of the care plans revealed there was no current care plan to reflect pressure ulcers to the bilateral heels which started on 10/09/18, and there was no care plan in place to reflect a pressure ulcer that started on 02/19/18 to the left knee. A record review of the physician orders revealed there were wound treatment orders in place to treat the right heel which was an unstageable pressure ulcer, the left heel which was a stage 3 pressure ulcer and the right knee pressure ulcer. A review of a physician ' s order revealed an order written on 10/09/18 to float heels while in bed. An observation of Resident #58 on 02/18/18 at 11:30 am, revealed a confused and pleasant resident lying in bed. She was noted to have bilateral dressings in place to her lower	F 657	accurate diagnosis and interventions to include actual skin impairment and interventions for wound care management. It was identified the care plan did not reflect current information due to nursed failure to update care plan immediately following change in skin condition. All residents with pressure ulcers according to resident skin assessments were reviewed and updated by the MDS nurse on 2/222/2018 with proper interventions in place. All nurses will receive education on updating care plans upon any change in resident's condition by the Staff Development Coordinator by 3/15/2018. An audit will be completed of resident's care plans with new or existing wounds weekly by the DON or designee for 12 weeks. Audits will be reviewed in risk meeting weekly and monthly in QAPI to ensure ongoing compliance.	

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F 657	Continued From page 5 extremities with both feet lying flat on the bed. Her legs were bare and her right leg was contracted and pressed on the left knee. There was no pillow or cushion noted between her contracted legs. An interview was conducted with the MDS/Care Plan nurse on 02/20/18 at 3:30 pm. The nurse stated there was a care plan in place for at risk for alteration in skin integrity, but the Director of Nursing (DON) told her she needed to have an updated care plan to reflect the resident had actual pressure ulcers. The nurse stated she had no knowledge of an intervention to include floating heels or any new interventions to prevent further skin breakdown. The nurse stated when the care plan was updated, the system automatically updated the Kardex which was a tool the nursing assistants used to know how to take care of the resident. The nurse indicated she would go to the clinical meeting each morning and learn of any new diagnoses or concerns on each resident and she would then update the care plan. The nurse stated she was not aware of any new orders for Resident #58 pertaining to pressure ulcers. A review of the Kardex with the MDS/Care Plan nurse revealed the resident had no information regarding floating heels. An interview was conducted with the DON on 02/22/18 at 4:30 pm. The DON reported she expected care plans and the Kardex to be updated to reflect the care that was being provided for the resident.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		3/15/18

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F 658	Continued From page 6 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow a physician's order for the placement of an ankle elopement prevention device for 1 of 3 residents reviewed for elopement devices (Resident #69). The findings included: Resident #69 was admitted to the facility's locked memory unit on 04/20/16 with diagnoses which included dementia, major depression, Schizophrenia, mood disorder, and Alzheimer's. A Minimum Data Set (MDS) dated 02/2/18 indicated the resident had moderate to severe cognitive impairments. A review of Resident #69's medical record revealed a physician order dated 01/22/17 for a warguard-check placement every shift, day, evening, and night. An observation on 02/18/18 at 5:00 PM with Nurse #6 revealed Resident #69 he did not have a wanderguard in place. An interview on 02/18/18 at 5:03 PM with Nurse #6 revealed Resident #69 did not have on his wanderguard, and should have had one on per order. She stated she did not check the resident for wanderguard placement prior to 5:00 PM. She said the last time she checked Resident #69 for a wanderguard was last Friday. She stated	F 658	All residents with an order for a wanderguard had a medical record audit on 2/23/2018 to include: order, placement, care plan and function. The MAR was audited for each resident by the DON and the audit revealed accuracy regarding such orders. The nurse for resident #69 failed to document accuracy of placement of wanderguard in the resident record. DON reviewed all orders to compile a current list of devices including wanderguards. Nursing staff will be re-educated on documentation and following physician orders by Staff Development Coordinator by 3/15/2018. Current device list will be audited 5 days a week for 6 weeks, then 3 days a week for 6 weeks by the DON and/or designee to ensure accuracy in documentation as it relates to physician orders. The device list will be updated weekly in risk meeting. Audits will be reviewed in risk meeting weekly and in QAPI meeting monthly for three months to ensure ongoing compliance.	

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F 658	Continued From page 7 she did not know where his wanderguard was or how it came off. The nurse said she would immediately go and find a new one. The nurse checked the orders and verified there was an active wanderguard order, and then said she was going to go find another wanderguard for the Resident #69. An hour later Nurse #6 returned and stated Resident #69's order for a wanderguard was just discontinued per physician order dated 02/18/18 at 6:08 PM. The nurse and Administrator said later that the resident did not need a wanderguard since he was in a locked memory unit. An interview on 02/21/18 at 11:11 AM with Medical Director revealed that Resident #69 should have had on his ordered (order date of 01/22/18) wanderguard on 02/18/18 at 5:00 PM, and did not. The Medical Doctor (MD) said the facility should follow a MD order. During an interview with the facility Director of Nursing (DON) on 01/22/18 at 9:20 AM., the DON indicated that it was her expectation that Resident #69's wanderguard should have been checked for placement during each shift by the nurse per physician order, and did not. She stated the nursing staff was supposed to check all wanderguards per shift for function and placement. During an interview with the facility Administrator on 01/22/18 at 9:30 AM., the Administrator indicated that it was his expectation that all wanderguard orders be followed by nursing staff, and were not on 02/18/18 by Nurse #6.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		3/15/18

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F 677	Continued From page 8	F 677		
	§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide incontinent care and failed to trim long fingernails for 1 of 1 dependent residents (Resident #39) whose care was observed. Findings included: Review of Resident #39's medical record revealed an initial admission date of 12/20/13 and diagnoses of left and right hand contractures, dysphagia and anxiety disorder. Review of Resident #39's quarterly Minimum Data Set (MDS) dated 12/31/17 revealed Resident #39 was readmitted to the facility on 02/23/17 and was totally dependent on staff for bed mobility, hygiene, dressing and eating. Resident #39 was always incontinent of bladder and frequently incontinent of bowel. Resident #39 did not reject care and had functional limitations in Range of Motion (ROM) on the upper extremities. Review of the Care Plan updated 01/02/18 revealed Resident #39 was at risk for skin breakdown related to incontinence of bowel and bladder and hand contractures. Interventions included to keep Resident #39 clean and dry, provide adequate pericare, to monitor for skin breakdown and to place hand rolls to both hands every shift for contractures. Review of the February 2018 Physician Orders		CNA assigned to the area failed to provide timely care to resident #39 due to inability to prioritize resident care. Nurse assigned to the resident provided nail care and ensured incontinence care was provided. Nursing staff will be re-educated by the Staff Development Coordinator on person care and hygiene by 3/15/2018. DON and/or designee will audit hygiene and personal care of all residents 5 days a week for 6 weeks, then 3 days a week for 6 weeks. Audits will be reviewed in the QAPI meeting for months to ensure ongoing compliance.	

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revealed an order for hand rolls to be placed in the palms of Resident #39's hands every shift.

In an observation on 02/18/18 at 11:55 AM Resident #39 did not have hand rolls in the palms of her hands and the fingernails in her contracted hands were long.

In an observation on 02/19/18 at 12:25 PM Resident #39 did not have hand rolls in the palms of her hands. Her fingernails were still untrimmed.

In an observation on 02/19/18 at 4:05 PM Resident #39 had a hand roll in her left hand. Her fingernails were still untrimmed.

In an observation on 02/20/18 at 8:44 AM Resident #39 did not have hand rolls in place and her fingernails were still untrimmed.

In an observation on 02/20/18 at 10:47 AM Resident #39 did not have hand rolls in place. NA #1 was able to open Resident #39's hands slightly and indentations from her long nails were seen on the palms of both hands.

In an observation and interview on 02/20/18 at 12:05 PM NA #1 was providing morning care to Resident #39. There was a strong smell of urine in the room. Resident #39's brief had been removed and thrown in the trash. The bottom bed sheet was wet with urine. Resident #39 had rolled up washcloths in both her hands and her fingernails had been trimmed. NA #1 stated incontinence rounds should be completed every two hours and residents changed at that time if wet or soiled. She indicated that this was the first time she had been able to provide care to

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F 677	Continued From page 10	F 677		

Resident #39 that day. She stated she usually worked second shift on an as needed basis and that she had been busy getting other residents up and that she just went down the line and provided care to each resident. NA #1 stated Nurse #12 had placed the hand rolls in Resident #39's hands after the nurse had trimmed her fingernails.

In an interview on 02/20/18 at 2:20 PM Nurse #12 stated she had seen Resident #39's long fingernails and had trimmed them. Nurse #12 stated aides could and should trim resident fingernails during care rounds. She stated she saw the indentations in Resident #39's palms caused by the long fingernails when she trimmed them and that Resident 39's fingernails should have been trimmed before they grew so long. She indicated incontinence rounds should be conducted every two hours and that she was unaware NA #1 had been unable to conduct her rounds. She stated residents should not be left wet or soiled for long periods of time.

In an interview on 02/21/18 at 3:37 PM NA #14 stated that day shift aides usually checked resident's fingernails during their baths but that fingernail care could be done by aides or nurses on any shift.

In an interview on 02/22/18 at 10:25 AM NA #15 indicated when she provided morning care it consisted of bathing, dressing, and providing mouth, hair and fingernail care to residents. She stated if fingernails left marks in a resident's palm that the fingernails were too long.

In an interview on 02/22/18 at 11:40 AM the Director of Nursing (DON) stated it was her expectation that incontinence rounds be

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F 677	Continued From page 11 conducted at least every two hours and more often if needed. She indicated residents should not go multiple hours without being checked and should not be left wet or soiled. She indicated it was her expectation that the NAs perform routine fingernail care and that fingernails should never be allowed to grow so long as to create indentations in the palms of the hands.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to; a) follow the prescribed physician orders for wound treatment and an order to prevent wounds from worsening and, b) failed to prevent an avoidable pressure ulcer on 1 of 3 residents (Resident #58) observed for pressure ulcers. Findings included: Resident #58 was admitted to the facility on	F 686	The facility failed to provide ordered care to resident #58 as well as having appropriate interventions in place to prevent new or worsening wounds. Nurse contacted provider to clarify orders, updated orders in EMR and care plan. Interventions were put into place to prevent new or worsening pressure ulcers for resident #58 and updated in the care plan.	3/15/18

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F 686 Continued From page 12

09/29/17. Diagnoses included, in part, Alzheimer's, anxiety and protein calorie malnutrition.

The Minimum Data Set (MDS) dated 01/6/18 revealed the resident was severely cognitively impaired. Resident #58 had one or more unhealed pressure ulcers at stage 1 or higher, was at risk for developing pressure ulcers, and had 3 unstageable pressure ulcers. Resident #58 had a pressure reducing mattress. Resident #58 was not admitted to the facility with any pressure ulcers.

A review of the care plans revealed there was no current care plan to reflect pressure ulcers to the bilateral heels which started on 10/09/18, and there was no care plan in place to reflect a pressure ulcer that started on 02/19/18 to the left knee.

a) A review of a physician ' s order written on 10/09/17 revealed to float heels while in bed.

A review of the weekly measurements from 01/03/18 - 02/12/18 for the right heel revealed the following measurements:

01/03/18 Length/Width/Depth 4.0cm X 4.0cm X 0.1cm
01/08/18 Length/Width/Depth 5.0cm X 4.5cm X 0.1cm
01/15/18 Length/Width/Depth 4.8cm X 4.5cm X 0.3cm
01/24/18 Length/Width/Depth 4.6cm X 4.7cm X 0.2cm
01/31/18 Length/Width/Depth 4.0cm X 4.8cm X 1.1cm
02/05/18 Length/Width/Depth 5.2cm X 4.7cm

F 686

Nursing staff will be re-educated by the Staff Development Coordinator on identifying residents at risk for pressures ulcers using the Braden Scale Pressure Ulcer Assessment tool, updating the care plan to reflect changes and potential for changes in resident's condition, entering orders accurately and ensuring that residents at risk for pressure ulcers have appropriate interventions in place to prevent new or worsening wounds by 3/15/2018.

Clinical team will meet weekly in risk meeting to review and audit residents at risk for or having pressure areas based on the nurse's Braden Scale Assessments. Team will ensure that each identified resident has appropriate care plan and interventions in place to help prevent new or worsening pressure areas.

The audits will be reviewed in the QAPI meeting monthly for three months to ensure ongoing compliance.

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X 1.1cm
02/12/18 Length/Width/Depth 6.2cm X 5.9cm X 0.8cm

A review of the physician ' s order written on 02/01/18 revealed an order to cleanse the right heel with Dakin ' s solution, apply gauze soaked Dakin ' s solution dressing to the right heel and cover with a dry dressing daily and as needed.

A review of the physician ' s order written on 02/12/18 revealed to apply mupirocin ointment 2% (a topical antibiotic) to the right heel topically and cover with a dry dressing daily and as needed.

An observation of Resident #58 on 02/18/18 at 11:30 am revealed a confused and pleasant resident lying in bed. She was noted to have bilateral dressings in place to her lower extremities with both feet lying flat on the bed. Her legs were bare and her right leg was contracted and positioned on the left knee. There was no pillow or cushion noted between her contracted legs.

An observation of Resident #58 on 02/18/18 at 4:00 pm revealed a confused and pleasant resident lying in bed. She was noted to have bilateral dressings in place to her lower extremities with both feet lying flat on the bed. Her legs were bare and her right leg was contracted and positioned on the left knee. There was no pillow or cushion noted between her contracted legs.

An observation of Resident #58 on 02/19/18 at 11:30 am revealed a confused and pleasant resident lying in bed. She was noted to have

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bilateral dressings in place to her lower extremities with both feet lying flat on the bed. Her legs were bare and her right leg was contracted and positioned on the left knee. There was no pillow or cushion noted between her contracted legs.

An observation of Resident #58 on 02/19/18 at 3:30 pm revealed a confused and pleasant resident lying in bed. She was noted to have bilateral dressings in place to her lower extremities with both feet lying flat on the bed. Her legs were bare and her right leg was contracted and positioned on the left knee. There was no pillow or cushion noted between her contracted legs.

An interview was conducted with Nursing Assistant (NA) #1 on 02/20/18 at 8:45 am. NA #1 stated Resident #58 had some wounds to her heels and she thought she may have had some redness to her knees. NA #1 stated if she identified any new skin concerns, she would notify the nurse. NA #1 indicated she cared for Resident #58 by turning and repositioning her every 2 hours and kept her lower extremities elevated and floated while she was in bed. NA #1 stated Resident #58 used to wear an off loading boot, but she did not think she wore one anymore. NA #1 stated she was about to get Resident #58 out of bed so her heels were not floated at this time. NA #1 could not recall if they were floated at the start of her shift.

An interview with Nurse #4 regarding wound care treatment for Resident #58 was conducted on 02/20/18 at 9:10 am. Nurse #4 pointed out on the computer that although the treatment for the mupirocin ointment was not written with the order

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for the Dakin ' s solution, it was supposed to be applied at the time of the dressing change. The following orders were reviewed prior to the treatment with Nurse #4:

1) Cleanse right heel with Dakin ' s solution, apply gauze soaked Dakin ' s solution, and cover with a dry dressing.
2) Mupirocin Ointment 2% apply to right heel daily.

An observation of the wound care was conducted on 02/20/18 at 9:15 am. Upon entering Resident #58 ' s room, the nurse knocked on the door and proceeded to inform the resident that she needed to change her dressings. The resident was noted be alert and pleasant and lying in bed with dressings to her bilateral feet. Resident #58 ' s feet were lying flat on the bed. Nurse #4 prepared her clean field, she removed the dated dressing (02/19/18) from the right foot. Resident #58 was screaming at the nurse while she was removing it, yelling "OW" and cursing at the nurse. The dressing was saturated with a scant amount of bloody drainage noted. The right heel was noted to have a large open area on the heel with granulated tissue and the edges were noted to be necrotic (dead tissue). Nurse #4 cleansed the area with Dakin ' s solution and left the soaked Dakin ' s dressing on the heel for a short time. Resident #58 continued to curse and scream out. Nurse #4 spoke with a soft voice and responded to Resident #58 stating she was sorry and she was almost done. Nurse #4 then removed the Dakin ' s gauze and applied the 4 X 4 gauze with the mupirocin ointment on it to the right heel and proceeded to wrap the heel in a dry dressing. At this time, the nurse was asked if this was the correct order. Nurse #4 replied and

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stated leaving the Dakin ' s soaked gauze dressing to the heel was no longer the order, and that the Nurse Practioner had changed the order after the wound was cultured and Resident #58 was started on the antibiotic treatment. Nurse #4 stated we just cleanse with Dakin ' s solution and apply mupirocin ointment and cover with a dressing.

An interview was conducted with Nurse #4 at 9:40 am. Nurse #4 indicated the order for the right heel was changed to discontinue leaving the Dakin ' s solution on the right heel after the wound was cultured and Resident #58 was started on an antibiotic. Nurse #4 confirmed the way the order was written was to leave the Dakin ' s solution in place and cover with dry dressing. Nurse #4 also added the order for the Mupirocin ointment 2% was confusing and that it should have been with the right heel treatment order and not written as a separate order. Nurse #4 stated she was on vacation for 4 days and the way the order was written was probably the way the staff nurses were doing the dressing as they were not aware of the Dakin ' s soaked gauze to be discontinued. Nurse #4 stated it was the wrong order and changed the order in the computer at this time. Nurse #4 stated the resident was always crying out whenever she changed the dressing. Nurse #4 stated it was hard to tell if she was in pain or a behavior. Nurse #4 stated she never medicated the resident prior to any pressure ulcer treatment changes. Additionally, she reported the wound to her heel had been slow to improve despite the wound supplements and adequate oral nutrition. Nurse #4 stated the last time the wound to the right heel was measured on 02/12/18 it had increased in size. Nurse #4 stated her heels were to be floated

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F 686	Continued From page 17 anytime she was in bed and confirmed that they were not floated upon entering the room to begin the treatment. Nurse #4 stated she had off-loading boots but those were discontinued back in January, 2018 to alleviate additional pressure but her heels should be floated at all times up on a pillow or wedge. An interview was conducted with Nurse #3 on 02/20/18 at 10:00 am. Nurse #3 stated the resident was on wound healing supplements including Prostat 30 milliliters twice per day, Stress plus Zinc tablet daily and Resource 2.0 four times per day. Nurse #3 reported the resident had an order to keep heels floated as well. Nurse #3 stated the resident had a good appetite and ate about 75 - 100% of most meals most of the time, but on occasion, may have about 50%. Nurse #3 stated Resident #58 was compliant with her resource supplement as well as all her medications. Nurse #3 stated Resident #58 had orders for pain medications to be given as needed for pain. Nurse #3 stated according to the Medication Administration Record (MAR), she had never received any thing for pain since her admission on 09/29/18. Nurse #3 reported she had no knowledge that Resident #58 ' s heels were not floated and stated, again, "She had an order to float her heels, so her heels should be floated." An interview was conducted with the Wound Care Nurse Practioner (NP) on 02/21/18 at 4:45 pm. The NP stated the order for Resident #58 ' s right heel treatment should be cleansed with Dakin ' s solution, apply mupirocin ointment, cover with Dakin ' s soaked gauze and cover with dry dressing. The NP stated she did not know why Nurse #4 thought the Dakin ' s soaked gauze	F 686		

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order was discontinued and stated she must have misunderstood her and the order got lost in translation. The NP reported her expectation of Nurse #4 would have been to clarify the order with her before making any changes to the existing order. The NP stated the resident ' s heels should be floated to prevent worsening and confirmed she discontinued the off-loading boots.

An interview was conducted with the facility physician on 02/22/18 at 9:30 am. The facility physician reported Resident #58 was doing well, she had no behaviors and confirmed she had wounds to her heels. The physician stated the resident ' s heels should be floated.

An interview was conducted with the Director of Nursing (DON) on 02/22/18 at 4:30 pm. The DON stated her expectation of the nurses was to follow the orders as they were written and to call the Nurse Practioner or the Physician if they needed clarification.

b) A review of the physician ' s order written on 02/18/18 revealed to cleanse the left knee with normal saline, apply medi-honey and cover with padded dressing daily.

An interview was conducted with Nursing Assistant (NA) #1 on 02/20/18 at 8:45 am. NA #1 stated Resident #58 had some wounds to her heels and she thought she may have had some redness to her knees. NA #1 stated she would put a wedge or a pillow between her legs because she was contracted and her right leg would lay on the left knee. NA #1 searched the room for an extra pillow or the wedge to apply on the resident. NA #1 was unable to locate either one and stated she should have something

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F 686	Continued From page 19 between her legs. An interview with Nurse #4 regarding wound care treatment for Resident #58 was conducted on 02/20/18 at 9:10 am. Nurse #4 indicated Resident #58 had a new pressure ulcer and a new treatment was in place for her left knee. An observation of wound care treatment was conducted with Nurse #4 on 02/20/18 at 9:10 am. Nurse #4 began to remove the dated dressing on Resident #58 ' s left knee. Resident #58 was noted to have bare legs, and a thin fitted sheet in between her legs. Nurse #4 began to separate the contracted right leg to get access to the left knee. Resident #58 screamed "OWWW" all the while the nurse was trying to gain access to the left knee. Resident #58 cursed and grimaced and showed signs of pain during this treatment change. Nurse #4 continued to tell the Resident she was sorry and she was almost done. Nurse #4 stated she always screamed out during the dressing change and stated she did not pre medicate her. Nurse #4 removed the dated dressing (2/19/18) from the left knee, the open area to the knee was noted to be located on a boney prominence. The area was noted to have slough on the wound bed and redness around the wound. The area was cleansed with normal saline, medi honey was applied and it was covered with a padded dressing. Resident #58 continued to scream while the treatment was being done. Nurse #4 placed a blanket she found in the resident ' s closet between her legs and floated her bilateral heels on a pillow. An interview was conducted with Nurse #4 on 02/20/18 at 9:40 am. Nurse #4 reported the pressure ulcer between her legs on her left knee	F 686		

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F 686	Continued From page 20 was new since she came back from vacation. Nurse #4 reported the pressure ulcer could have been avoided if a pillow or cushion or some other pressure relieving device was placed between Resident #58 ' s legs. An interview with the Rehab Director on 02/20/18 at 4:30 pm revealed the therapy department was not aware of any new skin conditions with Resident #58. The Rehab Director stated she recalled Resident #58 was being followed by therapy from 10/2/17 through 01/22/18 for positioning while out of bed in her wheelchair. The Rehab Director stated she was using a wedge in her wheelchair for positioning not for between her legs. An interview was conducted with the facility physician on 02/22/18 at 9:30 am. The physician was not aware of the new wound to her knee. The physician stated Resident #58 should have a form of padding between her legs since she was so contracted to prevent from further skin breakdown. An interview was conducted with the Director of Nursing (DON) on 02/22/18 at 4:30 pm. The DON stated her expectation of the nursing staff was that they should have obtained an order to place padding between Resident #58 ' s contracted legs to prevent skin breakdown.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		3/15/18

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F 688	Continued From page 21 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide splinting services for contracture management for 1 of 2 residents (Resident #39) who did not have physician ordered hand rolls in place. Findings included: Review of Resident #39's medical record revealed an initial admission date of 12/20/13 and diagnoses of left and right hand contractures. Review of Resident #39's quarterly Minimum Data Set (MDS) dated 12/31/17 revealed Resident #39 was readmitted to the facility on 02/23/17 and was totally dependent on staff for bed mobility, hygiene, dressing and eating. Resident #39 did not reject care and had functional limitations in Range of Motion (ROM) on the upper extremities. Review of the Bedside Kardex Report showing an admission date of 02/23/17 and used by the Nursing Assistants (NA) to guide resident care,	F 688	Hand rolls were placed by nurse when she became aware that the hand rolls were not applied to Resident #39's hands. The hand rolls were not on the resident due to assigned CNA not following the care plan for that resident, thereby not ensuring the hand rolls were applied. All nursing staff will receive education from the Staff Development Coordinator regarding the use of the care plan to provide treatment and services to each resident by 3/15/2018. Placement of mobility devices will be verified by the nurse and entered on the MAR. Current device list will be audited five days a week for six weeks and then three days a week for six weeks by the DON and/or designee to ensure accuracy in documentation as it relates to physician orders. The device list will be updated weekly in risk meeting.	

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F 688	Continued From page 22 revealed Resident #39 was to have her hands cleaned with soap and water and hand rolls were to be placed in the palms of both hands. Review of the Care Plan updated 01/02/18 revealed Resident #39 had an alteration in her musculoskeletal status related to contractures of the left and right hands. Interventions included hand rolls to both hands for the contractures every shift. Review of the February 2018 Physician Orders revealed an order for hand rolls to be placed in the palms of Resident #39's hands every shift. In an observation on 02/18/18 at 11:55 AM Resident #39 did not have hand rolls in the palms of her hands. In an observation on 02/19/18 at 12:25 PM Resident #39 did not have hand rolls in the palms of her hands. In an observation on 02/19/18 at 4:05 PM Resident #39 had a hand roll in her left hand. In an observation on 02/20/18 at 8:44 AM Resident #39 did not have hand rolls in place. In an observation on 02/20/18 at 10:47 AM Resident #39 did not have hand rolls in place. NA #1 was able to open Resident #39's hands slightly and indentations from her fingernails were seen on the palms of both hands. In an observation and interview on 02/20/18 at 12:05 PM Resident #39 had rolled up washcloths in both her hands. NA #1 stated Nurse #12 had placed the hand rolls in Resident #39's hands.	F 688	Audits will be reviewed in risk meeting weekly and in QAPI meeting monthly for three months to ensure continued compliance.	

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F 688	Continued From page 23 She indicated she usually worked second shift on an as needed basis and was not that familiar with Resident #39. In an interview on 02/20/18 at 2:20 PM Nurse #12 stated the purpose of Resident #39's hand rolls was to keep her hands from being clenched and to prevent the worsening of her contractures. She indicated Resident #39 should have hand rolls in her hands on all shifts. In an interview on 02/20/18 at 3:47 PM the Rehabilitation Director stated the purpose of Resident #30's hand rolls was to prevent further contractures, prevent wounds and to keep the hands clean. In an interview on 02/22/18 at 11:40 AM the Director of Nursing stated it was her expectation that the NAs follow the Kardex. She indicated Resident #39 should have had hand rolls in place.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		3/15/18

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F 690	Continued From page 24 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to; a) remove a urinary leg bag and apply a urinary drainage bag per the physician order while in bed for 1 of 1 residents (Resident #71), and b) failed to obtain a physician ' s written order for an indwelling suprapubic catheter for 1 of 1 resident (Resident #71) observed for urinary catheter care. Findings included: Resident #71 was admitted to the facility on 08/16/16 with a recent readmission on 10/16/17. Resident #71 had a diagnoses, in part, of neuromuscular dysfunction of the bladder, prostate cancer and urinary tract infections (UTI).	F 690	Nursing staff failed to ensure that the leg bag was removed while Resident #71 was in the bed and nursing staff failed to ensure an order was obtained for a catheter for the resident. All nursing staff will receive education regarding policies and procedures for catheter care and following physician orders from the Staff Development Coordinator 3/15/2018. The DON and/or designee will audit all residents with catheters five days a week for six weeks and then three days a week for six weeks. Audits will be reviewed weekly in risk meeting and monthly in the	

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F 690	Continued From page 25 The Minimum Data Set (MDS) quarterly assessment dated 01/05/18 revealed the resident was moderately cognitively impaired. Resident #71 required an extensive assist with the assistance of one staff member with bed mobility, transfers, dressing, eating, toileting and personal hygiene. Resident #71 had no impairments, used a wheelchair, had an indwelling urinary suprapubic catheter and was frequently incontinent of bowel. A review of Resident #71 ' s plan of care revealed an alteration in elimination related to neurogenic bladder secondary to a suprapubic catheter. An intervention included to use the urinary leg bag during the day while out of bed and apply the large Foley drainage bag during the evening while in bed. a. A record review of Resident #71 ' s physician ' s order revealed an order written on 10/16/17 to maintain catheter drainage bag below bladder level each shift. An observation of Resident #71 on 02/20/18 at 9:00 am revealed Resident #71 was lying in his bed and there was no urinary drainage bag below the bladder level. An interview with the nursing assistant (NA) #3 on 02/20/18 at 9:00 am was conducted. NA #3 stated the resident had his urinary leg bag on. NA #3 stated they must have not changed the leg bag last night. NA #3 stated the urinary leg bag would not hold that much urine and it was important to apply the large urinary drainage bag at night below the bladder level because the drainage bag held much more urine.	F 690	QAPI meeting for three months to ensure continued compliance.	

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F 690	Continued From page 26 An interview with Nurse #3 on 02/20/18 at 10:00 am was conducted. Nurse #3 confirmed the urinary leg bag was on the resident while in bed and the urinary drainage bag should have been applied to drain below the bladder level. Nurse #3 stated the resident could be at risk for the urine backing up into the catheter if the urinary leg bag remained on the leg while in bed which could cause a urinary tract infection. Nurse #3 also added the urinary leg bag could hold up to 500 milliliters of urine while the urinary drainage bag could hold a significant amount more. An interview with Nurse #2 on 02/20/18 at 8:00 pm via phone was conducted. Nurse #2 reported she was responsible for removing the urinary leg bag and applying the urinary drainage bag during her shift (7pm - 11pm). Nurse #2 reported she forgot to change the leg bag to the urinary drainage bag. Nurse #2 stated she understood the importance of changing the urinary leg bag while the resident was in bed to a urinary drainage bag because the urine could back up the catheter and put the resident at further risk for a urinary tract infection. An interview with the facility physician on 02/22/18 at 9:30 am revealed Resident #71 was continuously at risk for urinary tract infections due to his prognosis of prostate cancer and having a suprapubic catheter. The physician reported he would expect the nurses to apply the urinary drainage bag whenever the resident was in bed to prevent back flow of urine and potentially cause a urinary tract infection. An interview with the Director of Nursing (DON) on 02/22/18 at 4:30 pm revealed her expectation was for the nurses to follow the order as written	F 690		

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F 690	Continued From page 27 and to make sure the urinary drainage bag was in place below bladder level whenever the resident was in bed. b. A record review of the physician ' s orders revealed there was no order for Resident #71 to have a suprapubic urinary catheter. An interview with Nurse #3 on 02/20/18 at 10:00 am confirmed there was no order in place for the suprapubic urinary catheter. An interview with the DON on 02/20/18 at 10:05 am confirmed there was no order in place for the suprapubic catheter and there should have been an order in place for Resident #71 with the qualifying diagnoses. The DON reported her expectation of the nursing staff was to review the orders to ensure the appropriate orders were in place. .	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692		3/15/18

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balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on 1 dining observation, staff interviews, and record review, the facility failed to provide double portions per physician order to resident with a history of weight loss for 1 of 10 sampled residents reviewed for nutrition (Resident #89). Based on observation, staff interview, and record review the facility also failed to restrict fluid intake as ordered by physician for 1 of 1 sampled residents with a physician order for a fluid restriction (Resident #78).

The findings included:

1. Resident #89 was admitted to the facility on 08/24/17 with diagnoses including: anemia, myelodysplastic syndrome, vitamin D deficiency, and dementia.

A medical review revealed an order summary report dated 08/24/17 which reported Resident #89 would receive double portions with all meals for nutritional support.

Resident #89's 01/25/18 Minimum Data Set (MDS) indicated that resident had severe cognitive impairments. The resident needed assistance with meal set-up.

Upon review of residents #89 and #78 there were appropriate orders in the EMR that were not entered into the electronic tray card system.
100% audit was completed by the RD on 2/20/18 to ensure accuracy between the EMR and the tray card system.

Dietary Manager will be educated on the use of the electronic tray card system by the RD by 3/15/18.

A dietary audit will be conducted for 10 random residents, 5 days a week for 12 weeks by the dietary manager or designee on accuracy between the tray card system and the EMR.

Audits will be reviewed in weekly risk meeting and the QAPI meeting monthly for 3 months to ensure ongoing compliance.

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A care plan, revised 01/25/18, identified Resident #89 had and increased nutritional/hydration risk related to his diagnosis (dementia).

An observation on 02/21/18 at 12:30 PM revealed Resident #89 was in the locked unit dining room. A review of his tray card revealed he should receive a regular diet with his meal, which he received. Resident #89 ate 100% of his regular lunch meal.

An interview on 02/21/18 at 12:55 PM with the Registered Dietitian (RD) revealed Resident #89 had a history of weight loss and should receive double portions with his meals per the physician order since 08/24/17, and had not. She stated that she expected all residents to receive their diets as ordered.

An interview with the Director of Nursing (DON) on 02/21/18 at 1:15 PM revealed it was her expectation that Resident #89 should have been receiving double portions per physician order since 08/24/17, and had not.

An interview on 02/22/18 at 9:30 AM with the facility Administrator revealed it was his expectation that Resident #89 should have received double portions per physician order, and had not.

An interview on 02/22/18 at 11:00 AM with the Dietary Manager (DM) revealed Resident #89 had a current physician order for double portions in the electronic medical record, and she failed to add double portions to her electronic meal tray card tracking system, and should have.

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2. Resident #78 was admitted to the facility on 04/25/15. His documented diagnoses included hemodialysis, congestive heart failure, atrial fibrillation, hypertension, diabetes, and dementia with behavioral disturbances.

A 02/22/16 physician order documented, "Fluid restriction: Dietary 720 ml (milliliters)/day and Nursing 780 ml/day = Total 1500 ml/day."

On 05/25/17 "Resident receives dialysis treatments 3 times weekly and is on a fluid restriction" was identified as a problem in the resident's care plan. Goals for the problem included, "Will maintain fluid restrictions per MD (physician) orders through next review." Interventions for the problem included, "Fluid restrictions as ordered."

Resident #78's 01/18/18 quarterly minimum data set (MDS) documented his cognition was severely impaired, he required supervision by a staff member with eating, his weight was stable, and the facility provided the resident with dialysis services.

On 02/19/18 at 12:20 PM Resident #78 was eating lunch in the unit dining room. No fluid restriction was documented on his tray slip. Resident #78 received 8 ounces of tea (240 ml) on his lunch meal tray.

On 02/19/18 at 5:50 PM Resident #78 was getting ready to eat supper in the facility's main dining room with a family member present. The staff

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was providing residents in the main dining room with beverages while they were waiting on their food to arrive. Resident #78 was provided with 8 ounces (240 ml) of coffee in a plastic mug while waiting on his supper meal to arrive.

At 6:02 PM on 02/19/18 Resident #78 received his supper meal tray, and on the tray he received 8 ounces (240 ml) of water and 8 ounces (240 ml) of tea.

On 02/20/18 at 8:47 AM Resident #78 had finished eating breakfast in the unit dining room. Nursing assistant #6 stated the resident always received 8 ounces (240 ml) of fruit juice on his breakfast trays. (Therefore Resident #78 would have received 240 ml of juice on his 02/19/18 breakfast tray + 240 ml of tea on his 02/19/18 lunch tray + 720 ml of fluid at the 02/19/18 supper meal = 1200 ml of fluid --with only 720 ml supposed to come from dietary per the physician order).

A 02/20/18 5:07 PM a Nutrition/Weight progress noted documented Resident #78's weight was stable, his meal intake was 76 - 100%, and he was on a 1500 ml fluid restriction.

On 02/21/17 5:28 PM Resident #78 was getting ready to eat supper in the main dining room with a family member present. He received 8 ounces (240 ml) of coffee in a plastic mug before the meal arrived.

At 5:45 PM on 02/21/18 Resident #78 received 8 ounces (240 ml) of tea on his supper meal tray.

On 02/21/18 at 6:03 PM the dietary manager stated she would expect that fluid restrictions be

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F 692	Continued From page 32 noted on resident tray slips so the dietary employees working the trayline would know how much fluid to place on meal trays and so NAs working in the dining room would know not to give residents more fluids than allowed in their physician order. She reported usually if a resident could only received 720 ml of fluid from dietary, they received only 8 ounces or 240 ml of fluid on each of their three meal trays. On 2/21/18 at 6:05 PM dietary aides working the supper tray line stated fluid restriction status should be documented on the tray slips. They reported they needed to know on the tray slip for each meal how much fluid they could place on the meal tray so the residents' fluids provided by dietary were not exceeded. On 02/21/18 at 6:12 PM NA # 16, assigned main dining room duty on 02/21/18 stated she was not aware of any residents currently in the dining room being on fluid restriction. She reported the most convenient way to find out if a resident was on a fluid restriction in the dining room was to view the tray slip since the NAs assigned dining room duty were not supposed to leave the dining room to access resident Kardexes and care plans or to even seek out nurses to ask about fluid restrictions. She commented the facility pre-poured beverages to residents who ate supper in the main dining room because the often arrived early and had to wait for food to be delivered out of the kitchen. On 02/22/18 at 11:18 AM the director of nursing (DON) stated the problem with Resident #78's lack of fluid restriction documentation on his tray slips was created when a change of diet form was submitted to ensure the resident would start	F 692		

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F 692	Continued From page 33 receiving double protein portions on 0 2/15/18. She explained the DM took out the existing information in the computer about the resident's fluid restriction and replaced it with the double portion information rather than just adding the double portion information. She reported the resident has been on fluid restriction since admission. The DON commented it was important to restrict Resident #78's fluids to help reduce the chance that the resident might go into fluid overload related to his diagnoses of congestive heart failure and hemodialysis.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to assess and medicate for pain on 1 of 3 residents (Resident #58) observed for pressure ulcers. Findings included: Resident #58 was admitted to the facility on 09/29/17. Diagnoses included, in part, Alzheimer's, anxiety and protein calorie malnutrition. The Minimum Data Set (MDS) dated 01/6/18 revealed the resident was severely cognitively impaired. Resident #58 had one or more	F 697	The nurse provided wound care for Resident #58 did not assess and medicate resident for pain prior to providing treatment. The following day, the nurse did assess and medicate the resident for pain prior to providing her wound care treatment. All nurses will receive education from the Staff Development Coordinator on assessing for pain for residents by 3/15/2018. The education will include determining the appropriate pain scale to use based on each resident's level of cognition. The DON and/or designee will audit by	3/15/18

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F 697	Continued From page 34 unhealed pressure ulcers at stage 1 or higher, was at risk for developing pressure ulcers, and had 3 unstageable pressure ulcers. Resident had not received any opioids (narcotic pain medication). Resident #58 had no pain during this look back period. A review of the care plans revealed there was no current care plan to reflect pressure ulcers to the bilateral heels which started on 10/09/18, and there was no care plan in place to reflect a pressure ulcer that started on 02/19/18 to the left knee. A plan of care for impaired ability to make self understood related to decline in cognitive status secondary to Alzheimer ' s disease was in place to include an intervention to observe resident for signs or symptoms of pain. An observation of Resident #58 on 02/18/18 at 11:30 am revealed a confused and pleasant resident lying in bed. She was not crying out or screaming during this observation. She was noted to have bilateral dressings in place to her lower extremities with both feet lying flat on the bed. Her legs were bare and her right leg was contracted and pressed on the left knee. There was no pillow or cushion noted between her contracted legs. An observation of Resident #58 on 02/18/18 at 4:00 pm revealed a confused and pleasant resident lying in bed. She was not crying out or screaming during this observation. She was noted to have bilateral dressings in place to her lower extremities with both feet lying flat on the bed. Her legs were bare and her right leg was contracted and pressed on the left knee. There was no pillow or cushion noted between her contracted legs.	F 697	method of wound care observation each treatment weekly for 12 weeks to ensure proper pain assessment and medication administration is provided. The audits will be reviewed weekly in risk meeting and monthly in the QAPI meeting for three months to ensure continued compliance.	

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An observation of Resident #58 on 02/19/18 at 11:30 am revealed a confused and pleasant resident lying in bed. She was not crying out or screaming during this observation. She was noted to have bilateral dressings in place to her lower extremities with both feet lying flat on the bed. Her legs were bare and her right leg was contracted and pressed on the left knee. There was no pillow or cushion noted between her contracted legs.

An observation of Resident #58 on 02/19/18 at 3:30 pm revealed a confused and pleasant resident lying in bed. She was not crying out or screaming during this observation. She was noted to have bilateral dressings in place to her lower extremities with both feet lying flat on the bed. Her legs were bare and her right leg was contracted and pressed on the left knee. There was no pillow or cushion noted between her contracted legs.

An observation of wound care treatment was conducted with Nurse #4 on 02/20/18 at 9:20 am. Nurse #4 began to do the dressing change on Resident #58 ' s left knee. Resident #58 was noted to have bare legs and a thin fitted sheet in between her legs. Nurse #4 began to separate the contracted right leg to get access to the left knee. Resident #58 screamed "OWWW" all the while the nurse was trying to gain access to the left knee. Resident #58 cursed and grimaced and showed signs of pain during this treatment change. Nurse #4 spoke in a soft voice and told the Resident she was sorry and she was almost done. Nurse #4 stated she always screamed out during the dressing change and stated she did not pre medicate her. Nurse #4 removed the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	**1206 N FULTON STREET 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 697	Continued From page 36 dated dressing (2/19/18) from the left knee, the open area to the knee was noted to be located on a boney prominence. The area was noted to have slough on the wound bed and redness around the wound. The area was cleansed with normal saline, medi honey was applied and it was covered with a padded dressing. Resident #58 continued to scream while the treatment was being done. Nurse #4 placed a blanket she found in the resident ' s closet between her legs and floated her bilateral heels on a pillow. An interview was conducted with Nurse #4 at 9:40 am. Nurse #4 stated the resident was always crying out whenever she changed the dressing. Nurse #4 stated it was hard to tell if she was in pain or a behavior. Nurse #4 stated she never medicated the resident prior to any pressure ulcer treatment changes. An interview was conducted with Nurse #3 on 02/20/18 at 10:00 am. Nurse #3 stated Resident #58 had an order for pain medication to be given as needed for pain. Nurse #3 stated she has had changed the dressings on Resident #58 when Nurse #4 was not in the facility. Nurse #3 stated she would usually cry out during the dressing change, but she always cried out whenever we just touched her. Nurse #3 stated according to the Medication Administration Record (MAR), Resident #58 had never received any thing for pain since her admission on 09/29/18. Nurse #3 stated she thought the crying out was just a behavior and then stated she guessed the resident could have been in pain. Nurse #3 stated that signs and symptoms of pain for a cognitively impaired resident would be grimacing, crying, or yelling.	F 697		

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F 697	Continued From page 37 An interview was conducted with the Wound Care Nurse Practioner on 02/21/18 at 4:45 pm. The NP stated Resident #58 cried out frequently when she was in the room with her, and it was hard to tell if she was in pain or not, but the type of wounds the resident had could cause her pain. An interview was conducted with Nurse #4 on 02/21/18 at 6:20 pm. Nurse #4 stated the resident could have had pain during the dressing change and stated it was hard to tell because she would cry out randomly when staff walked into the room. Nurse #4 reported that signs and symptoms of pain for a disoriented resident were screaming out, grimacing, tight fists, and crying. Nurse #4 stated the crying out could have been because she was in pain. An interview was conducted with the facility physician on 02/22/18 at 9:30 am. The physician stated Resident #58 would randomly cry out when people entered the room. He stated she had no behaviors and did not need to be followed by psych services. He stated that the type of wounds she had could cause her pain and she would benefit from getting the pain medication that was ordered. An interview was conducted with Nurse #4 on 02/22/18 at 11:30 am. Nurse #4 reported the resident was medicated prior to her wound care on 02/22/18. Nurse #4 stated Resident #58 did better during the treatment and did not cry out as much. Nurse #4 felt the medication was helpful. An interview was conducted with the Director of Nursing (DON) on 02/22/18 at 4:30 pm. The DON stated her expectation of the nurses was to assess for pain and medicate as needed.	F 697		

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F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		3/15/18

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F 732	Continued From page 39 by: Based on observations and staff interviews, the facility failed to post up-to-date staffing information for one of five days of the recertification survey. The findings included: During the initial tour on Sunday, 02/18/18 at 11:40 AM, the staff posting on the wall by nursing station A was dated for Friday, 02/16/18. On 02/20/18 at 11:33 AM, an interview was conducted with the Facility Scheduler, who was responsible for posting the daily staffing Monday through Friday. She stated, that the A-hall nurse was responsible for posting the weekend daily staffing, and did not post the daily staffing on 02/17/18. During an interview with the facility Director of Nursing (DON) on 02/19/18 at 5:45 PM., the DON indicated that it was her expectation that the staff posting be posted daily, and it was not posted on 02/17/18. During an interview with the facility Administrator on 02/19/18 at 5:55 PM., the Administrator indicated that it was his expectation that the staff posting be current, posted daily, and that his expectation was not being met.	F 732	The weekend staff failed to update the required staff posting. The staff posting was updated to reflect current and accurate information the following day by the Scheduling Manager on Monday. All nurses will receive education from the Staff Development Coordinator on placement of staff posting, how to keep updated and who is responsible (weekend charge nurse is responsible for posting and updating on the weekends and holidays, and the Scheduling Manager or designee will be responsible for updating Monday through Friday) by 3/15/2018. The Administrator and/or designee will conduct daily audits to ensure ongoing compliance. Audits will be reviewed monthly in the QAPI meeting to ensure continued compliance.	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed	F 805		3/15/18

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F 805	Continued From page 40	F 805		

to meet individual needs.
This REQUIREMENT is not met as evidenced by:
Based on 1 dining observation, staff interviews, and record review, the facility failed to provide a mechanical soft diet with double portions per physician order to resident with a history of weight loss for 1 of 10 sampled residents reviewed for nutrition (Resident #89).

The findings included:

Resident #33 was admitted to the facility on 08/15/17 with cumulative diagnoses including: dysphagia, gastro-esophageal reflux disease (GERD), diabetes type II (NDD2), transient ischemic attack (TIA), cerebral infarction (CVA), and Alzheimer's.

A Medication Administration Record (MAR) dated 02/1/18 - 02/28/18 reported Resident #33 would receive no added salt (NAS) diet, mechanical soft texture, thin consistency, limited concentrated sweets (LCS); double portions with all meals for congestive heart failure (CHF)/ diabetes type II (NDD2).

A resident electronic dietary manager dated 02/20/18 for Resident #33 reported he would receive double portions, LCS, NAS, Mechanical Soft, (NDD2) diet for all meals.

Resident #33's 12/16/17 Minimum Data Set (MDS) indicated that resident had severe cognitive impairments. The resident needed assistance with meal tray set up.

A dietary note dated 12/11/17 for Resident #33 revealed the resident's diet texture was double

Upon review of Resident #33 it was determined that a meal tray was sent from kitchen without a tray cared to identify the resident.

Dietary staff will be educated by the Dietary Manager on ensuring that appropriate, identifying tray cards are placed on each tray prior to leaving the kitchen. Nursing staff will be educated by the staff development coordinator on ensuring that each tray that is passed has a tray card by 3/15/18.

A dietary audit will be conducted for 10 random residents, 5 days a week for 12 weeks by the dietary manager or designee to include tray card presence and tray accuracy.

Audits will be reviewed in weekly risk meeting and in QAPI meeting monthly for 3 months to ensure ongoing compliance.

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F 805	Continued From page 41 portions Mechanical soft, with double portions. A lunch observation dated 02/18/18 for Resident #33 revealed resident in a wheelchair in the memory unit dining room, fully dressed, with non-slip shoes on. The resident had a mechanical soft diet, and had a Nursing Aide (NA) to help him with feeding. The resident ate 75-100% of lunch meals both days. A meal observation on 02/19/18 at 12:20 PM revealed Resident #33 received and ate a Mechanical Soft diet tray, 100%, with no issues noted during the meal. At 5:45 PM on 02/19/18 Resident #33 was observed eating a whole fish sandwich off his meal tray. An interview on 02/20/18 at 11:20 AM with the Dietary Manager revealed that Resident #33 should have received a mechanical soft diet at dinner on 02/19/18 with a resident meal card, and did not. She said Nurse #7 could not find Resident #33's tray in the building so she went to the kitchen and received a regular diet tray for the resident, without a meal card identifying the resident's diet and preferences. The resident started to eat the regular diet fish sandwich brought to him by the nurse, and was stopped by NA #6 to recheck the resident's diet plan electronically before giving him a regular tray. The nurse said to NA #6 that she thought Resident #33 got a regular diet, and NA #6 asked again for Nurse #7 to verify electronically the resident's diet order. Nurse #7 did, and verified that Resident #33's diet order read mechanical soft diet, with double portions. The nurse then re-ordered the resident a new mechanical soft dinner tray, which	F 805		

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F 805	Continued From page 42 he received and ate 75-100% of the meal. The Dietary Manager said the resident's dinner meal tray on 02/19/18 should have had the correct diet, with the resident's meal slip on it, and it did not. She stated, once Nurse #7, observed the resident's tray was missing, should have first looked in the computer system for the resident's ordered diet and copied the appropriate meal tray slip to go with the correct meal tray, and she did not. The Dietary Manager said she should have also checked behind the nurse when she came and got a regular diet tray, and did not. The Dietary Manager revealed that it was her expectation that Resident #33 should have received a mechanical soft meal tray, with a tray slip on 02/19/18 at 5:45 PM, and had not. An interview on 02/21/18 at 12:55 PM with the Registered Dietitian (RD) revealed Resident #33 should receive double portions, LCS, NAS, Mechanical Soft, (NDD2) diet for all meals, and did not on the 02/19/18 dinner meal. She stated that she expected all residents to receive their diets as ordered. An interview with the Director of Nursing (DON) on 02/21/18 at 1:15 PM revealed it was her expectation that Resident #33 should have received a mechanical soft double portion dinner tray on 02/19/18, and had not. An interview on 02/22/18 at 9:30 AM with the facility Administrator revealed it was his expectation that at dinner at 02/19/18 Resident #33 should have received a mechanical soft diet per physician order, and had not. An interview on 02/22/18 at 11:11 AM with the Dietary Manager revealed that it was her	F 805		

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F 805	Continued From page 43 expectation that Resident #33 should have received a mechanical soft meal tray, with a tray slip on 02/19/18 at 5:45 PM, and did not.	F 805		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance (QA) process failed to prevent the reoccurrence of deficient practice related to pressure ulcers and range of motion which resulted in repeat deficiencies at F314/F686 and F318/F688. The re-citing of F314/F686 and F318/F688 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to:	F 865	The physician order for wound care for resident #58 was not followed during treatment provided on 2/20/28 by treatment nurse. The order was immediately verified with provider and checked for accuracy by DON on 2/21/18. CNA did not apply hand rolls to resident #39 on the morning of 2/20/18. Upon identifying the hand rolls were not in place, the nurse assigned to the resident applied hand rolls to both hands per physician's order.	3/15/18

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F 865	Continued From page 44 F686: Pressure Ulcers: Based on observations, record review and staff interviews the facility failed to; a) follow the prescribed physician orders for wound treatment and an order to prevent wounds from worsening and, b) failed to prevent an avoidable pressure ulcer on 1 of 3 residents (Resident #58) observed for pressure ulcers. F688: Range of Motion: Based on observation, record review and staff interviews the facility failed to provide splinting services for contracture management for 1 of 2 residents (Resident #39) who did not have physician ordered hand rolls in place. Review of the facility's survey history revealed F314/F686 and F318/F688 were cited during the facility's 03/10/17 annual recertification/complaint investigation survey, and were re-cited during the current 02/22/18 annual recertification/complaint investigation survey. At 2:56 PM on 02/22/18 the director of nursing (DON) stated the facility had reduced the number of pressure ulcers in the building since its 2017 annual survey so she was not sure why the QA process had not solved pressure ulcer issues in 2018. She reported investigation seemed to allude to a possible communication issue regarding pressure ulcers between the hall staff and the treatment nurse so the treatment nurse was now going to be required to attend morning clinical meetings. According to the DON, she thought some of the on-going problem with range of motion stemmed from the facility's efforts to focus corrective action on residents with new restorative/therapy orders versus those who already had restorative/therapy orders in the	F 865	Education will be provided to all nursing staff by the Staff Development Coordinator by 3/15/18 regarding all elements related to pressure ulcers to include assessment and prevention, identifying residents at risk for pressure ulcers using the Braden Scale Pressure Ulcer Assessment, updating care plan to reflect changes and potential for changes in resident's condition, entering orders accurately, ensuring that residents at risk for pressure ulcers have appropriate interventions in place to prevent new or worsening wounds and use of the care plan to provide treatment and services to each resident. The Staff Development Coordinator will educate staff regarding all elements of Range of Motion to include assessment to prevent contractures, use of stop and watch tool to communicate change in condition and process of referral to therapy. A current device list will be audited 5 days a week for twelve weeks and then 3 days a week for an additional twelve weeks by the DON and/or designee to ensure accuracy in documenting as it relates to physician orders and necessary interventions regarding identification and prevention of contractures as it relates to range of motion. The device list will be updated weekly in risk meeting, ongoing. Therapy referrals and Stop and watch communications forms will be reviewed each morning in clinical meeting and weekly in risk meeting In addition, a review and audit of residents who are at	

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F 865	Continued From page 45 system. She commented the range of motion problem seemed to be more related to a problem with data input which resulted in residents not having the devices that had been ordered for contracture management.	F 865	risk for or having pressure areas based on the nurses Braden scale assessments will also be conducted each week in the risk meeting, ongoing. The risk team will ensure that each identified resident has the appropriate care plans and interventions in place to prevent new or worsening pressure areas. All areas related to Range of Motion and mobility devices and pressure ulcers will be reviewed in the monthly QAPI meeting for 12 months to ensure continued compliance by maintaining a process to prevent the reoccurrence of deficient practice related to pressure ulcers and range of motion. Risk meeting minutes related to all elements of Range of Motion and Pressures Ulcers will be reviewed by the Monthly QAPI team for twelve months.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		3/15/18

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F 880	Continued From page 46	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which 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; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 47 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to handle dirty linen in a sanitary manner by placing it on the floor for 1 of 1 sampled residents (Resident #39). Findings included: In an observation on 02/20/18 at 12:05 PM Resident #39's visibly urine soaked bottom sheet was removed from the bed by Nursing Assistant (NA) #1. NA #1 rolled up the sheet and dropped it onto the floor next to the bed with other visibly wet linens. In an interview on 02/20/18 at 12:12 PM NA #1 stated she should have placed the wet linens in a plastic bag. She indicated soiled or wet linen should never be placed on the floor and she did not know why she had thrown it on the floor. NA #1 then picked up the linens and placed them in an empty plastic bag which had been on the floor on the opposite side of the bed. In an interview on 02/22/18 at 11:40 AM the Director of Nursing stated it was her expectation that soiled linen be bagged at the bedside as soon as the linen was removed. She stated soiled or wet linens should never be placed	F 880	The CNA failed to practice proper infection control by placing linen on the floor in resident #39's room. CNA did immediately acknowledge that she should have placed the linens in a plastic bag and did so on 2/20/18. All nursing staff will receive education by the staff development coordinator regarding best practice related to infection control and prevention by 3/15/18. The DON and/or designee will conduct an audit 5 days a week for 10 residents per day that includes various CNAs on various shifts for 6 weeks, then 3 days a week for 6 weeks to observe infection control techniques. The audits will be reviewed in the monthly QAPI meeting to ensure ongoing compliance and if discrepancies are noted, further actions will be implemented.	

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 02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	1206 N FULTON STREET 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 880	Continued From page 48 directly on the floor.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the call bell failed to activate when pressed in 1 of 1 resident rooms (beds 406D and 406W) in the facility. The findings included: On 02/18/18 beginning at 5:45 PM, call bells were tested in 1 resident room. In 1 of the 1 rooms (beds 604D and 604W) when the call bell was activated, the call light did not illuminate outside the resident door, and the call bell failed to sound at the nursing station. An interview on 02/20/18 at 10:45 AM with the Maintenance Director (MD) revealed the problem with room #604's call bells were that the two call bell cords needed to be un-plugged and plugged back in. A call bell audit dated 02/20/18 by the Maintenance Director (MD) revealed one room (308) where call bells were not working, and fixed the issue. The MD said all the call bells in the	F 919	Call lights were identified not to be operable 2/21/18 in resident room 604. The maintenance director repaired the call lights on 2/21/18 as well as conducted a facility audit. No other issues were identified. The maintenance director was not aware a call light audit should be performed. The Maintenance Director was educated by the Administrator on 2.23.18 to perform call light audits 3x week. Department managers will also verify call bells are working properly five days a week on their ambassador rounds. The maintenance director will audit call bell functioning 3x week (Monday, Wednesday, and Friday)for 6 weeks and then, weekly thereafter and ongoing. The audits will be reviewed in the monthly QAPI meeting for 3 months to ensure ongoing compliance. If discrepancies are	3/15/18

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 02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	**1206 N FULTON STREET RAEFORD, NC 28376**

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F 919	Continued From page 49	F 919		

building were currently functioning properly, including rooms 604 and 308. Prior to the survey the MD was not aware of a problem with the call bell system in room 604 or 308. He commented he did not know the exact date when the call bells were last checked in room 604 or 308.

On 01/20/18 at 11:50 AM., Nursing Aide (NA) #7 stated she was not aware that a call light was not working inside room and above the door for room 604. She stated both residents were not capable of using their call light, but they had not voiced any complaints about it not working. She stated if the residents needed anything, they would could just call out for an aide or nurse. She stated she never checked if their call lights were working or not working.

An observation on 01/20/18 at 11:50 AM revealed the non-functioning call lights in room 604 and 308 were fixed and functioning properly.

During an interview with the facility Director of Nursing (DON) on 01/22/18 at 9:20 AM., the DON indicated that it was her expectation that all call lights would be working, and her expectation was not being met. She stated the nursing staff should check call lights daily.

During an interview with the facility Administrator on 01/22/18 at 9:30 AM., the Administrator indicated that it was his expectation that all call lights would be working, and his expectation was not being met with regard to the residents in room 308 and 604. He stated if a call light was not working, the staff would report the problem to in-house maintenance.

Provider's plan of correction (F 919): noted, further actions will be implemented.