STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 10/27/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 observations, record review, and interviews the facility failed to provide nail care for one (1) of three (3) residents reviewed for assistance with activities of daily living. (Resident # 81) The findings are: Resident #81 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease, Rheumatoid Arthritis (RA), and Diabetes Mellitus. An admission Minimum Data Set (MDS) dated 09/05/2011 revealed the resident was cognitively intact, had no memory problems, and was able to make his needs known. The admission MDS indicated Resident #81 required limited assistance with personal hygiene and extensive assistance with bathing. No behaviors or rejection of care were noted on the admission MDS. The Care Area Assessment (CAA) summary for ADL (activities of daily living) functional status/Rehabilitation Potential dated 09/07/2011 revealed Resident #81 was admitted to the facility for therapy and required supervision to limited assistance with activities of daily living. The CAA	F 312	Preparation and submission of this Plan of Correction does not constitute an admission or agreement of the facts alleged on the correctness of this statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal law. F312 1.) Resident's nails were trimmed and cleaned during the survey on 10/27/2011. 2.) An audit of all residents' nails was performed on 10/31/2011 to ensure that all nails were cleaned and trimmed properly.	11/19/2011 11/19/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn M. Wolfe | TITLE: Administrator | (X6) DATE: 11-17-2011

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 312	Continued From page 1 summary noted the resident had RA and reported ongoing pain. A care plan for personal hygiene dated 08/29/2011 stated Resident #81 needed assistance with bathing, dressing, and grooming. Interventions included to assist with personal hygiene as needed. Review of the skin/shower work sheets for 09/01/2011 through 10/24/2011 revealed Resident #81 was scheduled to receive showers every Monday and Thursday. The skin/shower work sheet dated 10/24/2011 indicated Resident #81's nails were not trimmed. Observations of Resident #81 were as follows: - On 10/24/2011 at 4:58 PM all ten fingernails extended approximately 1/4 of an inch beyond his fingertips with black debris noted under all ten fingernails. - On 10/26/2011 at 8:45 AM all ten fingernails extended approximately 1/4 of an inch beyond his fingertips with black debris noted under all ten fingernails. - On 10/27/2011 at 8:30 AM all ten fingernails extended approximately 1/4 of an inch beyond his fingertips with black debris noted under all ten fingernails. The resident was holding buttered bread in one hand. An interview was conducted with Resident #81 on 10/24/2011 at 4:48 PM. During the interview he stated a staff member had looked at his fingernails last week and told him they would be back to clean and trim his fingernails. Resident	F 312	3.) An audit of all residents' nails is performed weekly by a designee of the Director of Nursing to ensure that all nails are properly maintained. 4.) Reports of these audits are communicated by the Director of Nursing or her designee during the monthly QA meetings for the next three months. 5.) Compliance date is 11/19/2011	11/19/2011

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F 312	Continued From page 2 #81 indicated his fingernails still needed to be cleaned and trimmed. Interview with nursing assistant (NA) #1 on 10/26/2011 at 3:07 PM revealed fingernails were cleaned and trimmed with showers and as needed. NA #2 was interviewed on 10/26/2011 at 3:25 PM and stated she cleaned residents fingernails during showers and trimmed fingernails if needed. During an interview on 10/27/11 at 10:30 AM the Director of Nursing (DON) stated she expected nursing assistants to clean and trim residents fingernails with showers and as needed. At 10:30 AM the DON observed Resident #81's fingernails and stated he needed to have his fingernails cleaned and trimmed.	F 312		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to ensure one (1) of four (4) sampled residents received psychiatric services as ordered by the physician. (Resident #88) The findings are:	F 319	F319 1.) The referral for the psych consult was submitted on 10/27/2011 and resident was seen by Paradigm on 11/9/2011. 2.) An audit of orders from the past month was performed on 10/27/2011 to ensure that all psych consults were referred properly to Paradigm or another mental health service and that the residents were seen by the proper mental health professionals.	11/19/2011

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F 319	Continued From page 3 Resident #88 was admitted to the facility with diagnoses which included bipolar disease. Physician orders on admission included Depakote (a medication used to treat behaviors) and Cymbalta (an antidepressant). An admission assessment dated 10/24/2011 assessed Resident #88 with no impairment of short or long term memory and cognitively intact. This assessment triggered an assessment review in the area of behaviors due to the resident's recent move to a nursing home and recent change in health. This assessment triggered an assessment review in the area of psychotropic medication use due to being on an antianxiety and antidepressant medication. This review noted Resident #88 had a history of bipolar disorder with likely long term psychiatric medication use. This review also noted a 09/19/2011 hospital history and physical (H&P) indicating she had a recent psychiatric stay with medication changes that made her dizzy contributing to her fall at home. The review noted a psychiatric consult had been ordered since admission to the facility due to episodes of tearfulness and verbalizing depression. The care plan for Resident #88 dated 10/10/2011 included the problem area of Social/Adjustment Needs. Approaches to address this problem included: encourage to verbalize feelings, monitor adjustment to placement, monitor for signs/symptoms of depression, psychiatric consult pending. Progress Notes since admission included the following note: 09/29/2011-"Resident told Speech Therapist that	F 319	3.) An audit of all orders is performed monthly by the Director of Nursing or her designee to ensure that all psychiatric consults are properly referred and that the resident is seen by the mental health service. 4.) Reports of these monthly audits are presented by the Director of Nursing or her designee during the monthly QA meetings for the next three months to ensure that residents are seen by the mental health professionals. 5.) Compliance date is 11/19/2011.	11/19/2011

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F 319	Continued From page 4 she was depressed and needed to talk to someone. Social worker aware of order for psych consult." On 09/28/2011 an order was written for a psychiatric consult for Resident #88. On 10/25/2011 at approximately 10:00 AM Resident #88 voiced being depressed. On 10/27/2011 at 5:50 PM Resident #88 again reported how depressed she has been since admitted to the nursing home. Review of the medical record of Resident #88 revealed a psychiatric consult had not been done since it was ordered on 09/28/2011. On 10/27/2011 at 4:00 PM the facility Social Worker reported he was not aware a psychiatric consult had not been ordered for Resident #88. The Social Worker stated he was out on leave at the time the psychiatric service was ordered for Resident #88. The Social Worker stated he did not have an assistant and management staff covered for him in his absence. On 10/27/2011 at 5:15 PM the facility administrator and Director of Nursing reported they could not tell the psychiatric consult had ever been done for Resident #88 or that the contract service had been notified of the need for services.	F 319		