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

AMENDED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE PO BOX 6208 STATESVILLE, NC 28677

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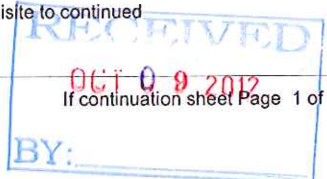
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to review a criminal background check upon hire and permitted an employee to work in the facility for one (1) of five (5) employee files reviewed. (Employee #1). The findings are: A review of a facility policy titled "Abuse Prevention, Investigation and Reporting" with a revised date of 10/04 contained a section titled "Criminal Background Check" and indicated the following statements: It is the policy of the facility to obtain a Criminal Background Check on all potential employees in the determination of their eligibility for employment and pursuant to state licensure regulations. "The facility has entered into an agreement with the North Carolina State Bureau of Investigation to provide complete background check information on potential employees who have not been a resident of North Carolina for at least five years." A review of employee files revealed Employee #1 began employment in the facility on 5/1/12 as a nurse and was currently employed in the facility.	F 226	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared or executed solely because it is required by the provisions of federal and state law. Said law requires that the plan of correction address five specific questions, henceforth referred to as 1 – 5 as follows: 1. Address how the corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice; 3. Address what measures will be put into place or systemic changes made to ensure that the alleged deficient practice will not recur; 4. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: K Daniel Goodwin
TITLE: Administrator
(X6) DATE: 10/2/12

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.

original signature 9-17-12 mh



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F 226	Continued From page 1 A review of a document titled North Carolina Department of Health and Human Services (DHHS) Criminal Record Check Unit dated 5/16/12 indicated DHHS had received the results of the State Bureau of Investigation (SBI) and Federal Bureau of Investigation (FBI) fingerprint check on the applicant. During an interview on 8/22/12 at 11:31 AM the payroll clerk stated she maintained personnel records as part of her facility duties. She explained Employee #1 was hired on 5/1/12 from a long term care facility in Virginia. She further explained Employee #1 had not been a North Carolina resident so she had to be fingerprinted and her fingerprints were mailed by facility staff to the SBI in North Carolina on May 2, 2012. She stated there was also a document that Employee #1 had to complete with her name, address and signature to release the criminal background information to the facility. She further stated Employee #1 filled out the form and the payroll clerk put a stamp on it and mailed it for her. The payroll clerk also stated she wrote a note when she mailed the form on May 28, 2012 and told Employee #1 when she got the criminal background check results to bring them to her. She stated she did not hear anything else from Employee #1 about the results. She further stated she did not know what the results of the criminal background check was and was not aware if anyone in the facility had called the SBI to follow up on the results. The payroll clerk verified she was aware of the criminal background check policy and should have gotten the criminal background check information. During a follow up interview on 8/22/12 at 12:58	F 226	must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility; and 5. Include dates when corrective action will be completed. The dates of corrective action must be acceptable to the State. Please accept the following PoC and the included attachments as the facility's ***Credible Allegation of Substantial Compliance.*** F226 1.&2. There was no actual harm to any resident. Employee #1 criminal background report was obtained and brought to the facility on 08/23/12. The Payroll Clerk was re-inserviced by the Administrator on 08/23/12 for following state and federal law requirements for fingerprinting and the new additions added to the current Abuse, Prevention, Investigation and Reporting Policy. #3 Specifically added to the current Abuse Prevention Policy a section which reads: "Employees transferred from Virginia Autumn Care locations will require a criminal background check if the employee has not been a resident of North Carolina for at least five years." #4 The payroll clerk completed a 100% audit of all	9/20/12

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F 226	Continued From page 2 PM the payroll clerk stated she had talked to Employee #1 and she had the criminal background results at her house and would go get them and bring them back to the facility today. During an interview on 8/22/12 at 1:50 PM Employee #1 stated she worked in a long term care facility in Virginia before she moved to North Carolina and was told when she applied for her job that since she hadn't lived or worked in North Carolina she had to get fingerprinted. She explained she got her fingerprints and took them back to the facility and they mailed them for her. She further explained she received the criminal background check results a month or so ago but she forgot to bring them to the facility until she was asked about them today and went home and got them and brought them back to the facility. During an interview on 8/22/12 at 4:09 PM the administrator stated when the employee moved from Virginia to North Carolina it triggered the requirement in the policy to complete the criminal background check since the employee had not been a resident of North Carolina for at least five (5) years and the criminal background check results should have been obtained and reviewed.	F 226	active employees to ensure proper background checks on 08/23/12. No other employees were identified. The payroll clerk is responsible for compliance and reports concerns for all new applicants Criminal Background Check to the Administrator. Furthermore, a quality assurance tool has been re-designed to include "N.C. resident for more than 5 years?" "If no, fingerprints received on __DATE__." The payroll clerk monitors each new prospective employee Criminal Background Check, and reports findings to quality assurance committee quarterly. F241: 1.&2. Though there was no actual harm to any resident, all other residents with a catheter had the potential to be affected by the alleged deficient practice. Catheter bag for resident #40 was covered by DON on 8/19/12 at 5:00 pm. To accomplish corrective action for all those having the potential to be affected and those who may have been affected, a combination of re-education and systemic reinforcement has been conducted in with all nursing staff. Furthermore a 100% audit by DON was conducted to make sure all catheter bags were in compliance with F241 3. As a systemic change to insure that the alleged deficient practice does not reoccur, all nurses were educated that catheter bags	9/20/12
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241		

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F 241	Continued From page 3 Based on observations, staff, resident and family interviews, and medical record reviews the facility failed to ensure that one (1) of three (3) resident's urinary catheter drainage bags were covered with a privacy cover (Resident #40). The findings are: A medical record review revealed Resident #40 was admitted to the facility on 02/18/09, and was re-admitted on 08/17/12. The Minimum Data Set (MDS) dated 08/17/12 revealed Resident #40 was cognitively impaired. Resident #40's care plan dated 08/17/12 revealed a care plan for a urinary device. Interventions included providing a privacy bag cover for the drainage bag. An observation made on 08/19/12 at 3:35 PM revealed Resident #40 was being assisted to a sitting area in the front of the facility by her family member. The urinary drainage bag was observed attached to the outer left frame of her wheelchair. The urinary drainage bag was transparent and clear, yellow urine was visible in the urinary drainage bag and the attached tubing. An observation made on 08/19/12 at 4:40 PM revealed Resident #40 sitting in her wheelchair in her room. A family member was sitting beside her, and Resident #40 ' s room mate was lying on her bed and had two (2) visitors. The transparent urinary drainage bag was attached to the frame of Resident #40's wheelchair. Clear, yellow urine was visible in the drainage bag and the attached tubing. An interview with Nursing Assistant (NA) #3 on 08/19/12 at 5:35 PM revealed Resident #40's	F 241	should be replaced with facility "fig leaf" catheter bags (which have their own cover attached) immediately upon admission and or readmission to facility. The ADON will ensure that catheter bags are replaced with fig leaf catheter bag during 24 hours quality assurance interview of resident, the results of which are reported in the daily stand-up meeting. The ADON includes this in her reporting to the management team for 90 days until the system is firmly established. On 8/20/12 all nursing staff were re-educated on proper use of fig leaf catheter bags. 4. In order to monitor performance and make sure that solutions are sustained, the ADON reports the results of her 24 hour quality assurance review to the management team meeting daily, and for 90 days this reporting includes results of the catheter audit where applicable. 5. Compliance with this regulation will be accomplished on or before September 20, 2012 and is the responsibility of the ADON. F323: 1.&2 Resident #29 has been assessed for shower chair and lift sling that aids in best possible positioning and safety. To accomplish corrective action for all those having the potential to be affected and those who may have been affected, a combination of re-education and systemic reinforcement has been conducted with all	9/20/12

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F 241	Continued From page 4 care plan indicated her urinary drainage bag should be covered with a privacy cover. The interview further revealed the facility had privacy covers in stock to cover transparent urinary drainage bags. NA #3 also revealed he emptied urine from Resident #40's urinary drainage bag and had not noticed the urinary drainage bag was not covered by a privacy cover. An interview with the Director of Nursing (DON) on 08/19/12 at 5:50 PM revealed she expected urinary catheter drainage bags to be covered with a privacy cover.	F 241	nursing. ADON completed a 100% audit on all residents for shower chair safety and positioning. Assistant Administrator and ADON completed a 100% audit to ensure all shower chairs are in proper working order. 3. Direct care staff re-educated by the Assistant Director of Nursing for securely connecting shoulder and leg straps to the lift machine prior to any attempt to reposition a resident 8/14/14. NA #1 was re-educated by ADON on 08/14/12 to securely connect shoulder and leg straps to the lift machine prior to any attempt to	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to properly transfer a resident using a mechanical lift for 1 (one) of 2 (two) residents requiring transfer with lift. (Resident #29) The findings are: Resident #29 was admitted with diagnoses including Osteoarthritis and Cerebrovascular accident (CVA). Minimum Data Set (MDS) dated	F 323	reposition a resident. 4. The house supervisor audits 5 random resident transfers per week using all types of mechanical lift for 30 days and reports findings to the Director of Nursing. The House Supervisor is responsible for monitoring and compliance and reports to the quality assurance committee quarterly. As noted in the SOD, much other quality improvement activity had been conducted prior to the observations and findings of the survey team including staff education, systems review and professional consultation by a lift safety professional, thus restatement is not required here. 5. Compliance with this regulation will be accomplished on or before September 20, 2012 and is the responsibility of the house supervisor. ~~F 371~~	9/20/12

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F 323	Continued From page 5 6/25/12 assessed the resident as non-ambulatory, requiring extensive assistance with bed mobility and transfers. Review of facility Mobility/Transfer Profile dated 7/2/12 assessed Resident #29 as requiring a total lift for transfers. Resident #29 was care planned for mechanical lift usage dated 1/30/12 due to limited mobility and non weight bearing status. Care plan goal was for the resident to be transferred safely with total lift daily. Care plan interventions included total lift transfers with two person assistance. Review of mechanical lift skills demonstration checklist indicated that two caregivers were required for all transfers to ensure safety. The skills checklist indicated that all four clips of the sling attached to the lift should be checked before each transfer. Review of Incident Report dated 8/9/12 at 11:00 AM revealed Resident #29 fell in her room during a transfer from a shower chair to the bed. Review of nurses notes revealed Resident #29 was transferred to the hospital on 8/9/12 for evaluation and returned to the facility on the same day. Review of hospital x-ray results revealed no fractures and no head trauma. Hospital discharge instructions provided orders for antibiotic ointment to right lower extremity skin tear with daily dressing changes. On 8/21/12 at 2:20 PM NA #1 and NA #2 were observed performing a safe transfer of Resident #29 with total mechanical lift from the bed to a shower chair. Interview with NA #1 was conducted on 8/22/12	F 323	1.&2. Though there was no actual harm to any resident, all residents had the potential to be affected by the alleged deficient practice. To accomplish corrective action for all those having the potential to be affected and those who may have been affected, a combination of re-education and systemic reinforcement has been conducted with all kitchen staff. 3. As a systemic change to insure that the alleged deficient practice does not reoccur, the temperature recording and checking method is followed as indicated on the existing "Food Temperature Record" presently in use. This method involves the review of recorded temperatures by the dietary manager on a daily basis, an indication of whether or not temperatures were acceptable, and follow-up intervention with staff members in the event of any variance from acceptable temperature levels. . On 8/19/12 the Dietary Manager was re-educated by the Registered Dietician on proper food temperatures and the danger zone of food temperatures. On 8/19/12 all dietary staff were re-educated on proper food temperatures and the danger zone of food temperatures. Staff were re-educated on 8/24/12 on location and proper use of the food temperature book. Additional signage was added to Food Temperature Log to remind staff of proper food temperatures	9/20/12

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F 323	Continued From page 6 at 9:10 AM. NA #1 stated she had performed transfer of Resident #29 on 8/9/12. NA #1 stated that two staff members were required for mechanical lift transfers and that NA #3 was present to assist with the transfer. NA #1 stated she positioned the sling on Resident #29 and had attached the leg straps to the lift. NA #1 stated as she adjusted the position of the lift in order to attach the shoulder clips this raised the resident's legs causing the shower chair to tilt backward and fall. NA #1 stated NA #3 was adjusting the bed linen to prepare for the transfer and was unable to intervene to prevent the shower chair from falling. Interview with the Clinical Nurse Educator who trained facility key coaches was conducted 8/22/12 at 1:50 PM. The Nurse Educator stated review of manufacturer guidelines revealed there was no specific order outlined for securing the upper/lower sling clips to the lift. The Nurse Educator stated the mechanical lift training emphasized the need for two person assistance to monitor the resident, guide the equipment, assist with placement of the sling, and to avoid any obstacles that may impede the transfer. Interview with the Assistant Director of Nursing (ADON) was conducted 8/22/12 at 2:15 PM. The ADON stated she served as a key coach to provide lift training for facility staff. The ADON stated staff were trained to perform all mechanical lift transfers with two staff members present. The ADON stated staff were trained to attach upper body clips first and then attach the leg clips. Once secured one staff member was responsible for operating the mechanical lift controls while the other staff member was	F 323	and the danger zone. Dietary Manager has enrolled in the two day Serve Safe course. 4. In order to monitor performance and make sure that solutions are sustained, the food temperature logs will be reviewed by the Quality Improvement Committee at its monthly meeting each month for the next 90 days. The committee will also hear reporting from the dietary manager regarding any corrective actions which have been made as a result of his monitoring the log. 5. Compliance with this regulation will be accomplished on or before September 20, 2012, and the dietary services manager is responsible for compliance.	

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F 323	Continued From page 7 instructed to use a hands on approach to guide the resident in the sling to avoid obstacles and ensure a safe transfer from one surface to another. The ADON stated staff was re-educated about proper use of lift equipment with inservice training dated 8/14/12. Review of inservice attendance log dated 8/14/12 did not indicate that NA #3 participated in the training. The ADON stated that staff education was ongoing and that she had not seen NA #3 to complete the inservice training. The ADON stated NA #3 was scheduled to work the 3PM-11PM evening shift on 8/22/12 and would be inserviced at that time. Interview with NA #3 was conducted 8/22/12 at 3:50 PM. NA #3 stated she assisted with the transfer of Resident #29 on 8/9/12. NA #3 stated the resident's leg straps were secured to the lift and that NA #1 was adjusting the lift in order to secure the shoulder straps to the lift. NA #3 stated she was adjusting the resident's bed linen and was not assisting NA #1 to guide the equipment and assist with placement of the sling at the time of the fall. Interview with the Director of Nursing (DON) was conducted 8/22/12 at 4:30 PM. The DON stated staff were expected to secure slings appropriately and monitor residents to ensure safe transfers with mechanical lift equipment.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

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F 371	Continued From page 8 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to serve cold food at safe temperatures during the dinner meal service. The findings are: A review of a facility policy titled "Food Service" and not dated indicated in part "cold foods will leave the kitchen at a maximum temperature of 41 degrees Fahrenheit." A review of a recipe titled "Cole Slaw" and not dated indicated in part to blend the cabbage with salad dressing/mayonnaise, sugar, salt and vinegar. Chill in two (2) inch deep container to 41 degrees Fahrenheit or below. Hold on ice for service at 41 degrees Fahrenheit or below for up to one (1) hour. Discard any product that exceeds 41 degrees Fahrenheit during service. A review of a document titled "Therapeutic Spreadsheet for - Sunday Week 5" indicated coleslaw was on the menu for the dinner meal service for all diets which included regular, mechanical soft, pureed and low concentrated sweets. During an observation on 8/19/12 at 5:14 PM of the tray line during the evening meal service the	F 371		

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F 371	Continued From page 9	F 371		

Dietary Manager (DM) checked the temperature of each food item that was to be served to the residents and recorded it on a temperature log. The DM pulled a tray of individual servings of coleslaw from a walk-in refrigerator and checked the temperature with a digital thermometer. The temperature reading was verified by the DM as 51 degrees Fahrenheit. The DM placed the coleslaw back inside the walk-in refrigerator and continued to check the temperatures of other food items.

During an interview on 8/19/12 at 5:18 PM the DM stated it was acceptable to serve the coleslaw at 51 degrees Fahrenheit as long as the temperature did not go up higher and if it was served within one-half hour or so. He further stated the mayonnaise in it was kept refrigerated and the cabbage was pre cut so it should be alright. He explained the usual range for serving cold foods was 40-41 degrees Fahrenheit and they tried to keep cold food items between 40-41 degrees during the meal service. He further stated he did not know when the coleslaw was made.

During an interview on 8/19/12 at 5:21 PM the Cook stated she made the coleslaw when she came in to work at 12:30 PM today and she put the coleslaw in the walk-in refrigerator immediately after she made it.

During an observation on 8/19/12 at 5:22 PM the DM placed ice in a shallow baking sheet and set it on a cart next to the serving line. He then removed the individual containers of coleslaw from the walk-in refrigerator and sat each of the containers on top of the ice. Dietary Aide #1

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F 371	Continued From page 10 immediately picked up several containers of coleslaw and placed them on resident's food trays. The DM checked the temperature of the coleslaw on the resident's meal trays and the temperature reading in the first container by a digital thermometer was verified by the DM at 49 degrees Fahrenheit. The DM checked the temperature of a second container of coleslaw and the temperature was verified by the DM at 50 degrees Fahrenheit. During an interview on 8/19/12 at 5:25 PM the DM stated he thought it was okay to serve the coleslaw and instructed dietary staff to continue plating the food and filling the dining carts for distribution to the resident halls and dining rooms. During an observation on 8/19/12 at 5:40 PM the first dining cart was rolled out of the kitchen with coleslaw on the resident's trays by the Assistant Dietary Manager. During an interview on 8/19/12 at 6:14 PM the Cook stated she did not go by a recipe to make the coleslaw. She explained the cabbage was already chopped when it was delivered but she ran it through the food processor again to make sure it was in small pieces and then she added mayonnaise, sugar and vinegar. During an interview on 8/19/12 at 6:22 PM the DM stated their policy was to keep cold food at 41 degrees Fahrenheit and obviously we weren't there. He stated the walk-in refrigerator was fairly new and he was not sure why the temperature of the coleslaw didn't go down. During a follow up interview on 8/22/12 at 1:40	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE PO BOX 6208 STATESVILLE, NC 28677

(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 371	Continued From page 11 PM the Cook explained after she made the coleslaw, she put it in a large clear bowl and put it in the walk-in refrigerator. She explained Dietary Aide #2 put the coleslaw in the individual cups around 4:00 PM and put them back in the walk-in refrigerator until it was served at the dinner meal service.	F 371		