

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirements under states and federal laws.</p> <p>All non-covered letters for identified residents and all other residents have been reviewed. All non-covered letters for residents for prior three months have been reviewed. Business Office Manager, Social Worker, and Admissions Coordinator were inserviced by the Administrator on proper completion of non-coverage letters and Advanced Beneficiary Notices and timely notification to residents/families on 12/20/12 and 12/21/12. Administrator will review each Non-Coverage letter to ensure the letters were given within the 2 day time period and included the reason for non-coverage and the estimated costs for the next eight</p>	12/28/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

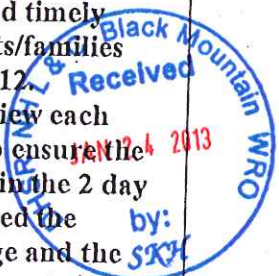
Administrator

(X6) DATE

January 23, 2013

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 12-21-12 mh



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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 156	<p>Continued From page 1</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This</p>	F 156	<p>weeks and then will review 1 Non-Coverage weekly for the next eight weeks. Administrator provides a report of reviews to the Quality Assurance Committee quarterly.</p> <p>Medicare notification eligibility posting was replaced during survey. This posting is verified weekly for four weeks by visual observation by Administrator. Results of the visual posting verification are recorded on a QA monitoring form. The Medicare Notification Eligibility Posting is then recorded every two weeks on the QA Monitoring form for the next 2 months. These reports will be reported to the QA committee quarterly.</p>		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 156	<p>Continued From page 2</p> <p>includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide Medicare non-coverage letters with all required information for 3 of 3 residents reviewed (Residents #47, #55, and #18), failed to provide Medicare non-coverage letters within the 2 day time requirement for 1 of 3 residents (Resident #47) and failed to post information relating to applying and using Medicare benefits.</p> <p>The findings are:</p> <p>1. The Medicare non-coverage letters were incomplete as follows:</p> <p>a. Resident #47's Medicare non-coverage letter for services ending 08/08/12 did not include a reason Medicare covered services were ending nor the expected payment for services. The place</p>	F 156			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 156	<p>Continued From page 3</p> <p>on the form for the estimated cost of services and reason services were ending was blank. In addition the responsible party did not mark if she wanted to receive or not receive these services, hence indicating if she wanted an appeal review by Medicare.</p> <p>On 11/30/12 at 4:19 PM the Business Office Manager (BOM) described the process for notification of Medicare non-coverage. She stated that either therapy or the Minimum Data Set (MDS) nurse notified her of the expected end in therapies and that it was discussed in morning meetings. The BOM stated she called the responsible party and told them of the pending notice and need to sign the form. She stated she explained the date of non-coverage and usually the reason for meeting maximum potential. She stated she did not know she was to be more specific in the reasons Medicare coverage was ending, nor that she had to include estimated costs for continued services in the notification letter. She further stated the corporate staff obtained the responsible parties signature and did not ensure the option for an appeal was checked.</p> <p>The BOM further stated that she was off work when this notice originated on 08/02/12. She stated when she was off, then MDS would often take over for her or if out for longer periods of time, corporate staff would take over the responsibility of sending the notifications. The BOM stated that there was no actual person assigned to handle the Medicare non-coverage letters when the BOM was off work.</p> <p>On 11/30/12 at 4:37 PM, MDS nurse stated that</p>	F 156		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 156	<p>Continued From page 4</p> <p>the MDS staff try to work together in regards to executing the Medicare non-coverage letters timely, but there was no specific person who was responsible for handling the notifications when and if the BOM was off work.</p> <p>On 11/30/12 at 4:59 PM the Administrator stated that the corporate staff was notified on 08/02/12 of the impending end in Medicare coverage for Resident #47 but did not know why the letter was incomplete.</p> <p>b. Resident #55's Medicare non-coverage letter for services ending 07/23/12 did not include a specific reason Medicare covered services were ending nor the expected payment for services to continue. The form gave the vague reason "no longer meets Care A criteria." The place on the form for the estimated cost of services was blank.</p> <p>On 11/30/12 at 4:19 PM the Business Office Manager (BOM) described the process for notification of Medicare non-coverage. She stated that either therapy or the Minimum Data Set (MDS) nurse notified her of the expected end in therapies and that it was discussed in morning meetings. The BOM stated she called the responsible party and told them of the pending notice and need to sign the form. She stated she explained the date of non-coverage and usually the reason for meeting maximum potential. She stated she did not know she was to be more specific in the reasons Medicare coverage was ending, nor that she had to include estimated costs for continued services in the notification letter.</p> <p>c. Resident #18's Medicare non-coverage letter</p>	F 156		
-------	--	-------	--	--

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 156	<p>Continued From page 5</p> <p>for services ending 06/29/12 did not include a reason Medicare covered services were ending nor the expected payment for services to continue. The form gave the vague reason "no longer meets Care A criteria." The place on the form for the estimated cost of services was blank.</p> <p>On 11/30/12 at 4:19 PM the Business Office Manager (BOM) described the process for notification of Medicare non-coverage. She stated that either therapy or the Minimum Data Set (MDS) nurse notified her of the expected end in therapies and that it was discussed in morning meetings. The BOM stated she called the responsible party and told them of the pending notice and need to sign the form. She stated she explained the date of non-coverage and usually the reason for meeting maximum potential. She stated she did not know she was to be more specific in the reasons Medicare coverage was ending, nor that she had to include estimated costs for continued services in the notification letter.</p> <p>2. A two day notice of Medicare non-coverage was not provided as follows:</p> <p>a. Resident #47's medicare non-coverage letter which stated Medicare covered services were ending on 08/08/12 included a handwritten not that the responsible party was notified via phone on 08/07/12. The responsible party signed the notice on 08/08/12.</p> <p>On 11/30/12 at 4:19 PM interview with the BOM revealed that she was off work when this notice originated from therapy on 08/02/12. She stated when she was off, then MDS would often take</p>	F 156			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 156	Continued From page 6 over for her or if out for longer periods of time, corporate staff would take over the responsibility of sending the notifications. The BOM stated that there was no actual person assigned to handle the Medicare non-coverage letters when the BOM was off work. On 11/30/12 at 4:37 PM, MDS nurse stated that the MDS staff try to work together in regards to executing the Medicare non-coverage letters timely, but there was no specific person who was responsible for handling the notifications when and if the BOM was off work. On 11/30/12 at 4:59 PM the Administrator stated that the corporate staff was notified on 08/02/12 of the impending end in Medicare coverage for Resident #47 but did not know why the notice was late. 3. Observations on 11/30/12 at 9:11 AM and at 1:01 PM revealed there was no posted information related to informing residents how to apply for and use Medicare benefits. On 11/30/12 at 1:01 PM the Administrator stated he was responsible for ensuring the required postings were up and available. The Administrator stated he checked the postings regularly and did so as late as last week. He stated he thought it was posted with the other postings. Upon review of the posted information, the Medicare information was not present, nor was there a blank spot indicating the posting was removed. The administrator stated he may have missed checking for the Medicare information when he checked the posting regularly.	F 156			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 225	<p>Continued From page 7 ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>Residents #'s 21, 14, and 113 experienced no negative outcomes. The DON, ADON, and Administrator were re-inserviced by Regional QA Nurse for reporting all allegations of abuse and neglect within 24 hours. Followed up with complete investigation of witness statements, interviews, notification of police, and state agencies as required in the five day follow up. A QA tool (form) was devised to log allegations – date of 24 hour report – who informed, witness statements, interviews, 5-day completed and faxed date using fax report or red stamp. A fax verification form or <u>Fax Stamp</u> is maintained with or attached to the allegation on the date the information is faxed to state agency. All allegations are logged on the QA Log Form by the DON or ADON on the day the allegation is reported to the HCPR. <i>This is an ongoing process.</i> The DON is responsible for monitoring and maintaining compliance by reviewing and auditing all allegations and reports to the QA Committee quarterly.</p>	12/27/12	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 225	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to report an allegation of abuse within 24 hours to the state's Health Care Personnel Registry (HCPR) for 3 of 18 allegations of staff to resident abuse (Residents #21, #14 and #113).</p> <p>The findings are:</p> <p>1. Resident #21 was admitted to the facility on 12/14/11 with diagnoses that included hypertension, diabetes and others. The most recent Minimum Data Set (MDS) dated 10/18/12 specified the resident's cognition was not impaired.</p> <p>Review of a written statement dated 01/17/12 made by nurse aide (NA) #1 specified Resident #21 complained to NA #1 that NA #2 was rude and mean to the resident during care and refused to assist her.</p> <p>A review of the 24 hour initial report dated 01/18/12 revealed a completed abuse allegation which read in part Resident #21 complained that nurse aide #2 was rude and mean. Fax confirmation of the 24 hour report specified the allegation was reported to the state on 01/24/12.</p> <p>On 11/30/12 at 12:45 PM NA #1 was interviewed and reported on 01/17/12 she reported for her usual assignment that included Resident #21. She added that while she was providing care for Resident #21 the resident told her that NA #2 spoke rudely to her and treated her meanly and did not assist her. NA #1 stated that she was</p>	F 225			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 225	<p>Continued From page 9</p> <p>trained to report concerns regarding abuse and neglect immediately to a nurse. She stated she notified the night shift nurse and also wrote a statement that was given to the Director of Nursing regarding Resident #21's concerns with the treatment she had received from NA #2.</p> <p>On 11/29/12 at 12:05 PM the Director of Nursing (DON) was interviewed and reported that when she received allegations of resident abuse she immediately initiated a "24-hour Initial Report." She stated that she was aware the report was required to be faxed to the HCPR within 24 hours of receiving an allegation of resident abuse. The DON reviewed the 24-Hour Initial Report dated 01/18/12 and the corresponding fax confirmation dated 01/24/12. The DON stated it was an oversight that the report was submitted late. The DON stated that when she received complaints from alert and oriented residents regarding staff rudeness she took it seriously and proceeded with an abuse investigation. The DON stated she considered being mean and rude to a resident to be abusive.</p> <p>On 11/29/12 at 12:30 PM the Administrator was interviewed and reported he expected the allegation to have been reported to the state agency within 24 hrs when the facility became aware of the alleged allegation of employee to resident abuse.</p> <p>2. Resident #14 was admitted to the facility on 04/06/12 and expired on 11/29/12. The most recent Minimum Data Set (MDS) dated 09/12/12 specified the resident's cognition was not impaired.</p>	F 225			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 225	<p>Continued From page 10</p> <p>Review of a written statement dated 01/17/12 made by nurse aide (NA) #1 specified Resident #14 complained that NA #2 was rude and mean to the resident during care and stated she was scared of NA #2 and the harsh way she treated the resident.</p> <p>A review of the 24 hour initial report dated 01/18/12 revealed a completed abuse allegation which read in part multiple residents complain that nurse aide #2 is rude and mean. Fax confirmation of the 24 hour report specified the allegation was reported to the state on 01/24/12.</p> <p>On 11/30/12 at 12:45 PM NA #1 was interviewed and reported that on 01/17/12 she provided care to Resident #14. She stated that during her shift the resident began crying and stated she was scared on NA #2 because the way the NA had treated the resident. NA #1 stated that she was trained to report concerns regarding abuse and neglect immediately to a nurse. She stated she notified the night shift nurse and also wrote a statement that was given to the Director of Nursing regarding Resident #14's concerns with the treatment she had received from NA #2.</p> <p>On 11/29/12 at 12:05 PM the Director of Nursing (DON) was interviewed and reported that when she received allegations of resident abuse she immediately initiated a "24-hour Initial Report." The DON stated she considered being mean and rude to a resident to be abusive. She also added that she considered the allegation to be potentially abusive because Resident #14 was scared of NA #2. She stated that she was aware the report was required to be faxed to the HCPR within 24 hours of receiving an allegation of</p>	F 225		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 225	<p>Continued From page 11</p> <p>resident abuse. The DON reviewed the 24-Hour Initial Report dated 01/18/12 and the corresponding fax confirmation dated 01/24/12. The DON stated it was an oversight that the report was submitted late.</p> <p>On 11/29/12 at 12:30 PM the Administrator was interviewed and reported he expected the allegation to have been reported to the state agency within 24 hrs when the facility became aware of the alleged allegation of employee to resident abuse.</p> <p>3. Resident #113 was admitted to the facility on 05/19/12 and discharged to home. The most recent Minimum Data Set (MDS) dated 10/16/12 specified the resident's cognition was not impaired.</p> <p>Review of a written statement dated 09/21/12 specified Resident #113 complained that staff member #2 was hateful and rude and told the resident, "I'm done with you."</p> <p>A review of the 24 hour initial report dated 09/21/12 revealed a completed abuse allegation which read in part resident complained that staff member #2 is hateful and rude. Fax confirmation of the 24 hour report specified the allegation was reported to the state on 09/25/12</p> <p>On 11/29/12 at 12:05 PM the Director of Nursing (DON) was interviewed and reported that when she received allegations of resident abuse she immediately initiated a "24-hour Initial Report." She stated that she was aware the report was required to be faxed to the HCPR within 24 hours of receiving an allegation of resident abuse. The</p>	F 225			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 225	Continued From page 12 DON reviewed the 24-Hour Initial Report dated 09/21/12 and the corresponding fax confirmation dated 09/25/12. The DON stated it was an oversight that the report was submitted late. On 11/29/12 at 12:30 PM the Administrator was interviewed and reported he expected the allegation to have been reported to the state agency within 24 hrs when the facility became aware of the alleged allegation of employee to resident abuse.	F 225			
F 226 SS=E	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 observations, staff interviews and record reviews the facility failed to fully investigate an allegation that an alert and oriented resident (Resident #42) acted sexually inappropriate to another resident (Resident #13) for 1 of 1 allegation of sexual abuse and failed to review a nurse aide's Health Care Personnel Registry (HCPR) verification report for 1 of 5 new employees (Nurse Aide #3). The findings are: 1. A document titled "Autumn Care of Mocksville Abuse and Neglect Policy" (not dated) read in part, "Autumn Care of Mocksville will not tolerate	F 226	Allegation for resident abuse neglect for resident's # 42 and resident # 13 was investigated by administrative staff at the facility: Neither resident experienced negative outcomes from the allegation or investigation results. Resident # 42 no longer resides in the facility. Autumn Care of Mocksville reports all allegations of abuse, neglect, and misappropriation as required by state and federal regulation using the steps provided in F226: 1. Screening 2. Training 3. Prevention 4. Identification 5. Investigation 6. Protection 7. Reporting/Response	12/27/12	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 226	<p>Continued From page 13</p> <p>any form of resident abuse. The Administrator and Director of Nursing (DON) will vigorously investigation all allegations of abuse." The policy specified that an abuse investigation would include:</p> <p>- signed and dated statements from all persons involved.</p> <p>Resident #42 was admitted to the facility on 07/20/12 with diagnoses that included post-traumatic stress disorder, schizophrenia and psychosis. The most recent Minimum Data Set (MDS) dated 10/23/12 specified the resident's cognition was not impaired. The MDS also specified the resident had no documented behaviors.</p> <p>Resident #13 was admitted to the facility on 04/13/12 with diagnoses that included dementia, depression and anxiety. Resident #13 had a court appointed legal guardian. Resident #13 had a cognition care plan dated 04/25/12 that specified she needed cueing related to poor safety awareness, had difficulty finishing thoughts, needed supervision and cueing for decision making, exhibited recollection problems and was unable to provide specific details. The most recent Minimum Data Set (MDS) dated 09/10/12 specified the resident had no cognitive impairment.</p> <p>Review of Resident #42's nurses' notes specified the resident was out of his room daily and interacted with residents. Nurses' notes indicated he was alert and oriented to name, date, time and location. Nurses' notes also indicated Resident</p>	F 226	<p>The DON and ADON were inserviced reviewing State and Federal Regulations for Reporting and Investigating Abuse/Neglect/and Misappropriation by the regional QA nurse. In-service consisted of reporting allegations, 24 and 5-Day reporting, obtaining witness statements, and interviews of other staff, visitors, or residents as may be indicated according to whomever witnessed the allegation or may have been potentially affected by the allegation.</p> <p>Resident #42 was immediately removed from the dining room and was provided 1-1 observation by staff until transfer to hospital for evaluation.</p> <p>No other residents were at risk for a recurrence of this behavior from resident #42 as 1-1 staff provided observation around the clock until discharge 10/31/2012.</p> <p>A QA tool is devised to log all reports of abuse/neglect to better ensure allegations are thoroughly investigated. The log reveals the date of the reported allegation, date of 24 hour report, witness</p>	
-------	--	-------	--	--

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 226	<p>Continued From page 14</p> <p>#42 was allowed outside unsupervised with other residents.</p> <p>A nurses' entry dated 10/25/12 specified Resident #42 was observed by staff member #1 in the dining room with his hand underneath Resident #13's nightgown.</p> <p>A document dated 10/25/12 written by staff member #1 specified on 10/25/12 at 4:30 PM she observed "Resident #42 with his hand between Resident #13's legs."</p> <p>Review of Resident #42's medical record revealed he was sent to the Emergency Department for a psychiatric evaluation and returned to the facility on 10/26/12 with no new physician's orders. After Resident #42 returned to the facility he was placed on one to one supervision.</p> <p>Review of Resident #13's medical record revealed she was sent to a separate Emergency Department for evaluation of sexual abuse and returned to the facility on 10/25/12 with no evidence of sexual abuse.</p> <p>A document titled "24-Hour Initial Report" dated 10/25/12 was faxed to the state's Health Care Personnel Registry (HCPR) that specified the facility was going to investigate an allegation of resident to resident sexual abuse.</p> <p>The facility provided their complete investigation of the observed incident that revealed the investigation consisted of a witness statement from staff member #1. Staff member #1 reported that upon entering the dining room she observed</p>	F 226	<p>statements for investigation/follow up. All allegations for any type of abuse, neglect, or misappropriation are thoroughly investigated, obtaining witness statements from staff, visitors, or residents who witnessed or were at risk for harm from the alleged behavior.</p> <p>This QA tool serves as a permanent process and all allegations are logged by the DON or ADON. The DON is responsible for monitoring, compliance, and reports findings to QA Committee quarterly.</p> <p>Autumn Care of Mocksville follows all guidelines in the state and federal regulation as required for conducting investigations for allegations of abuse/neglect/and misappropriation.</p> <p>Autumn Care of Mocksville follows all state and federal regulations for pre-screening of nurse aides with the HCPR prior to hire.</p> <p>NA #3 was checked online with HCPR on 9/13/2012. NA #3 had</p>		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 226	<p>Continued From page 15</p> <p>Resident #42 with his hand between Resident #13's legs and when she entered the dining room Resident #42 withdrew his hand and moved away from Resident #13. The investigation summary completed by the Director of Nursing (DON) specified the allegation of abuse was unsubstantiated.</p> <p>On 11/29/12 at 12:00 PM the DON was interviewed and stated she was responsible for investigating allegations of abuse. She explained that her process for conducting an abuse investigation consisted of interviewing residents that were involved and witnesses. The DON confirmed she did not interview Resident #42 regarding the observed allegation of sexual abuse on 10/25/12. The DON stated the residents had been alone in the dining room and she did not interview other staff members to find out if anyone else had witnessed the incident. The DON reported that during the investigation of sexual abuse she did not interview other residents to determine if Resident #42 had sexually abused any other female residents. She stated that she believed concerns would have been reported to her and didn't feel it was necessary to talk with other residents. The DON confirmed that since Resident #42's admission to the facility he had been alone with other female residents.</p> <p>A document titled "Mocksville Police Department Investigation Report" dated 10/25/12 specified Resident #13's legal guardian spoke to her about the incident. Resident #13's legal guardian reported to the police that Resident #13 would not tell anyone what Resident #42 had done to her because she did not want to be thought badly of.</p>	F 226	<p>no allegation of abuse/neglect and began work at the facility on 10/2/2012. On 10/16/2012, she was randomly checked by Payroll Staff and the result indicated that she has "1 pending investigation for an allegation of neglect of a resident." Regulation reveals a facility must not employ individuals who have been "found guilty of abusing, neglecting, or mistreating residents by a court of law" or "have had a finding entered in to state nurse aide registry, concerning abuse, neglect, mistreatment of residents or misappropriation of their property." A "Finding" is "defined as a determination made by the state that validates allegation of abuse, neglect, mistreatment of residents, or misappropriation of their property." 483.13. NA #3 did not meet the criteria for "Finding" as is defined in regulation 483.13. NA #3 was interviewed by Regional QA Nurse, Administrator, DON, and State Surveyor during survey. Disciplinary action was enforced and NA #3 is no longer employed at Autumn Care as she failed to inform facility for pending</p>	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 226	<p>Continued From page 16</p> <p>On 11/29/12 at 12:00 PM the Administrator was present during the interview with the DON and confirmed no other residents were interviewed to determine if Resident #42 had been observed touching other residents inappropriately. He stated he believed the incident was isolated but had no documentation. The Administrator also reported that Resident #42 was discharged to another skilled nursing facility on 10/31/12.</p> <p>2. A document titled "Autumn Care of Mocksville Abuse and Neglect Policy" (not dated) read in part that procedures to ensure residents were free from verbal, sexual, physical and mental abuse included a new employee screening process. The policy specified that any positive findings that indicate a history of abuse will prevent hiring or result in immediate termination. Steps to screen potential employees included:</p> <ul style="list-style-type: none"> - License/Certification verification with the North Carolina Board of Nursing (NCBON) and CNA Health Care Personnel Registry (HCPR). <p>On 11/29/12 at 9:10 AM the Payroll Office was interviewed regarding the process for screening potential new employees. She stated that she was responsible for running a criminal background check on all potential new employees and gave reports with findings to the Administrator for review. The Payroll Officer stated that the Director of Nursing (DON) was responsible for performing license and certification verifications on all nursing staff (HCPR reports). NA #3's personnel record was randomly selected for review for evidence of pre-screening. NA #3's personnel record</p>	F 226	<p>allegations. DON performed 100% check for all other nurse aides currently employed and found certification intact with no allegation of abuse/neglect or misappropriation. All potential new hire nurse aides are checked for allegations prior to being hired, and then rechecked with HCPR within 90 days of hire date, by the DON, ADON, or Administrator. If allegations are present, further investigation is done by DON or Administrator. Only the DON, ADON, or Administrator performs checks and reviews with HCPR. No nurse aide is ever offered a job if "Findings" are substantiated on certification. DON maintains certification notebook for nurse aides. The DON is responsible for compliance and reports findings to QA Committee quarterly.</p>		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 226	<p>Continued From page 17</p> <p>revealed she was hired on 10/02/12. Review of her HCPR report dated 10/16/12 specified she had the following findings:</p> <ul style="list-style-type: none"> - 1 pending investigation for an allegation of Abuse of a Resident - 1 pending investigation for an allegation of Neglect of a Resident. <p>The Payroll Officer stated that she was unaware of results and added it was the DON's responsibility to review the results of NA #3's HCPR report.</p> <p>On 11/29/12 at 9:30 AM the DON reviewed NA #3's HCPR report dated 10/16/12 and stated she was unaware the NA had 2 pending investigations of resident abuse and resident neglect. She stated her usual practice was to run the HCPR report during the interview process to verify if the potential new employee had any history of abuse of a resident. The DON stated that had she been aware of the pending allegations she would have investigated by asking NA #3 about the findings and would have called the HCPR for more information. She stated that pending investigations would have likely made a difference whether or not the employee was hired.</p> <p>On 11/29/12 at 10:15 AM NA #3 was observed working independently with residents in the facility.</p> <p>On 11/29/12 at 11:00 AM the Payroll Officer was interviewed again and stated that she had been asked by the Administrator on 10/16/12 to audit the personnel records to ensure all necessary</p>	F 226			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 226	<p>Continued From page 18</p> <p>documentation was in place. She stated that she observed NA #3's personnel record that revealed the nurse aide did not have a HCPR report on file so she ran a new one on 10/16/12. She stated she was trained to look at the "top portion" of the report to verify the license/certification was current. She stated she did not look at the bottom section of the report that specified NA #3 had 2 pending investigations of resident abuse and resident neglect. She added that the report was filed and not shared with the DON or Administrator.</p> <p>On 11/29/12 at 11:15 AM the Administrator was interviewed and stated he was aware the Payroll Officer had audited personnel files. He stated he expected the Payroll Officer to review HCPR reports to verify nurse aides employed by the facility did not have any substantiated findings of resident abuse or resident neglect. He confirmed that the Payroll Officer had not reviewed NA #3's report in its entirety. He stated he would expect the Payroll Officer to have notified the DON of the findings on NA #3's HCPR report. The Administrator also added that he would expect NA #3 to notify the DON of an impending investigation by the HCPR. He stated that NA #3 was told during the orientation process to report changes in her HCPR status to the DON. He provided NA #3's signed acknowledgement in her new employee handbook that she would notify the facility of community misconduct.</p> <p>On 11/29/12 at 4:00 PM the DON provided documentation that specified NA #3 was interviewed on 09/13/12 and her HCPR report was reviewed and revealed there were no pending investigations of abuse or neglect. The</p>	F 226		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 226 F 253 SS=E	<p>Continued From page 19</p> <p>DON stated that report had been kept in her email and had not been printed and filed in NA #3's personnel record.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to clean stained bathroom floors and grout, failed to secure wallpaper and baseboards, repair and clean toilets seats, maintain the varnish on furniture and keep door frames free of chips and jagged edges. This was observed on 3 of 4 halls. (Halls 200, 300 and 400).</p> <p>The findings are:</p> <p>1. Bathrooms were not clean and orderly as follows: a. The bathroom between Rooms 405 and 407, shared between 4 residents, was observed on 11/28/12 at 9:11 AM with the vinyl baseboard pulled away from the wall approximately 6 inches and protruding several inches. The toilet seat extender was not properly in place, secured in the nonskid leg holders, and the seams of the seat's vinyl were yellowish brown. On 11/28/12 at 5:01 PM, on 12/01/12 at 10:44 AM the baseboard had been glued but all else remained the same. b. The bathroom between Room 204 and Room 205, shared by 4 residents, was observed with</p>	F 226 F 253	<p>All bathroom floors identified during the survey have been stripped/waxed or are in the process of being replaced. Materials to replace flooring have been ordered. Identified toilet seat extenders, toilets, baseboards, wallpaper and doorframe moldings are in process of being repaired or replaced.</p> <p>A 100% audit on 12/18/12 of all resident bathrooms was performed. Identified areas are being corrected. The floor of one bathroom and the wallpaper/baseboard of one bathroom will be repaired or replaced each week until all bathrooms that need repair have been addressed. Completion time is 12 months.</p> <p>The Maintenance Supervisor or designee completes facility rounds of all resident bathroom floors, wallpaper, baseboards, toilet seat extenders, toilet seats, and doorframe coverings 1 time per week for next 2 months. These rounds will continue as part of the Maintenance rounds on a permanent basis. Areas identified</p>	12/29/12

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 253	Continued From page 20 dark brown grout around the toilet at the floor level on 11/28/12 at approximately 11:45 AM. This remained the same on 11/28/12 at 5:06 PM and on 12/01/12 at 10:01 AM. c. The bathroom between Room 209 and Room 207, shared by 4 residents, had an elevated toilet seat with rusty support bars close to the toilet seat on 11/28/12 at 10:05 AM and 5:06 PM. This remained the same on 12/01/12 at 10:06 AM. d. The bathroom between Room 210 and Room 208, shared by 3 residents, had a stained plastic toilet seat and the lid of the toilet's water reservoir was chipped and jagged on 11/28/12 at 9:38 AM. In addition, the wallpaper and baseboards were buckling away from the walls. The wallpaper seams by the sink were separating and the wall beneath darkened. The grout around the commode was dark and stained as was the floor. This was the same on 12/01/12 at 10:06 AM, except the toilet seat had been replaced. e. The bathroom between room 211 and 213 shared by 3 residents was observed with a stained tile floor, darkened grout around the commode and with a toilet seat extender with support bars with peeling paint and rusty metal on 11/28/12 at 10:08 AM. In addition, the wallpaper was peeling in a shape of a T and peeled back exposing a discolored wallboard. This remained the same on 11/28/12 at 5:10 PM and on 12/01/12 at 10:07 AM. f. The bathroom between Room 212 and Room 214 shared by 4 residents was observed at 11/28/12 at 10:22 AM with brown stains on the floor and around the grout of the commode. The plastic toilet seat was cracked in front at least 2 inches (at 7 o'clock position) with separation. The floor was sticky with a stale odor. The wallpaper and baseboards were buckling. This remained	F 253	will be repaired at that time or scheduled to be repaired. Report of findings/concerns is presented to the Quality Assurance Committee quarterly.		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 253	<p>Continued From page 21</p> <p>the same on 11/28/12 at 5:11 PM and at 12/01/12 at 10:18 AM.</p> <p>g. The bathroom between Room 215 and Room 217 shared by 4 residents was observed at 11/28/12 at 9:30 AM with buckling wallpaper and baseboards and torn sticky wallpaper in the shape of a T by the sink. The discolored brown wallboard was visible where the wallpaper was torn and curled. The grout around the commode was darkened and discolored and the floor was sticky. This remained the same on 11/28/12 at 5:11 PM and on 12/01/12 at 10:20 AM.</p> <p>On 11/29/12 at 9:25 AM, Housekeeper #2 stated the caulking was discolored because it was old. She stated she tried to scrape and scrub the grout and sometimes maintenance helped clean it. She also stated items needing repair were reported to the Maintenance Supervisor.</p> <p>On 11/29/12 at 11:19 AM Nurse Aide #11 stated she reported maintenance issues to the maintenance supervisor or reported things to the nurse. Staff always fixed the things she had reported.</p> <p>On 11/29/12 at 12:20 PM Housekeeper #1 reported environmental concerns to the maintenance supervisor. She tried try to scrub the grout and reported it to the Maintenance Supervisor if she could not clean it up well enough.</p> <p>On 11/29/12 at 1:32 PM Nurse Aide #6 stated any maintenance issues were reported to the Maintenance Supervisor, Administrator, Director of Nursing or Assisted Director of Nursing. She further stated when she reported things, they</p>	F 253			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 253	<p>Continued From page 22 were quickly fixed.</p> <p>On 12/01/12 at 10:01 AM interview with the Maintenance Supervisor revealed that when the grout and floor got bad, he removed the toilets, replaced the tiles and grout. He further stated there were bathrooms he still had to get to that were in need of repair. The Maintenance Supervisor also stated that they had just changed the chemicals used for floor cleaning as the previous cleaner left a sticky residue. He stated that usually he had a list of things needing attention when he arrived on Mondays. He had not known about the cracked toilet seat, the chipped toilet bowl cover or the support bars on the elevated toilet seats. He further stated he repaired the torn wallpaper several times and just tried to be more creative in order for the wallpaper to stay secured to the walls.</p> <p>Interview with the Maintenance Supervisor on 12/01/12 at 10:06 AM revealed that staff either verbally informed him of needed repairs, filled out a maintenance form or leave him handwritten notes about things that needed attention.</p> <p>On 12/01/12 at 10:09 AM the maintenance supervisor stated that the baseboards and wallpaper were buckling due to too much water over time with leaks and/or floor cleaning and buffing. The maintenance supervisor and Administrator stated they have been discussing calling in a professional to address these areas.</p> <p>2. Wallpaper was separated or frayed: a. On 11/28/12 at 9:11 AM the wallpaper seam above room 405 in the hall was separated from the top of the door to the ceiling.</p>	F 253			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 253	<p>Continued From page 23</p> <p>b. On 11/28/12 at 9:16 AM the wallpaper on the wall edge in Room 309, between the sink and bathroom, was ripped approximately one and a half feet from the floor. It remained that way on 12/01/12 at 10:37 AM.</p> <p>c. On 11/28/12 at 9:38 AM. the wallpaper above bed B in Room 210 was separating for a length of at least two feet.</p> <p>Interview with the Maintenance Supervisor on 12/01/12 at 10:06 AM revealed that staff either verbally informed him of needed repairs, filled out a maintenance form or left him handwritten notes about things that need attention. He stated he continued to repair wallpaper as needed. He further stated he had fixed wallpaper in the past and fixed wallpaper as he saw the need or it was reported.</p> <p>3. Doorframes were chipped and jagged: a. On 11/28/12 at 11:41 AM, Room 300's doorframe was covered partially with a plastic molding. This molding was cracked and jagged at the bottom near the floor and pulled away a couple of inches. This remained the same on 12/01/12 at 10:30 AM. b. On 11/28/12 at 11:41 AM, Room 302's doorframe was covered partially with a plastic molding. This molding was cracked and jagged at the bottom near the floor. This remained the same on 12/01/12 at 10:30 AM.</p> <p>On 12/01/12 at 10:30 AM, interview with the maintenance supervisor and the Administrator revealed the door frames had been covered in plastic covers in the past. Trying to remove the plastic caused more damage to the doors. The Administrator and Maintenance stated they were</p>	F 253			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 253	<p>Continued From page 24</p> <p>considering bringing in a professional to handle the door frames since it was facility wide.</p> <p>4. Furniture with worn varnish and exposed wood:</p> <p>a. On 11/28/12 at 10:00 AM and at 4:58 PM, the bed side tables in Room 301 had the had the varnish rubbed off the top edges exposing unfinished wood. This remained the same on 12/01/12 at 10:35 AM.</p> <p>b. On 11/28/12 at 2:43 PM and at 5:10 PM the bedside table in Room 211 had chipped Formica exposing the wood underneath at the edges. This remained the same on 12/01/12 at 10:18 AM.</p> <p>c. On 11/28/12 at 9:30 AM in Room 215 the varnish on the bedside table edges were worn, leaving exposed wood. This remained the same on 11/28/12 at 5:11 PM and on 12/01/12 at 10:20 AM.</p> <p>Interview with the Maintenance Supervisor on 12/01/12 at 10:06 AM revealed that staff either verbally informed him of needed repairs, filled out a maintenance form or left him handwritten notes about things that need attention.</p> <p>On 12/01/12 at 10:18 AM the Administrator stated that the furniture was replaced as the varnish was observed worn away. Some of the furniture was getting to the point of needing to be replaced.</p> <p>5. Personal Care Equipment not stored in a sanitary manner:</p> <p>a. On 11/28/12 at approximately 11:45 AM, in the bathroom between Room 204 and Room 205, shared by 4 residents, was a soiled unlabeled bed pan directly on the floor unbagged with bagged bedpan on top. This remained the same</p>	F 253		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 253	Continued From page 25 on 11/28/12 at 5:06 PM. The bed pans were gone on 12/01/12 at 10:01 AM but the floor was sticky. b. On 11/28/12 at 10:22 PM in the bathroom between Room 212 and Room 214, shared by four male residents had two unlabeled urinals on each side of the commode seat extender arms which were soiled. This remained at 11/28/12 at 5:11 PM. On 11/29/12 at 11:19 AM Nurse Aide #11 that personal care equipment should be labeled, bagged and stored. On 11/29/12 at 1:32 PM Nurse Aide #6 stated personal care equipment should be labeled and stored in plastic bags. Interviews on 12/01/12 at 9:48 AM with the Director of Nursing revealed personal care equipment such as urinals and bedpans should be labeled, rinsed and stored off the floor in a cabinet or under a sink.	F 253			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272	Resident #53 experienced no negative outcomes. A behavior care plan was initiated 7/10/2012 and revised 7/13/2012, 7/24/2012, 7/26/2012, 7/27/2012 and 11/29/2012. The Social Worker and MDS Nurses were re-inserviced by the Regional QA Nurse and DON for proper coding of behaviors of MDS and	12/27/12	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 272	<p>Continued From page 26</p> <p>Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to comprehensively assess 1 of 1 sampled resident for behaviors. (Resident #53).</p> <p>The findings are:</p> <p>Resident #53 was admitted to the facility on 07/10/12 with diagnoses including dementia with behaviors.</p>	F 272	<p>thorough completion of comprehensive and quarterly assessments, by reviewing narrative notes, mood/behavior sheets, and staff/family interviews in order to trigger the CAA when behaviors are identified in the look back period for an MDS. A QA Behavior Log Tool is initiated when the MDS Nurse sets the ARD Date. This tool prompts review of behaviors in the look back by reviewing mood/behavior sheets, interviews, and narrative notes in the look back period to ensure an accurate comprehensive/quarterly assessment, The Tool is given to the Social Worker to review and date completion of behaviors in the look back period, for all comprehensive and quarterly assessments. When the Social Worker completes the QA tool used to review behaviors identified on the comprehensive or quarterly assessment, the QA tool is returned to the respective MDS Nurse who reviews accuracy of the comprehensive or quarterly assessment MDS, according to review of the Log and follow up with staff/family interviews,</p>	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 272	<p>Continued From page 27</p> <p>Nursing notes dated 07/10/12 revealed Resident #53 became very combative, getting out of bed, refusing to be helped, and cursing at staff. The note stated family came with food and stated that this was normal behavior.</p> <p>A behavior needs assessment dated 07/11/12 stated he needed behavior interventions, help with adjustment, redirection, spend one on one time, monitoring of agitation, pain and changes in mental status.</p> <p>Nursing notes dated 07/14/12 at 2:39 AM revealed he was found on his back on the floor at 1:20 AM. Resident #53 was confused and cussing.</p> <p>Review of the admission Minimum Data Set dated 07/17/12 coded Resident #53 as having no behaviors. There was no Care Area Assessment (CAA) completed for behaviors. CAA for psychotropic medication use dated 07/26/12 mentioned the resident "has exhibited some behaviors." CAA for falls dated 07/26/12 referred to the nursing note of 07/10/12 relating to "combativeness and verbal aggression (sic) with staff; has extensive HX (history) of this." Neither CAA described more of a description of the problems, the causes, contributing factors and risk factors related to behaviors. A care plan for behaviors was developed 10/25/12 which included the interventions of distraction, medication administration and monitoring.</p> <p>Interview on 12/01/12 at 1:05 PM with the MDS nurse #1 stated the social worker was responsible for coding and assessing the areas of his discipline, such as cognition, behaviors, and</p>	F 272	<p>narrative documentation and review of mood behavior, questionnaires. The MDS Nurse then turns QA Tool in to DON who does third review for accuracy of the assessment. Audits for behaviors and accuracy of the comprehensive or quarterly assessment for all MDS x 2 weeks beginning 12/19/2012, by Social Worker, MDS Nurse, and DON, then audit 6 residents/week for 2 weeks, then 3 random weekly audits for 8 weeks. The DON is responsible for monitoring compliance and reports findings to the QA Committee quarterly.</p>		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 4007 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 272	Continued From page 28 mood. She further stated the resident had behaviors which she referred to in other CAAs. On 12/01/12 at 1:10 PM the social worker stated he was responsible for coding the MDS sections of behaviors and the CAAs for his triggered areas. He stated he usually reviewed nursing notes to identify behaviors and that by miscoding the MDS, the computer did not trigger behaviors as requiring a comprehensive assessment of Resident #53's behaviors. He stated he was aware of Resident #53's behaviors and should have comprehensively assessed this area on the CAA form. The Director of Nursing also present at this time, confirmed behaviors should have been comprehensively assessed.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	Resident #53 bowel and bladder status was reassessed on 12/19/12 by the Regional QA Nurse. Individualized interventions include resident #53 placed on scheduled toilet for bladder using urinal with clothing and urinal assistance provided by staff. Resident #53 denies awareness for bowel urge, but will be offered opportunity for bowel-movement, when urinal offered during care rounds. Resident #53 is offered bed pan or toilet using maxi lift for transfer. Care plan goal revised 12/19/12 "will have less than 3 urinary incontinence episodes daily. Resident #53 continues to have frequent incontinent episodes and does not verbalize toileting needs.	12/27/12

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 29 under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop care plans with measurable goals and individualized interventions for 2 of 3 sampled residents with incontinence (Residents #53 and #104) and 1 of 4 sampled residents with falls (Resident #34).</p> <p>The findings are:</p> <p>1. Resident #53 was admitted to the facility on 07/10/12 with diagnoses including dementia with behaviors, renal failure, diabetes, dementia, prostatic disorder, and urine retention.</p> <p>The admission Minimum Data Set dated 07/17/12 coded Resident #53 as requiring extensive assistance with transfers and toileting and being frequently incontinent of bladder.</p> <p>The Care Area Assessment (CAA) which addressed incontinence dated 07/26/12 stated Resident #53 had a diagnoses of prostatic hypertrophy and was on medication. The CAA stated the resident "does report the urge to void but through staff interview, he does not communicate this. A urinal is noted in his room and he says he does not use it." Documentation under analysis revealed staff reported better bowel control and they have assisted him to toilet via maxi lift. Therapy had assisted him too but reported he usually did not use the toilet. The plan was to proceed to a care plan.</p>	F 279	<p>Individualized interventions for resident #104 include being reassessed for bowel bladder needs 12/19/12 by the Regional QA Nurse. The resident does not respond to questions. Per interview with nurse aide resident is placed on scheduled toileting with care rounds which are approximately every 2 hours using sara lift for transfer to toilet or bedpan during waking hours. Individual interventions put in place were included in the care plan goal revised 12/19/12. "Resident will have less than 3 urinary incontinence episodes during waking hours." Resident continues to have episodes of incontinence.</p> <p>Bowel bladder reassessments were completed on all residents found on facility quality measures "Low risk bowel/bladder" list. In addition a 100% review of all resident care plans for bowel and bladder has been reviewed with interventions and measureable goals revised.</p>	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 30</p> <p>Review of the current care plan developed 07/26/12 revealed the problem of "Bladder Elimination Needs." The goal was for the resident to have elimination needs met daily with assistance as needed from staff through next review." Interventions included extensive assistance needed, total assistance needed, used adult briefs and pads, may assist to toilet with maxi lift as indicated, consult with rehab as needed and assist resident with peri-care as needed after toileting.</p> <p>Interviews with nurse aides revealed different understandings relating to Resident #53's needs as follows:</p> <p>*Nurse Aide (NA) #7 stated 11/28/12 at 12:00 PM that at times the resident sometimes asked for a urinal and was more alert relating to voiding needs when up in the wheelchair.</p> <p>*Nurse #13 stated on 11/28/12 at 4:26 PM Resident #53 was totally incontinent.</p> <p>*NA #9 stated on 11/28/12 at 4:37 PM that she never offered to take him to the commode and just checked and changed him as he was totally incontinent.</p> <p>*NA #14 stated on 11/30/12 at 8:52 AM that Resident #53 was not offered a urinal or taken to the bathroom.</p> <p>*Nurse #7 stated on 11/30/12 at 8:56 AM the resident will not ask to go to the commode and that he was totally incontinent.</p> <p>*On 11/30/12 at 5:31 PM NA #12 stated that he will take the resident to the commode when he asks. Per NA #12 when he asked to go to the bathroom, Resident #53 was dry and successfully use the commode. NA #12 stated it is like he was "continent" at times. Other times he just checked and changed the resident.</p>	F 279	<p>Further all new residents bowel and bladder are assessed at admission and a follow up audit to review elimination needs and care plan is completed within 24 hours to ensure interventions and measureable goals.</p> <p>Licensed nurses and nurse aides were re-inserviced for assisting residents to maintain highest level of continence through appropriate assessment using the bowel and bladder assessment and toileting with care rounds and as needed per each individual assessment. Each new admission is assessed for bowel & bladder needs on admission, quarterly, and prn with condition changes and care plans with measurable goals implemented, based on the assessment, narrative documentation, including staff, resident and family interviews. MDS nurses review each Bowel & Bladder Questionnaire and look at nurses notes based on history. Measurable goals are implemented according to each resident's individual needs. A QA tool is used by the MDS</p>	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	Continued From page 31 Interview with the MDS Nurse #1 on 12/01/12 at 1:22 PM revealed that per the CAA, Resident #53 did not tell staff when he needed to void. MDS nurse #1 stated the resident's behaviors was a factor in developing the care plan and whether Resident #53 would be taken to the commode, offered a urinal or just changing his incontinent brief when soiled. When asked what Resident #53's elimination needs were she could not be specific. MDS Nurse #1 further stated assisting him to the toilet as indicated meant that if he tried to go to the commode the nurse aides should take him. The Director of Nursing, present at this interview stated the intervention of assisting to the toilet "as indicated" was vague. 2. Resident #104 was admitted to the facility on 06/19/12 with diagnoses including altered mental status, Alzheimer's Disease, benign hypertension, and a history of urinary tract infections. The admission Minimum Data Set (MDS) dated 06/19/12 coded her with severely impaired cognitive abilities, requiring extensive assistance for transfers and toileting, and being frequently incontinent. The Care Area Assessment (CAA) dated 6/29/12 stated a care plan would be developed due to incontinent care needs. The CAA continued stating that with therapy, Resident #104 required maximum assist to take off soiled briefs and apply a new one. Family requested pull ups and reported the resident had a history of urinary tract infections. Staff reported that Resident #104 did not communicate to them before voiding.	F 279	nurses to monitor bowel/bladder assessments to ensure measurable goals are implemented. Individualized interventions for resident #34 include resident being reassessed for falls on 12/20/12. Resident #34 continues to be noncompliant for asking for assistance and is high risk for falls. Nurse aide care guide revised on 12/20/12 addressing behaviors of noncompliance for requesting assistance and frequent visual checks under safety during care rounds by care givers. Individualized interventions for care plan for Resident 34 were revised 12/20/12 and added frequent visual checks and inconsistent use of call light for assistance. Revised fall goal reveals: "will have less than 4 falls/week through next review." Revised 12/20/2012.	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 32</p> <p>The care plan which addressed the problem of bladder elimination needs had the goal for the resident to have elimination needs met daily with assistance as needed from staff through next review. Interventions included extensive assist needed, perform personal hygiene as tolerated and able, use adult briefs/pads, family prefers pull-ups during the day, and she did not consistently report her need to void.</p> <p>Nurse Aide (NA) #8 stated on 11/28/12 at 12:45 PM Resident #104 was totally incontinent and always had been incontinent. NA #8 stated she usually takes the resident to the commode three times a week for bowel movements and not always but often for toileting. Follow up interview with NA #8 revealed the NA took the resident to the commode once a shift for a bowel movement and just checked and changed her at other times.</p> <p>Nurse #9 stated on 11/30/12 at 9:00 AM that Resident #104 was incontinent and staff on second shift just checked and changed her.</p> <p>During interview with the MDS Nurse #1 on 12/01/12 at 1:44 PM, the nurse could not specify what was meant with the goal to have elimination needs met. The Director of Nursing (DON), present at this interview, stated the staff know to offer to take the resident to the bathroom. The DON further stated this was the family's expectation and what the resident needed.</p> <p>3. Resident #34 was admitted to the facility on 10/18/11 with diagnoses including osteoarthritis, peripheral vascular disease and cellulitis of her legs.</p>	F 279	<p>All residents with falls noted on facility matrix reassessed for falls risks using the falls risk assessment available in the computer system and care plan goals revised as needed by MDS nurses.</p> <p>A QA tool has been created and is used to monitor falls, bowel and bladder assessments, and measurable care plan goals. Measurable goals for bowel & bladder, falls, and care plan interventions are reviewed weekly during at risk meeting. This is an ongoing process done with each resident comprehensive and quarterly assessment. The MDS nurses are responsible for monitoring & compliance and report findings to QA Committee quarterly.</p>		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 33</p> <p>A review of the most recent annual Minimum Data Set (MDS) dated 09/22/12 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The MDS further indicated Resident #34 required extensive assistance by staff for transfers and ambulation.</p> <p>A review of a care plan titled Ambulation Needs and dated 07/12/12 indicated generalized weakness, unsteady gait, resident used walker, one person assist and consult with physical therapy as needed. The goals indicated Resident #34 would maintain current ability to ambulate as tolerated through next review of 01/05/13. The interventions indicated Resident #34 was ambulatory with assistance and ambulated with a walker.</p> <p>A review of a Care Area Assessment dated 10/02/12 indicated Resident #34 was at risk for falls due to a history of falls. The document further indicated Resident #34 got up without assistance, had an unsteady gait and required a walker to ambulate.</p> <p>A review of a care plan titled Fall Risk and dated 10/03/12 indicated Resident #34 was at risk for falls, had poor safety awareness and would not use her call bell. The interventions on the care plan indicated to keep call light in reach and provide frequent visual checks.</p> <p>A review of a facility document titled Event Investigation Report and dated 11/21/12 indicated Resident #34 had a history of falls and preventive measures were to place call light within her reach. The interventions listed was to remove the</p>	F 279		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 34 over bed table from her room.</p> <p>A review of a facility document titled Care Guide and dated 11/05/12 indicated in a section labeled "ambulation" that Resident #34 was ambulatory with assistance and ambulated with a walker. A section labeled "cognitive" indicated Resident #34 was able to use call bell and place within reach. A section labeled "safety/restraint" indicated Resident #34 was at risk for falls; no side rails and call light within reach.</p> <p>During an observation on 11/28/12 at 9:42 AM Resident #34's privacy curtain was pulled to the foot of her bed and Resident #34 was sitting behind it in a recliner chair next to her bed with an over bed table and a walker sitting in front of her. Both of her lower legs were elevated on the foot rest of her chair and her lower legs were wrapped in large dressings and the skin that was uncovered by dressings on each lower leg was bright red and swollen.</p> <p>During an interview on 11/28/12 at 10:35 AM Nurse #1 stated she encouraged Resident #34 to use her call light when she needed to go to the bathroom. She explained they tried a pressure alarm in Resident #34's chair in the past but it made her agitated so they discontinued it and had not tried it again. She stated they tried to keep the call bell by her side and told her to use it and everybody who walked by her room was supposed to check on her.</p> <p>During an interview on 11/28/12 at 12:00 PM Nurse Aide (NA) #4 stated Resident #34 got up frequently and walked herself to the bathroom. She further stated when she could catch Resident</p>	F 279			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	Continued From page 35 #34 getting up she assisted her to the bathroom but sometimes the resident got up and she didn't know she was up. She explained the nurses told them when a fall intervention was needed and it was supposed to be written on the care chart that was located inside the door of her closet. She stated they encouraged Resident #34 to use her bell but she was not aware of any other fall interventions that were in place. During an interview on 12/01/12 at 12:18 PM MDS Nurse #1 explained care plans were developed when residents were admitted and the nurses initiated the care plan. She further explained the CAA assessments were done when they did their scheduled MDS assessments and any new problem areas were supposed to be added to the resident's plan of care. During an interview on 12/01/12 at 12:20 PM MDS Nurse #2 stated they had a weekly meeting and resident falls were discussed and any new interventions to prevent falls should be added to the care plans. During an interview on 12/01/12 at 2:17 PM the Director of Nursing stated it was her expectation for staff to protect Resident #34 from injury because her falls were inevitable. She further stated the care plans should be updated when the resident had a fall and the care guides located inside Resident #34's closet should include all fall prevention interventions which included frequent visual checks of Resident #34.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	<p>Continued From page 36</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility staff failed to turn a resident in manner to prevent pain and to notify the nurse of a resident's pain during the provision of care for 1 of 2 sampled residents observed during incontinent care. (Resident #56).</p> <p>The findings are:</p> <p>Resident #56 was admitted to the facility with diagnoses of osteoporosis and diabetes. Review of Resident #56's most recent Quarterly Minimum Data Set (MDS), dated 09/18/12, revealed she had mild cognitive impairment and needed extensive assistance with all activities of daily living. Furthermore, the MDS assessed Resident #56 as requiring extensive assistance of one person for bed mobility.</p> <p>A review of Resident #56's care plan dated 11/27/12 revealed she had pain and comfort needs as evidenced by complaints of pain related to her recent fracture of her left femur. Staff was to observe for pain during turning and positioning. The goal was for Resident #56 to have no pain preventing activities of daily living care from being performed.</p>	F 309	<p>NA #6 was re-inserviced for turning and positioning using draw sheet or pad and inquiring about pain before providing care. If a resident complains of pain notify nurse and wait to administer care. Inservice was provided by the Regional QA Nurse on 12/18/12. All licensed nurses and nurse aides were inserviced by the Regional Nurse Consultant or DON for monitoring pain during care and proper technique using draw sheet or pad for turning or positioning. An audit tool has been created to monitor discomfort during care and proper turning and positioning. The DON or ADON audits 5 random aides weekly during delivery of resident care x 4 weeks, then the DON or ADON audits 3 aides weekly x 4 weeks during deliver of resident. The DON/ADON then performs 5 random visual audits during delivery of care monthly for</p>	12/27/12	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	<p>Continued From page 37</p> <p>Review of Medication Administration records revealed Resident #56 had Vicodin ordered for pain every 4 hours as needed for pain. Further review of the MAR revealed the she had not received this medication during the two weeks prior to 11/28/12.</p> <p>An observation of care was made on 11/28/12 at 11:36 AM for Resident #56 provided by Nurse Aide (NA) #6. While providing incontinence care and a bed bath for Resident #56, NA #6 turned the resident several times. Each time NA #6 turned the resident she placed her hands on the resident's upper left thigh and her back. A draw sheet was observed on the resident's bed but it was not utilized for turning the resident. Each time NA #6 turned Resident #56 she cried out in pain, "Oh, my leg". Once the resident was in a lying still she appeared comfortable. Resident #56 was observed wearing a leg immobilizer on her left leg during care.</p> <p>An interview was conducted on 11/28/12 at 11:50 AM with NA #6 who stated Resident #56 usually cried out in pain when she turned her while providing care. She stated she had never notified the nurse to let her know the resident was experiencing pain during care.</p> <p>An interview was conducted on 11/28/12 at 12:15 PM with Nurse #2. Nurse #2 stated she had worked with Resident #56 for about two weeks. She stated direct care staff had never notified her of Resident #56 experiencing pain during care and she had never medicated Resident #56 for pain prior to care.</p> <p>An interview was conducted on 11/28/12 at 2:42</p>	F 309	<p>dependent residents for 3 months. Specifically observing turning and repositioning techniques and any verbal or non-verbal indications during the delivery of care that the resident has pain. The DON is responsible for monitoring compliance and reports finding to QA Committee quarterly.</p>	
-------	---	-------	--	--

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	Continued From page 38 PM with NA #6. She stated she was unaware she should have turned the Resident #56 differently. She stated she was nervous and was not thinking. An interview was conducted on 11/30/12 at 11:50 AM with the Director of Nursing (DON). The DON stated it was her expectation for staff to turn residents using a draw sheet unless the resident can help themselves to turn. The DON further stated NA #6 should have reported to the nurse the resident was experiencing pain during care.	F 309			
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to cueing and encouragement to feed herself to maintain independent feeding ability for 1 of 3 sampled residents. (Resident #104). The findings are: Resident #104 was admitted with diagnoses including altered mental status, Alzheimer's	F 310	Resident #104 has been placed in restorative dining program to monitor assistance for verbal cues and physical needs during meals and ability to adequately feed self 6 days/week. NA #13 was re-inserviced for importance of residents completing ADL to maintain the highest level of independent care by the Regional QA Nurse 12/19/12 Licensed nurses and nurse aides were re-inserviced 12/19/12 for importance of helping/assisting residents to maintain ADL at the highest level of functioning. A QA tool was created and residents are observed during meal times 5 days per week for 8 weeks by the DON, ADON, or Administrator to monitor	12/27/12	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	<p>Continued From page 39 disease, and depressive disorder.</p> <p>The admission Minimum Data Set (MDS) dated 06/19/12 coded her with severely impaired cognitive impairment and being independent with eating with set up help only. No Care Area Assessment triggered for review of eating or other activities of daily living skills.</p> <p>The MDS quarterly dated 09/18/12 coded her as requiring supervision and one person physical assistance with eating.</p> <p>A current care plan which addressed Resident #104's eating needs was developed on 10/01/12. The goal was for the resident to maintain current abilities with eating through next review. Interventions included encourage self feeding, deliver and set up tray, open food containers, prepare food, i.e. cut up meat, assist with eating as needed, and provide cueing as needed to stay focused on meals and self feeding.</p> <p>Resident #104 was served her tray on 11/28/12 at 12:34 PM in the dining room. Nurse Aide (NA) #13 set up her meal tray and without walking away immediately began feeding her. Resident #104 would open her mouth when NA #13 provided a bite of food. NA #13 continued to feed her and hold her drink for her without providing an opportunity for Resident #104 to feed or drink independently.</p> <p>Interview on 11/28/12 at 12:45 PM with NA #8 who was regularly assigned to Resident #104 revealed the resident required set up and then usually staff went and checked on her throughout the meal. This morning NA #8 stated Resident</p>	F 310	<p>residents/ feeding/ADL needs. The QA tool reveals:</p> <ol style="list-style-type: none"> 1. Proper table height. 2. Residents who need verbal encouragement or cueing. 3. Residents who need physical assistance are allowed to feed themselves as much as possible. 4. Residents who play in their food are redirected. 5. Any residents identified as candidates for risk of decline. <p>Meal time audits are conducted 2 meals per week by the ADON or DON in order to identify resident's changing needs on an on-going basis. The DON is responsible for monitoring audit results & compliance and reports findings to QA Committee quarterly.</p>	
-------	---	-------	--	--

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	<p>Continued From page 40</p> <p>#104 fed herself the entire breakfast this morning in her room. NA #8 stated most of the time, Resident #104 feeds herself and staff will only help if she is not feeding herself.</p> <p>During interview on 11/28/12 at approximately 1:00 PM, NA #13 stated she set up Resident #104's tray, handed her a spoon and she started putting it in other foods and because she liked to eat paper decided to feed her. She further stated that if staff set one thing at a time in front of her she concentrated better than if the entire tray was in front of her.</p> <p>On 11/29/12 at 12:35 PM, Resident #104 was served her tray by an administrative staff. This staff uncovered food items and offered condiments, but failed to cut up her slices of ham or direct her to her utensils. At 12:37 PM Resident #104 attempted to drink her bowl of fruit. She proceeded to pick up her roll and bite into it independently. After she placed the roll on top of her bowl of fruit, at 12:41 NA #13 cut up her meat and began to feed her the food without handing her the utensil or cueing her to begin eating independently. At 12:43 PM, Resident #104 reached toward her food and NA #13 continued to feed her. At 12:46 PM NA #13 held the cup of tea to the resident's mouth so she could drink without trying to have Resident #104 hold the cup independently. At 12:48 PM, the resident was reaching toward her food again and NA #13 physically guided the resident's hand away and told her not to get her fingers in her food. Resident #104 then grabbed a bite of ham with her fingers and ate it. At no time during this observation did NA #13 encourage or physically assist Resident #104 to feed herself. At 12:50</p>	F 310			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	<p>Continued From page 41</p> <p>PM, the surveyor asked NA #13 if Resident #104 could feed herself with utensils. NA #13 responded "sometimes." NA #13 proceeded to hand Resident #104 food on a spoon and the resident proceeded to feed herself. Staff was observed at 12:51 PM to cue the resident to pick up her spoon and the resident did so and took another bite. Then NA #13 held the cup to the resident's mouth for her to drink. NA #13 did not provide her an opportunity to hold the cup and drink independently.</p> <p>On 11/29/12 at 12:55 PM, Resident #104 was independently eating her bowl of fruit. The surveyor asked NA #13 why she changed from feeding Resident #104 to allowing her to feed herself. NA #13 stated she let Resident #104 eat independently after the surveyor asked if Resident #104 could feed herself. She stated she would have let the resident try to feed herself at some point in the meal but she often picked up napkins and tried to eat them. At this time, the resident placed her spoon in her tea glass. NA #13 then removed the tea and the resident proceeded to feed herself the fruit.</p> <p>On 11/30/12 at 9:00 AM interview with Nurse #5 revealed Resident #104 could feed herself and he expected staff to set her up and check on her as she fed herself providing assistance as needed.</p> <p>On 12/01/12 at 1:44 PM, the Director of Nursing (DON) stated Resident #104 has changed in her eating abilities as she played in her food and did not always get food to her mouth. She further stated she ate better with staff feeding her. Per the DON, Resident #104 was sat at the table in the dining room indicating she needed cueing.</p>	F 310			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	Continued From page 42 Her expectation was that if the resident was not feeding herself, the staff need to start feeding her and assist her as necessary. The DON stated staff were expected to give Resident #104 the opportunity to feed herself and that NA #13 needed education.	F 310			
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, staff interviews, and medical record review, the facility staff failed to thoroughly and properly clean a female resident during 1 of 2 observations of incontinence care. (Resident #56). The findings are: Resident #56 was admitted to the facility with the diagnoses that included diabetes, osteoarthritis, and hypertension. A review of the most recent Quarterly Minimum Data Set (MDS) dated 09/18/12 revealed she had mild cognitive impairment and needed extensive assistance with all activities of daily living. Resident #56's current care plan, originated on 09/01/10, indicated she needed extensive assistance with bladder elimination related to her physical condition and cognitive impairment.	F 312	Resident #56 experienced no negative outcomes. NA #6 was re-inserviced for providing proper peri care using front to back technique on 12/19/12. NA #6 has been observed providing peri care and applies proper technique. Licensed nurses and nurse aides were re-inserviced for providing proper peri care using front to back technique to prevent contamination. A QA tool for incontinence care is used to monitor a variety of nurse aides applying peri care. Incontinence care audits are performed by the DON/ADON/Regional QA Nurse 5 x week for 4 weeks observing different nurse aides. Peri care visual audits are then done randomly 5 per month for 3 months. The visual audits may be observed by the licensed nurse. The DON is responsible to monitor compliance and reports finding to QA Committee quarterly.	12/27/12	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 43 Interventions included provide peri-care with each incontinent episode. An observation was made on 11/28/12 at 11:36 PM of incontinence care provided by Nurse Aide (NA) #6. NA #6 removed Resident #56's clothing and incontinence brief. NA #6 proceeded to wash the resident's peri-area using a wash cloth wiping front to back then back to front 3-4 times. As she cleaned she wiped only the outside of the resident's peri-area. The peri-area was rinsed and dried. The resident was turned on her side and the buttocks and anal areas were cleaned properly. An interview was conducted on 11/28/12 at 2:42 PM with NA #6. NA #6 stated she was taught to clean a female resident by wiping front to back, wiping each side and then down the middle. She stated she should have cleaned the resident the way she had been instructed. An interview was conducted on 11/30/12 at 9:19 AM with the Director of Nursing (DON). She stated it was her expectation that when staff provided incontinence care for female residents they should always clean by wiping front to back. She further stated the nursing assistant should have thoroughly cleaned the resident's peri-area.	F 312			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	Resident #53 bowel and bladder status was reassessed 12/19/12 by the Regional QA Nurse. Resident #53 was placed on scheduled toileting for bladder using urinal with clothing and urinal assistance provided by staff approximately every 2 hours with care rounds. Resident #53 denies awareness for bowel urge, but will be offered opportunity for bowels,	12/27/12	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	<p>Continued From page 44</p> <p>who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and family interview, the facility failed to develop and implement a toileting regimen for 2 of 3 sampled residents with incontinence (Residents #53 and #104) to maintain continence.</p> <p>The findings are:</p> <ol style="list-style-type: none"> Resident #53 was admitted to the facility with diagnosis including dementia with behaviors, renal failure, diabetes, dementia, prostatic disorder, and urine retention. <p>The admission Minimum Data Set dated 07/17/12 coded Resident #53 as requiring extensive assistance with transfers and toileting and being frequently incontinent of bladder. This MDS coded the resident with moderately impaired cognition.</p> <p>The Care Area Assessment (CAA) which addressed incontinence dated 07/26/12 stated Resident #53 had a diagnosis of benign prostatic hypertrophy and was on medication. The CAA stated the resident "does report the urge to void but through staff interview, he does not communicate this. A urinal is noted in his room and he says he does not use it." Documentation under analysis revealed staff reported better bowel control and they have assisted him to toilet</p>	F 315	<p>when urinal offered during care rounds. Resident #53 is offered bedpan or toilet using maxi lift. Resident #53 continues to have frequent episodes of incontinence.</p> <p>Resident #104 was reassessed for bowel bladder needs 12/19/12 by the Regional QA Nurse. The resident does not respond to questions. Per interview with nurse aide, resident is placed on scheduled toileting with care rounds which are approximately every 2 hours, using sara lift for transfer to toilet or bedpan during waking hours. Care plan goal revised 12/19/12. "Resident will have less than 3 urinary incontinence episodes during waking hours."</p> <p>All residents listed on the facility Quality Measures "Low risk bowel/bladder" have been reassessed using the bowel and bladder assessment in the computer and found to have care plans with individual measurable goals and interventions in place.</p> <p>Licensed nurses and nurse aides were re-inserviced for assisting residents to maintain highest level</p>	

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	<p>Continued From page 45 via maxi lift. Therapy have assisted him too but report he usually did not use the toilet. The plan was to proceed to a care plan.</p> <p>Review of the care plan, established 07/26/12 and current, revealed the problem of "Bladder Elimination Needs." The goal was for the resident to have elimination needs met daily with assistance as needed from staff through next review." Interventions included extensive assistance needed, total assistance needed, use adult briefs and pads, may assist to toilet with maxi lift as indicated, consult with rehab as needed and assist resident with peri-care as needed after toileting.</p> <p>The 30 day MDS, dated 08/07/12, coded Resident #53 with severe cognitive impairment and total incontinence.</p> <p>On 11/28/12 at 9:05 AM, Nurse Aide (NA) #7 and NA #4 provided Resident #53 with incontinent care. At this time his brief was wet with a smear of bowel movement. Staff did not offer the resident an opportunity to use the commode or urinal.</p> <p>On 11/28/12 at 11:37 AM, NA #7 and NA #10 checked Resident #104 for incontinence, noted his brief was dry and proceeded to transfer him to his wheelchair. Neither nurse aide offered the resident a urinal or an opportunity to use the commode. At 12:00 PM, NA #7 stated Resident #53 will sometimes ask for the urinal or tell you he has to go to the toilet. She further stated he will not use the call bell. When he asked to go the bathroom, NA #7 stated they would transfer him using the lift.</p>	F 315	<p>Each new admission is assessed for bowel & bladder needs on admission, and quarterly with care plans and measurable goals implemented. MDS nurses review each Bowel & Bladder Questionnaire and look at nurses notes based on history.</p> <p>A QA tool is used by the MDS Nurses to monitor bowel/bladder assessments and interventions and this will address residents with the ability to successfully be continent at times and will ensure that they are provided this opportunity. The tool identifies the resident, date of the bowel/bladder assessment, whether it is admission or quarterly assessment, if resident is candidate for bowel/bladder program or maintenance incontinence, is a voiding diary indicated and put in place based on interview with resident, staff, family members and whether it was necessary to revise or update care plan.</p>	
-------	---	-------	--	--

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	Continued From page 46 An interview with Nurse #3 on 11/28/12 at 4:26 PM revealed Resident #53 was totally incontinent.	F 315	This is an ongoing process; each resident is reviewed with quarterly and comprehensive assessment. Every resident will be monitored by this QA tool. The DON is responsible to monitor compliance by reviewing the QA tools and reports findings to QA Committee quarterly.		
	<p>NA #9 stated on 11/28/12 at 4:37 PM that she never offered to take Resident #53 to the commode and just checked and changed him as he was totally incontinent.</p> <p>NA #14 stated on 11/30/12 at 8:52 AM that Resident #53 was not offered a urinal or taken to the bathroom.</p> <p>Nurse #7 stated on 11/30/12 at 8:56 AM the resident will not ask to go to the commode and that he was totally incontinent.</p> <p>On 11/30/12 at 5:27 PM interview with visiting family revealed Resident #53 will occasionally express the need to use the bathroom.</p> <p>On 11/30/12 at 5:31 PM NA #12 stated that he will take the resident to the commode when the resident asked. Per NA #12 when he asked, Resident #53 will be dry and successfully use the commode. NA #12 stated it is like he was "continent" at times. Other times he just checked and changed the resident.</p> <p>Interview with the MDS Nurse #1 on 12/01/12 at 1:22 PM revealed no voiding trial was completed and no individualized toileting program was developed. When asked what was meant by Resident #53's goal to have his elimination needs met were, she could not be specific. MDS Nurse #1 further stated the intervention to assist him to the toilet as indicated meant that if he tried to go to the commode the nurse aides should take him.</p>				

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	<p>Continued From page 47</p> <p>She expected nurse aides to tell her if the resident had continent episodes, tried to use the commode, told staff he had to use the commode and/or staff offered him a urinal and he used it. The MDS Nurse #1 stated a voiding trial was considered based on risk assessments and family interviews. A toileting program would be considered based on a resident's cognition, medications, mobility, behaviors, history, and staff interviews. The Director of Nursing present during this interview stated staff have not communicated a voiding pattern to her.</p> <p>2. Resident #104 was admitted to the facility on 06/19/12 with diagnoses including altered mental status, Alzheimer's Disease, benign hypertension, and a history of urinary tract infections.</p> <p>The admission Minimum Data Set (MDS) dated 06/19/12 coded her with severely impaired cognitive abilities, requiring extensive assistance for transfers and toileting, and being frequently incontinent.</p> <p>The Care Area Assessment (CAA) dated 06/29/12 stated a care plan would be developed due to incontinent care needs. The CAA continued stating that with therapy, Resident #104 requires maximum assist to take off soiled briefs and apply a new one. Family requested pull ups and reported the resident had a history of urinary tract infections. Staff reported that Resident #104 did not communicate to them before voiding.</p> <p>The care plan, originated on 06/29/12 and current, which addressed the problem of bladder elimination needs had the goal for the resident to</p>	F 315			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	<p>Continued From page 48</p> <p>have elimination needs met daily with assistance as needed from staff through next review. Interventions included extensive assist needed, perform personal hygiene as tolerated and able, use adult briefs/pads, family prefers pull-ups during the day, and she did not consistently report her need to void.</p> <p>The 30 day MDS dated 07/17/12 coded Resident #104 as being always incontinent.</p> <p>Nurse Aide (NA) #8 stated on 11/28/12 at 12:45 PM Resident #104 was totally incontinent and always had been incontinent of urine. NA #8 stated she usually took the resident to the commode three times a week for bowel movements and often for toileting but not always.</p> <p>On 11/29/12 at 11:09 AM NA #8 took Resident #104 to the toilet using the sit to stand lift. Upon exit, NA #8 reported the resident was dry and used the commode. She stated she normally took Resident #104 to the commode once per shift and checked and changed her at other times.</p> <p>Nurse #5 stated on 11/30/12 at 9:00 AM that Resident #104 was incontinent. He further stated that he normally worked second shift and that staff on second shift just checked and changed her.</p> <p>During interview with the MDS Nurse #1 on 12/01/12 at 1:44 PM, the nurse could not specify what was meant by the goal to have elimination needs met. MDS Nurse #1 revealed no voiding trial was completed and no individualized toileting program was developed for this resident. The</p>	F 315		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	Continued From page 49 MDS Nurse #1 stated a voiding trial was considered based on risk assessments and family interviews. A toileting program would be considered based on a resident's cognition, medications, mobility, behaviors, history, and staff interviews. The Director of Nursing (DON), present at this interview, stated the staff knew to offer to take the resident to the bathroom. The DON further stated this was the family's expectation and what the resident needed. The DON stated she was sure she was offered to toilet once a shift.	F 315		
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 observations, record review and staff interviews, the facility failed to apply the alarm to 1 of 4 sampled residents (Resident #53) while in bed and in his wheelchair. The findings are: Resident #53 was admitted to the facility with diagnoses including dementia with behaviors, renal failure, diabetes, prostatic disorder, and urine retention.	F 323	Resident #53 has a pressure pad alarm in bed and chair. Resident #53 currently requires extensive to total assist for transfers. He is being referred to therapy. Resident #53 falls risk re-evaluation assessment redone 12/20/12. Resident #53 bed and chair sensor are scheduled to be checked for application and proper working every shift by licensed nurse and prn by CNAs. Nurse aide care guide updated 12/20/12 for sensor alarms to bed and chair. Random daily visual audits are performed throughout the day to ensure proper placement of resident #53 bed and chair sensor alarms. Licensed nurses and nurse aides were re-inserviced for proper placement and checking of alarms by the DON. The DON/ADON checks 5	12/27/12

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 50</p> <p>The admission Minimum Data Set (MDS) dated 07/17/12 coded Resident #53 as requiring extensive-assistance-with-bed-mobility, transfers, toileting and walking. The MDS noted he needed assistance with balancing and had fallen in the last month and previous 2 to 6 months since admission.</p> <p>The Care Area Assessment dated 07/26/12 related to falls stated Resident #53 had a history of falls prior to and since admission.</p> <p>The current care plan, last updated on 09/07/12 which addressed Resident #53 having a fall risk included the interventions of a bed alarm and chair alarm.</p> <p>The quarterly MDS dated 10/16/12 coded Resident #53 has having a history of falls, two without injury, since the prior assessment.</p> <p>Review of the medical record revealed Resident #53 had 10 falls since admission, both from bed and wheelchair.</p> <p>On 11/27/12 at 1:41 PM, Resident #53 was in bed eating from his overbed table and a personal clip alarm was connected to his pillow case not the resident's shirt. No other alarm was observed in place.</p> <p>On 11/28/12 at 8:59 AM, Resident #53 was observed in bed with the clip alarm connected to the top of the mattress sheet. No other alarm was observed. Observations of Nurse aide (NA) #7 and NA #4 changing and dressing him revealed the entire sheet was changed at this time. No pressure alarm was observed at this</p>	F 323	<p>residents daily Monday-Friday for alarms for proper placement and working condition x 4 weeks, then checks 5 residents weekly for proper placement and working condition of alarms times 3 months. Monitoring and placement of alarms is responsibility of all direct care givers on a daily basis from shift to shift by the direct care staff (LPNs, RNs, and CNAs). The DON is responsible for monitoring & compliance and reports to the QA Committee quarterly.</p>	
-------	---	-------	---	--

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 51</p> <p>time, nor did staff apply one when they left him in bed.</p> <p>On 11/28/12 at 9:51 AM, at 10:28 AM and at 11:37 AM, Resident #53 was in bed and the clip alarm was not attached to the resident but the clip was lying on the floor. There was no pressure alarm observed.</p> <p>On 11/28/12 at 11:37 AM, NA #7 and NA #10 were observed transferring Resident #53 from the bed to his wheelchair. No alarm sounded and no pressure alarm was observed on the bed. The clip alarm was not attached to the resident as the clip was lying on the floor. After the transfer, Resident #53 received his lunch tray at 11:56 AM and staff left him in his room in his wheelchair feeding himself lunch. Neither a clip nor pressure alarm was observed in place while Resident #53 was in the wheelchair.</p> <p>On 11/28/12 at 12:58 PM, NA #7 was asked about safety interventions for Resident #53. she did not include the need for an alarm when listing interventions, such as a scoop mattress and floor pad.</p> <p>On 11/28/12 at 4:02 PM, Resident #53 was sitting in his room in his wheelchair and he did not have a clip alarm nor a pressure alarm on his wheelchair.</p> <p>On 11/28/12 at 4:37 PM, Resident #53 was observed in his wheelchair with a clip alarm in place. NA #9 stated he will fall sometimes when he wants something. She stated he was provided a clip alarm in bed and in the wheelchair.</p>	F 323			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 52 On 11/29/12 at 1:29 PM, Nurse #4 stated he was to have a clip alarm while in the wheelchair and a pressure alarm when in bed. She could not recall if the alarms were in place on 11/27/12 or 11/28/12. On 11/30/12 at 5:18 PM NA #9 stated she only used the clip alarm and moved it between the wheelchair and the bed . On 12/01/12 at 10:34 AM, NA #7 stated she was sure Resident #53 had a pressure alarm on in the bed and that she put the clip alarm on him when he was transferred to the chair on 11/28/12. Interview with the Director of Nursing on 12/01/12 at 2:36 PM revealed Resident #53 should have a pressure alarm in bed and a clip alarm when in the wheelchair due to a history of falls.	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	Residents #34 and 109 experience no negative outcomes. NA #5 was re-inserviced for proper technique for cleaning individual wounds to prevent cross contamination by Regional QA Nurse. NA #6 was re-inserviced for proper hand hygiene by the DON. Resident #56 experienced no negative outcomes. LA #1 and 2 were inserviced specifically for proper gowning, gloving and hand hygiene to prevent cross contamination and handling of clean and soiled linens based on	12/28/12

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 53</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to prevent cross contamination between wounds, failed to wash hands between resident to resident care of dressing changes, incontinence care, handling clean linens and failed to remove a gown worn in the dirty laundry from before contact with a resident for 5 of 6 residents (Residents #34, #53, #56, #109 and an unidentified resident).</p> <p>The findings are:</p> <p>1. During an observation on 11/28/12 at 12:43 PM a wound doctor assessed wound lacerations on Resident #34's left (L) and right (R) lower legs.</p>	F 441	<p>"Infection Control in LTC Facilities." Licensed nurses and nurse aides have been re-inserviced for Infection Control Guidelines for hand hygiene and cross contamination risks by the DON. Multiple Infection Control Audits for hand hygiene during care and handling of linens have been completed. The DON audits 5 random employees daily Monday-Friday x 8 weeks for proper hand hygiene, and handling linen. Then the DON performs random audits on laundry, housekeeping, and nursing employees for hand hygiene, infection control issues, and handling of soiled linens. The DON is responsible for compliance and reports findings to QA Committee quarterly.</p>		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 54</p> <p>The wound on Resident #34's (R) leg was a jagged line with stitches at a diagonal angle on the (R) side of the shin bone and the wound on Resident #34's (L) leg was a straight line with stitches that was perpendicular to the (R) side of her shin bone. The skin on Resident #34's lower legs was bright red and both legs were swollen. Nurse Aide (NA) #5 who was assigned as a treatment technician put on gloves and poured saline onto several gauze 4 x 4's stacked on top of each other. He took the saturated gauze and cleaned the wound on Resident #34's (L) leg then with the same gauze pad saturated with saline he cleaned the wound on the resident's (R) lower leg. NA #5 did not turn the dressing saturated with saline or remove any of the gauze from the stack between touching each of the wounds on Resident #34's lower legs. NA #5 then put a non stick dressing on top of each wound and wrapped a dressing around each of Resident #34's lower legs to hold the non stick dressing in place.</p> <p>During an interview on 11/28/12 at 3:12 PM with NA #5 he stated he provided Resident #34's wound care each day. He explained Resident # 34 had a history of peripheral vascular disease (blockage of arteries with decreased blood flow) and cellulitis (a skin infection with redness, swelling, pain and warmth) in both of her lower legs. He stated Resident #34 had a recent fall and lacerated both of her legs and had seven stitches in each leg. He explained it was his usual procedure to either irrigate the wounds with saline solution or clean the wounds with gauze saturated with a saline wound cleaner. He stated the wounds should have been cleaned individually and he should not have touched the wound on Resident #34's (R) leg after he had</p>	F 441		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 55</p> <p>touched the wound on her (L) leg.</p> <p>During an interview on 11/30/12 at 8:45 AM the Director of Nursing explained NA #5 was the treatment technician and did dressing changes on resident wounds. She stated it was her expectation that he should have thrown the gauze away after he touched the first wound and should have removed his gloves and washed his hands. She further stated he then should have put on clean gloves and used clean gauze saturated with saline when he touched the second wound to prevent cross contamination of the wounds.</p> <p>2. An observation was made on 11/28/12 at 12:25 PM of sacral ulcer pressure ulcer wound care for Resident #109. Nurse Aide (NA) #5 was assisted by the Assistant Director of Nursing (ADON) to provide the dressing change. NA #5 removed the old dressing, and cleaned the wound. NA #5 then removed his gloves, washed his hands, and donned new gloves. NA #5 then replaced the resident's dressing to the sacral ulcer. NA #5 then removed his gloves and proceeded to push the treatment cart out of the resident's room but stopped in the doorway. The ADON who had been assisting NA #5 removed her gloves and washed her hands. The ADON left the water running for NA #5 to wash his hands. NA #5 walked to the sink picked up a paper towel and turned off the water to the sink. He did not wash his hands. He then threw the paper towel in the trash and proceeded to push the treatment cart into another resident's room to provide a dressing change.</p> <p>An interview was conducted on 11/28/12 at 4:44 PM with NA #5. NA #5 stated he did not realize</p>	F 441			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 56</p> <p>he had not washed his hands. He then stated he should have washed his hands after changing the resident's pressure ulcer dressing and before leaving the room.</p> <p>An interview was conducted on 11/30/12 at 9:30 AM with the Director of Nursing (DON). The DON stated NA #5 should have washed his hands after changing the resident's dressing and before leaving the resident's room.</p> <p>3. An observation of incontinence care was made on 11/28/12 at 11:36 AM provided by Nurse Aide (NA) #6 for Resident #56. NA #6 provided incontinence care as well as a bed bath for this resident. NA #6 finished care and removed her gloves. NA #6 then exited the room to retrieve a lift. NA #6 did not wash her hands after removing her gloves or prior to leaving the room and obtaining the common use lift. NA #6 came back into the room pushing the lift and proceeded to use the lift to get Resident #6 out of bed and into her geri-chair.</p> <p>An interview was conducted on 11/28/12 at 2:42 PM with NA #6. NA #6 stated she should have washed her hands after removing her gloves and prior retrieving the lift. She stated she was in a hurry.</p> <p>An interview was conducted on 11/30/12 at 9:19 AM with the Director of Nursing (DON). The DON stated NA #6 should have washed her hands after providing care and prior to retrieving the lift.</p> <p>4. On 11/28/12 at 4:02 PM, Nurse Aide (NA) #5 (also a treatment technician) was observed assisting the Assistant Director of Nursing with a</p>	F 441			

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 57</p> <p>dressing change. NA #5 washed his hands and regloved prior to applying a clean dressing to Resident #53's heel. NA #5 proceeded to go into the treatment cart and obtained more tape while wearing the same gloves. He proceeded to apply more tape to Resident #53's heel and replace the tape before removing his gloves and washing his hands.</p> <p>On 11/29/12 at 12:16 PM NA #5 stated he should have removed his gloves prior to retrieving tape from the treatment cart. He stated he was tired and knew better.</p> <p>5. During observations of the facility laundry facilities on 11/28/12 at 10:31 AM, Laundry Aide (LA) #1 was observed handling dirty linen while wearing a gown and gloves. LA #1 proceeded to then wear the gown and gloves out on the floor to gather bags of soiled linen. Once she was back in the laundry and separated the soiled linen into appropriate tubs, LA #1 removed her gown and disposed of her gloves. LA #1 proceeded to removed the clean laundry from the washer without washing her hands after removing her gloves.</p> <p>Interview with the housekeeping supervisor on 12/01/12 at 10:46 AM revealed staff should be washing their hands after removing their soiled gloves and before handling clean linen.</p> <p>6. On 11/26/12 at 12:26 PM Laundry Aide #2 was observed pushing an unidentified resident from the hall into the dining room. LA #2 was wearing a gown over her clothing. She proceeded to enter the central shower room. Interview with LA #2 after she came out of the</p>	F 441		

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 58 shower room revealed she often helps with getting the residents into the dining room. She stated that she had put that gown on in the morning and wore it while she handled and separated soiled clothing. She stated she changes her gown when visibly soiled or it smelled dirty. Interview with the housekeeping supervisor on 12/01/12 at 10:46 AM revealed the laundry staff are not to come into contact with any resident while wearing the gown they wear in the laundry room.	F 441			