

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

PRINTED: 04/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/28/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON ST RAEFORD, NC 28376		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities recertification and complaint investigation survey conducted on 3/28/13.	F 000			

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

TITLE

(X6) DATE

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.

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

PRINTED: 05/06/2013
FORM APPROVED
OMB NO/0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED MAY 17 2013 05/03/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1208 N FULTON ST RAEFORD, NC 28376	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. Facility is using NC special locking system. The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: door to dry storage room in kitchen was being blocked from closing, from boxes. Also, main entrance door to kitchen was not closing	K 000	This plan of correction will serve as the facility's allegation of compliance. Preparation and submission of this plan of correction is in response to HCFA 2567 for the 05-03-2013 survey and does not constitute an agreement or admission of Autumn Care of Raeford of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 05-13-2013. K029 On 5-3-2013, a box was found on the shelf blocking the door from closing in the dry storage room. This box was removed immediately upon discovery. All dietary staff was in-serviced on 5-13-2013 regarding not blocking door with any object. To ensure on-going compliance, the Food Service Director or her designee will audit the dry storage room daily for 4 weeks to ensure there is no object blocking the door from adequately closing. If substantial compliance is found, daily	
K 029 SS=E		K 029		

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

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.

Danielle Yates 5/17/13
FORM CMS-2687(02-98) Previous Versions Obsolete Event ID: FQW/K21 Facility ID: 022054 If continuation sheet Page 3 of 4

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

PRINTED: 05/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON ST RAEFORD, NC 28376	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 and latching.	K 029	auditing will be discontinued. Auditing will continue to be conducted during periodic kitchen rounds conducted by the Food Service Director or Administrator to ensure on-going compliance.	
K 038 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: at time of survey staff was not knowledgeable of emergency release switch located on corridor.	K 038	The results of these audits and areas of concern will be discussed with Administrator in morning meeting each Friday for four weeks for monitoring purposes. On 5-3-2013, the main entrance door to the kitchen was not closing and latching correctly. This was repaired by the Maintenance Director on 5-3-2013. To ensure on-going compliance, the door will be tested weekly for 4 weeks. If substantial compliance is found, weekly monitoring will be discontinued. For monitoring purposes, the Dietary Manager will report the weekly checks every Friday for 4 weeks to the Administrator in morning meeting.	
K 052 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	 K038 On 5-3-2013, a staff member were questioned about the emergency release switch was not knowledgeable of its purpose. This was corrected immediately by In-servicing staff. Remaining staff was In-serviced over the following several days.	

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

PRINTED: 05/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1208 N FULTON ST RAEFORD, NC 28376	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 2	K 052	To ensure on-going compliance, the purpose of the emergency release switch will be discussed with all staff immediately following the next three fire drills on each shift. If substantial compliance is found, discussion of the emergency release station will return to a periodic basis.	
K 061 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: tamper #23 did not send signal to fire alarm control panel when tested.	K 061	Discussion of the emergency release stations following every fire drill will be reported to the Administrator at the Quarterly QA meetings. K052 On 5-9-2013, the strobe that had been found defective was serviced and repaired so that it flashed appropriately. To ensure on-going compliance, the fire alarm system will be tested weekly for 4 weeks. If no deficiencies are found during weekly testing, we will return to regular quarterly testing on each shift. Findings of weekly testing will be reported to the Administrator during morning meeting on Fridays for monitoring purposes.	
K 067 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	K061 On 05-09-2013, tamper switch #23 was serviced and repaired so that it appropriately sends signal to fire alarm control panel when tested.	

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

PRINTED: 05/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON ST RAEFORD, NC 28376	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: return fire/smoke dampers in facility have excess lent on them. 42 CFR 483.70(a)	K 067	To ensure on-going compliance, dampers will be checked weekly for 4 weeks. If no deficiencies are noted, regular quarterly testing of system each shift will resume. Results of the weekly testing of the tamper switch will be discussed with Administrator each Friday in morning meeting. K067 On 5-10-13 all dampers in facility were cleaned. To ensure on-going compliance, Maintenance Director or his designee will clean dampers monthly. A cleaning schedule has been made as a means of documenting when dampers are cleaned. For monitoring purposes, the Maintenance Director will report to Administrator every time the dampers are cleaned and turn in the damper cleaning schedule monthly for 3 months. If substantial compliance is found, results of monthly damper cleaning will return to being discussed with Administrator at the Quarterly QA meeting.	