#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/15/2013 FORM APPROVED

		MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		345314	B. WNG				С
NAME OF P	ROVIDER OR SUPPLIER		77 7	-	OTDEET ADDRESS OF A PARTY	08	/01/2013
	THE THE STATE OF T				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF FOREST CITY				830 BETHANY CHURCH RD		
					FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	A83.20(b)(1) COMPRI ASSESSMENTS  The facility must cond a comprehensive, accorreproducible assessm functional capacity.  A facility must make a assessment of a resident assessment in by the State. The assessment in by the State in the additional assessment in the additional assessmen	n. Event ID #WH7O11. EHENSIVE  uct initially and periodically surate, standardized ent of each resident's  comprehensive ent's needs, using the instrument (RAI) specified essment must include at ographic information;  utterns; ing; ind structural problems; I health conditions; status;	F	272	Residents #'s 32, 89, & 23 experienced no negative outcome Signed certification from the physician has been obtained for each of these residents certifying months or less to live. Resident 89, & 23 MDS were modified an coded as "yes" under section J1 to reflect this status.  A 100% audit of all residents receiving hospice was complete and no other residents were identified with this concern.  MDS nurses were in-serviced by administrator, for reviewing hospidata for certification and accurate coding of the MDS.  A QA tool has been designed to monitor any new residents on hospice to ensure accurate coding on the MDS.	g 6 t #32, id 400 ed y the pice te	8-23-2013 8/19/13
THE	A ATT A TORNE OR PROVIDER/SL	JPPLIER REPRESENTATIVE'S SIGNATURE	(	1	Variable and	0	X6) DATE/
nul dotal and	totoment	Black A		11	11/10/11/11/	751	13115

Any deficiency statement ending with an asterisk (\*) denotes a reficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protegues 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

AUG 2 1 2013

by: PAM

FORM CMS-2567(02-99) Previous Versions Orsclete

Event ID: WH7O11

Facility ID: 923147

If continuation sheet Page 1 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  CARE OF FOREST CITY			830	REET ADDRESS, CITY, STATE, ZIP CODE  0 BETHANY CHURCH RD  0 REST CITY, NC 28043	1 00/	01/2013
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F 272	by: Based on observation and staff interviews the document on the Minit assessment the Programment of the Pr	is not met as evidenced  ns, medical record review, ne facility failed to accurately mum Data Set (MDS) nosis section under "Health ents with a life expectancy of r 3 of 3 established Hospice desident #23, #32 and #89) atus for 2 of 3 sampled #134 and # 152).  admitted to the facility on noses which included and high blood pressure. I record revealed Resident Hospice on 09/13/12 with nes of failure to thrive. 32's Minimum Data Set since her admission to d no MDS's documented a life expectancy of less #12, 03/28/13, 06/28/13).	F	272	The QA tool includes the following 1. Resident's name 2. Signed certification from MD to resident has 6 months or less live.  3. Coded under section J1400 or MDS 4. Coded under hospice MDS, section O100.  The DON audits all new resident with hospice orders, hospice residents are audited weekly to ensure accurate coding on MDS. The DON is responsible for compliance & reports findings to committee quarterly.	hat to f	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) D	ATE SURVEY OMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	343314	B, WING_	272777		08/01/2013
AUTUMN	CARE OF FOREST CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 830 BETHANY CHURCH RD FOREST CITY, NC 28043		
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	when a resident entermeans they have 6 mexpectancy. He confirmed as Hourrently receiving Ho On 08/01/13 at 12:10 Hospice Nurse (HN) a confirmed Resident #3 services of Hospice. Tresident was admitted the resident had 6 more of the resident was admitted the resident had 6 more of the resident was admitted the resident had 6 more of the resident was admitted the resident had 6 more of the resident was admitted the resident had 6 more of the resident was admitted the resident had 6 more of the resident was admitted the resident was admitted the resident was admitted the resident was admitted the resident was those residents rooms which included interview revealed she Worker or nursing whe Hospice Care. MDS Condified she initiated a assessment but the SV care plan and let all the so they could document with the SV care	s into Hospice Care it onths or less life irmed that Resident #32 lospice at this facility and spice Care and Services.  PM in an interview the ssigned to the facility 32 was under the care and The HN revealed when a to Hospice Care it meant in this or less life expectancy.  M in an interview MDS and her responsibility was to so in the even numbered Resident #32. Further was notified by the Social and a resident came under coordinator #1 noted once significant change W initiated the terminal enother departments know that in their MDS section.  Confirmed she would mark are care under the procedures, and Programs' saw the actual physician of a life expectancy of less not check the Prognosis ator #1 stated she had nined documents on the een documentation that id a life expectancy of less and not checked the	F 27	'2		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100		PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  CARE OF FOREST CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 830 BETHANY CHURCH RD FOREST CITY, NC 28043	1 08	8/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Assessments.  On 08/01/13 at 3:30 P Medical Records Staff her responsibility to so medical record on com revealed that once the resident entered Hosp gave it back to the Soc  On 08/01/13 at 3:40 P Worker (SW) revealed each nurse's station w to be scanned. The St documents were scann processed. The SW fo Hospice papers were s official and at that time for the Hospice resider "Terminal/Pallitive Care Coordinator who had th assessment and docum date the resident went SW confirmed the date plan was within the wer contract as Hospice ha the family for full Hospi  On 08/01/13 at 4:30 PM Director of Nurses (DO coordinator had a dead the Significant Change being admitted to Hosp revealed there was son	And in an interview the (MRS) confirmed it was an documents into the inputer. The MRS further initial contract when a ice care was scanned she cial Worker (SW).  M in an interview the Social there was a basket at there documents were put W noted once the ned they came to her to be writher revealed when the signed by the family it was she initiated the care plan at which was:  By, notified the MDS neat resident for mented in the chart the into Hospice Care. The of origination of the care extended the manual to the family signed the dot have permission from the services.  M in an interview the N) confirmed the MDS line of 14 days to make required by a resident ice Care. The DON netimes a delay getting the ice but she would expect to have the information	F	272	2			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	42 72	TIPLE CON	ISTRUCTION		E SURVEY PLETED
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	all the MDS assessment what was going on with be up to the person resection to make sure a documentation reflect.  On 08/01/13 at 4:40 P. Administrator revealed assessments to correct.  2. Resident #89 was a 04/03/13 already on H. that included diabetes respiratory failure and MDS assessments rev. MDS assessment (04/Coordinator #2 was m. a life expectancy of less latest MDS assessment responsibility of MDS of the prognosis section of 07/11/13 MDS assessments resident had short and problems. The Reside included the area: Termon 08/01/13 at 11:00 A County Hospice Home when a resident entersemeant they have 6 more expectancy. He confired was documented as Herman and county Hospice Home was documented as Herman and county Hospice Home when a resident entersemeant they have 6 more expectancy. He confired was documented as Herman and they have 6 more expectancy. He confired was documented as Herman and they have 6 more expectancy. He confired was documented as Herman and they have 6 more expectancy. He confired was documented as Herman and they have 6 more expectancy.	ements for a resident e DON noted she expected ents to accurately reflect the the resident and it would exponsible for a particular the assessment ed the resident.  M in an interview the d she expected the MDS citly reflect the resident.  Admitted to the facility on lospice care with diagnoses the muscle weakness, dysphagia. Review of the realed the initial Admission follo(13) signed by MDS arked with the prognosis of the stan 6 months. The fine of 07/11/13 now the Coordinator #1 did not have marked. Review of the ment documented the foliant to the facility on long term memory tents current care plan minal/Pallative care needs.  AM in an interview the Care Coordinator revealed the into Hospice Care it on the or less life freed that Resident #89 ospice at this facility and topice Care and Services.  PM in an interview the	F	272			

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AUTUMN	CARE OF FOREST CITY			830	BETHANY CHURCH RD REST CITY, NC 28043		
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	confirmed Resident ## services of Hospice. resident was admitted the resident had 6 mo On 08/01/13 at 2:30 P Coordinator #1 reveal assess those resident rooms which included interview revealed she Worker or nursing whe Hospice Care. MDS Contified she initiated a assessment but the Store plan and let all the so they could docume MDS Coordinator #1 c MDS section O for Hos "Special Treatments, F section but unless she signed documentation than 6 months she did section. MDS Coordin looked through the sca computer but had not stated Resident #89 had than 6 months so she if Prognosis section. MD confirmed when a resider less than 6 months and Hospice Care but she if with that Prognosis on On 08/01/13 at 3:30 PM Medical Records Staff (her responsibility to sca	By was under the care and The HN revealed when a to Hospice Care it meant in the HN revealed when a to Hospice Care it meant in the responsibility was to see the responsibility was to see the even numbered Resident #89. Further was notified by the Social en a resident came under Coordinator #1 noted once significant change W initiated the terminal en other departments know in the there would mark expice care under the Procedures, and Programs" saw the actual physician of a life expectancy of less not check the Prognosis ator #1 stated she had anned documents on the seen documentation that ad a life expectancy of less had not checked the DS Coordinator #1 dent was under Hospice in thad a life expectancy of the Resident #89 was under had not documented her her MDS assessments.  M in an interview the (MRS) confirmed it was an documents into the outer. The MRS further	F	272			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DA	NO. 0938-0391 TE SURVEY
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AUTUMN	CARE OF FOREST CITY				30 BETHANY CHURCH RD OREST CITY, NC 28043		
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	gave it back to the Social On 08/01/13 at 3:40 P Worker (SW) revealed each nurse 's station to be scanned. The S documents are scanned processed. The SW for Hospice papers were stationary official and at that time for the Hospice resident "Terminal/Pallitive Card Coordinator who had to assessment and document assessment and document of the Hospice had the resident went SW confirmed the date plan was within the we contract as Hospice had the family for full Hospical On 08/01/13 at 4:30 PM Director of Nurses (DO coordinator had a dead the Significant Change being admitted to Hospical the MDS Coordinators they needed in a timely meet the MDS Requirementering Hospice. The all the MDS assessment what was going on with	dice care was scanned she cial Worker (SW).  M in an interview the Social of there was a basket at where documents were put worker each they came to her to be curther revealed when the signed by the family it was a she initiated the care plan and which was:  e", notified the MDS that resident for mented in the chart the into Hospice Care. The end of origination of the care each the family signed the dot have permission from the care each the family signed the dot have permission from the care each the MDS would expect to have the information manner so they could ments for a resident DON noted she expected that to accurately reflect the resident and it would ponsible for a particular eassessment of the resident.	F	272			

STATEMENT		L				OMB N	<u>10. 0938-0391</u>
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
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AUTUMN	CARE OF FOREST CITY			83	30 BETHANY CHURCH RD		
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F 272	Continued From page	7		272			
		d she expected the MDS	F	272			
	accessments to corre	other specied the MDS					
	assessments to cone	ctly reflect the resident.		-			
	3 Resident #23 was a	admitted to the facility on					
	06/16/2011 with diagn	oses which included heart					
	failure, Parkinson's Di	sease and domentic					
	Review of the medical	record revealed Resident					
		lospice on 04/03/2013 with					
	diagnoses of failure to	thrive. Review of Resident		1			
	#23 's Minimum Data	Set Assessments (MDS)					
	since his admission to	Hospice care revealed no		1			
	MDS's documented wi	th the prognosis of a life					
1	expectancy of less tha	n 6 months.(MDS dated		1			
	04/16/13 and 07/16/13	) Resident #23's latest					
	MDS dated 07/16/13 d	ocumented the resident					
	had short and long teri	m memory problems. The					
	Resident's current care	plan included the area:					1
	Terminal/Pallative care	e needs.					
	On 08/01/13 at 11:00 A	AM in an interview the					
	County Hospice Home	Care Coordinator revealed					
	when a resident enters	into Hospice Care it				M	
	meant they have 6 mor	nths or less life					
	expectancy. He confir	med that Resident #23					
		ospice at this facility and		- 1			
	currently receiving Hos	pice Care and Services.					
	On 08/01/13 at 12:10 F	M in an interview the					
	Hospice Nurse (HN) as	signed to the facility					
	confirmed Resident #23	3 was under the care and					
1	services of Hospice. T	he HN revealed when a					
	resident was admitted t	o Hospice Care it meant				1	
1	the resident had 6 mon	ths or less life expectancy.					
	On 08/01/13 at 3:00 PM	I in an interview MDS					
(	Coordinator #2 revealed	d her responsibility was to					
8	assess those residents	in the odd numbered					
ſ	ooms which included F	Resident #23. Further					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100		E CONSTRUCTION		E SURVEY PLETED	Ī
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F 272	Continued From page	8	F	272				ı
	interview revealed the	facility process was for the						ı
	Social Marker to notife	the MDC Constitution						ı
	Social vvolker to notify	y the MDS Coordinators						ı
	when a resident came	under Hospice Care so	1					ı
	they could initiate a sig	gnificant change within the						ı
		S Coordinator #2 further	1					ı
	revealed she had to no	otify all the departments so						ı
	they could fill out their	part of the assessment and						ı
	she would mark MDS	section O for Hospice care						ı
	under the "Special Tre	eatments, Procedures, and						ı
		t unless she saw the actual						ı
	physician signed descri	t unless she saw the actual						ı
	physician signed docu	imentation of a life						ı
	expectancy of less tha	in 6 months she did not						ı
	check the Prognosis s	ection. MDS Coordinator						ı
	#2 noted sometimes th	ne Hospice documentation						ı
	was not scanned in rig	ht away and she was on a		1				ı
	deadline. MDS Coord	inator #2 confirmed when a						ı
	resident was under Ho	snice Care it meant a						ı
1	resident had a life expe	ectancy of loss than 6						ı
1	months and Resident	cotalley of less than o						ı
1								
1	#23 nad been admitted	d to Hospice Care but she		ı				
1		im with that prognosis on						
	the MDS assessments	i.e				}		
1				- 1		į.		
	On 08/01/13 at 3:30 Pt	M in an interview the						
		(MRS) confirmed it was						
	her responsibility to sca	an documents into the						
	revealed that are a the	puter. The MRS further	1					
	revealed that once the	initial contract when a	1					
	resident entered Hospi	ce care was scanned she						
	gave it back to the Soc	ial Worker (SW).						
la la	On 08/01/13 at 3:40 PM	M in an interview the Social						
	Worker (SW) revealed						l	
		nere documents were put						
	to be seened. The Or	Market and the					ı	
	to be scanned. The SV							
	documents are scanne	d they came to her to be						
	processed. The SW fu	rther revealed when the						
	Hospice papers were s	igned by the family it was					1	
	official and at that time	she initiated the care plan						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DAT	TE SURVEY
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NECT AND WAS PROPERTY	ROVIDER OR SUPPLIER  CARE OF FOREST CITY		8	TREET ADDRESS, CITY, STATE, ZIP CODE 30 BETHANY CHURCH RD OREST CITY, NC 28043	,	
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	date the resident went SW confirmed the date plan was within the we contract as Hospice had the family for full Hospice on 08/01/13 at 4:30 P Director of Nurses (DC coordinator had a dear the Significant Change being admitted to Hospice admitted to Hospice and the MDS Coordinators they needed in a timely meet the MDS Require entering Hospice. The all the MDS assessme what was going on with be up to the person resection to make sure the documentation reflected. On 08/01/13 at 4:40 PI Administrator revealed assessments to correct 4. Resident #134 was a 03/04/13 with diagnose Alzheimer's Disease and The Admission Minimu 03/11/13 documented to long term memory prob	ant which was:  re", notified the MDS that resident for mented in the chart the tinto Hospice Care. The e of origination of the care eek the family signed the ad to have permission from sice services.  M in an interview the DN) confirmed the MDS dline of 14 days to make e required by a resident pice Care. The DON metimes a delay getting the pice but she would expect to have the information y manner so they could ements for a resident e DON noted she expected into the resident and it would esponsible for a particular me assessment and the resident.  M in an interview the she expected the MDS tly reflect the resident.  admitted to the facility on es which included and leukocytosis.  m Data Set (MDS) date the resident had short and	F 272			

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	resident was document personal hygiene, whith as needing no set up was documented understatus that Resident # problems.  Review of the Care Pl. Resident #134 had ora up and staff assistance (whenever necessary)  On 07/30/13 at 9:51 A observed sitting in her Resident #134 smiled tooth. On interview Redenture partial out of his he did not wear her pwith two teeth missing stated she would like his could wear it.  On 08/01/13 at 2:30 Pl. Coordinator #1 revealed assess those residents rooms which included Coordinator #1 noted to came every few month was responsible for se MDS Coordinator #1 cassessments should complain and that Resident #134 did have poor derit fit exactly the choices status so she had check was present".	in (ADL). In addition, the inted under the section on included brushing teeth, for physical help. The MDS or the section for dental 134 had no dental 134 had no dental 134 had no dental 134 had no dental 135 and dental consult PRN 1.  M Resident #134 was room. When spoken to to reveal her broken front resident #134 took her iter table drawer and stated artial because of the gap 1. Resident #134 further iter partial repaired so she in the even numbered resident #134. MDS the facility had a dentist that is and the Social Worker titing the appointments. Confirmed the MDS pordinate with the Care intition but she did not think	F	272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  CARE OF FOREST CITY			8	TREET ADDRESS, CITY, STATE, ZIP CODE 30 BETHANY CHURCH RD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	was poor but she had see the facility dentist.  On 08/01/13 at 4:30 F. Director of Nurses (Deexpected all the MDS reflect what was going would be up to the perparticular section to modocumentation reflect.  On 08/01/13 at 4:40 F. Administrator revealed assessments to correst. Resident #152 was 07/12/13 with diagnost mellitus and periphera.  A review of Resident Data Set (MDS) dated resident was cognitive assistance with her act Further review of the 1 #152 under the section which included brushing or physical assistance with the resident #152 had one of the Care PI Resident #152 had one dental consult PRN (a missing teeth/broken/or 0n 07/31/13 at 2:45 Probserved sitting in her #152 was spoken to her was power of the consult process.	ed resident #134's dentition not put her on the list to at his next visit.  PM in an interview the ON) confirmed she assessments to accurately gon with the resident and it rson responsible for a nake sure the assessment ed the resident.  PM in an interview the dishe expected the MDS city reflect the resident.  PM in an interview the dishe expected the facility on ses which included diabetes all vascular disease.  #152's Admission Minimum of 07/19/13 revealed the ely intact and needed limited citivities of daily living (ADL).  MDS revealed Resident in of personal hygiene; and teeth, as needing no set ince with the task. The MDS is section for dental status and no oral/dental problems.  an dated 07/22/13 revealed al/dental needs, needed is needed) related to	F	272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345314	B. WNG	-		1	С
NAME OF PROVIDER OR SUPPLIER		040514	B. WING	STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u>  08</u>	3/01/2013
AUTUMN CARE OF FOREST CITY				BETHANY CHURCH RD REST CITY, NC 28043			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION S		ULD BE COMPLETION	
	problems with eating of her own mouth care. If she would like to have on 18 on	t #152 stated she had no or chewing and performed Resident #152 further stated a dental consult.  M in an interview MDS ed her responsibility as 1 of was to assess those numbered rooms which is a dentist that came every ocial Worker was the appointments. MDS ned the MDS assessments in the Care Plan and that we missing teeth and poor nator #1 further stated the ent Area on MDS were not sident #152's status so she the above were present".  M in an interview MDS ed her responsibility as 1 of was to assess those numbered rooms. MDS the facility had a dentist nonths and the Social le for setting the pordinator #2 confirmed the build coordinate with the dinator #2 further stated the nt Area on MDS should be above were present" when	F	272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345314	B. WNG	6000		01	C 8/01/2013
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF FOREST CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 830 BETHANY CHURCH RD FOREST CITY, NC 28043			1 00	0/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	every 3 months but Riconsult was pending f would visit the facility.  On 08/01/13 @ 3:55 F Director of Nursing (Dexpected all the MDS accurately reflected the would be the responsi Coordinators or Social check and have docur sections to have reflected to the coordinators of Social check and have docur sections to have reflected to 10 08/01/13 @ 4:40 F Administrator revealed.	esident #152's dental for the next date the dentist PM in an interview the ON) confirmed she assessments to have be individual resident and bility of the MDS I Worker to accurately mented the particular cted the resident.	F	272			