STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	**1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314**

(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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to notify the primary physician of a facility acquired pressure ulcer for	F 157	F157 This plan of correction will serve as the	1/8/15

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

Electronically Signed | 01/09/2015

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F 157	Continued From page 1 1 of 3 residents (Resident # 53) reviewed for pressures ulcers. Findings included: Resident #53 was admitted 4/20/12 with cumulative cerebral vascular accident (CVA), anemia, left sided hemiplegia, dysphagia, dementia and contractures. The 30 day Minimum Data Set (MDS) dated 11/24/14 indicated severe cognitive impairment, no behaviors and he was coded as extensive assistance with bed mobility and eating and total assistance with transfers, toileting, hygiene and bathing. Resident #53 was coded as non-ambulatory and incontinent of bladder and bowel. Record Review revealed evidence of weekly skin assessments. The weekly skin assessment completed 9/12/14, indicated no redness, no blisters or open areas to anywhere of Resident #53's body. The weekly skin assessment completed 9/15/14 also indicated no redness, no blisters or open areas to anywhere to Resident #53's body. Record review revealed a nursing note dated 9/18/14 at 2:34 PM indicating Resident #53 developed an open are to the right outer ankle appearing to be a "busted blister." The area measured "3mm (millimeters) L (Length) and 2.3 W" Width). The unit manager gave instructions to apply wound gel (ointment use to hydrate damaged tissue) and cover with dry gauze, foam pad and wrap area. There was no indication in the nursing note how often the dressing was to be changed or that the primary physician was notified of the newly acquired open area to Resident #53's right outer ankle. Record review revealed the next mention of	F 157	facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 12-11-14 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville 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 January 8, 2015. For the Resident affected: Resident #53 developed a wound on 9-18-2014, treatment was initiated at time of discovery per Wound Care Standing Orders. On 9-18-214 Physician was notified regarding the wound via entry in the communication book at the nurses□ station per physician□s request. During physician visit on 9-19-2014 physician initialed acknowledgment that she had reviewed the entry and the treatment which was initiated per the Facility□s standing orders for pressure sores. Treatment of the affected resident has continued including both treatment of the initial wound and further interventions	

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F 157	Continued From page 2 Resident #53's wound care needs was on 9/22/14 at 2:00 PM in a note labeled as a weekly wound assessment. The "dressing to the right leg was intact" and once removed the wound was described as an "unstageable pressure wound." The area was documented as measuring 2.0 cm (centimeters) L x 4 cm W with serous (thin, watery clear) drainage and the wound base was covered with soft yellow to black eschar (dead tissue). An "unstageable" pressure ulcer may be described as full thickness tissue loss with exposed bone, tendon or muscle. Necrosis/eschar may also be present. The note read treatment was changed to Santyl and a moisten gauze daily. A review of the "Wound Care Standing Orders" indicated a state 4 pressure ulcer with eschar or necrotic tissue was to be treated using Santyl and covered with a hydrocolloid or foam dressing daily. A review of the Treatment/Procedure Administration Record for September 21014 indicated the first documented pressure ulcer treatment was 9/22/14. In an interview on 12/11/14 at 9:35 AM, the treatment nurse stated she was not aware Resident #53 developed a blister to his right ankle on 9/18/14 until she received a copy of a skin alert sheet in her box dated 9/22/14. She recalled she assessed Resident #53's right out ankle and it was covered with eschar and considered an unstageable pressure ulcer at that time. She stated she did not recall contacting the primary physician at that time but followed the facility standing orders and recalled adding Resident #53 to the list of residents she wanted the wound consultant physician to see on his next visit on 9/29/14.	F 157	designed to promote healing and prevent additional wounds. These include alternating air pressure mattress, vascular surgeon referral regarding ABI results of left/right ankle, multi vitamin daily, vitamin C daily, zinc daily, lab work related to wound, and protective boots bilaterally. For the Residents with the potential to be affected: Nursing staff was in-serviced on 12-16-14, 12-20-14, and 1-7-14 related to the charge nurse must notify the Physician about any/all new wounds and/or worsening of an existing wound. Training included a review of the proper standing order to use based upon the stage/type of pressure sore. All current residents with pressure wounds were reviewed by Administrator on 1-6-2015 and1-7-2015, to ensure the physician has been notified and all notifications were found to have been made. Measures Put in Place/System Change: the Facility has updated Wound Care Standing Orders to include a reminder and confirmation that the Physician was notified at the time Wound Care Standing Orders are initiated. A Weekly Audit is being conducted by the DON to review Physician notifications of wounds at the time Wound care Standing Order Initiated and to ensure that such notification has occurred. In-services were held by DON and/or SDC on 12-16-14, 12-20-14, and 1-7-14 related to charge nurse must notify the Physician about any/all new wounds and/or worsening of an existing wound. Training included a review of the proper standing order to use based upon the stage/type of pressure sore.	

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F 157	Continued From page 3 In an interview on 12/11/14 at 11:13 AM, the unit manager recalled being asked to assess the area to Resident #53's right outer ankle. She stated it appeared as an open blister and she told the nurse to put wound gel on it and wrap it with gauze until the primary physician could be contacted for additional orders. She stated she did not contact the primary physician to get treatment orders but thought Nurse #1 contacted the physician. The unit manager stated wound gel was used for areas such as an open blister to keep them moist and normally were ordered to be changed every day to maintain the moisture. She stated she did not recall telling the floor nurse how often the area should re-dressed. In an interview on 12/11/14 12:18 PM, Nurse #1 recalled NA #2 informing her of an opened area to Resident #53's right outer ankle on 9/18/14. She recalled the unit manager assisting her with the assessment of the area. Nurse #1 stated the unit manager told her to put wound gel on the area and wrap it with gauze. She stated did not write any orders and was under the impression that the unit manager contacted the physician and wrote any orders given. Nurse #1 stated it was during her weekly skin assessment dated 9/22/14 she completed a skin alert form and put it in the treatment nurses box. She stated she did not think the area to Resident #53's right outer ankle had been redressed or assessed since its discovery on 9/18/14. Nurse #1 verified using the electronic medical record to document the care given to Resident #53 and there was no documented treatment on the treatment record for September 2014 until 9/22/14. She stated she wrote the discovery and treatment to the area in a nursing note on 9/18/14 only.	F 157	Monitoring: the DON or her Designee will review 5 residents per week for 4 weeks then 2 residents a month for 2 months to ensure physician notification when Wound Care Standing Order Initiated. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 157	Continued From page 4 In an interview on 12/11/14 at 12:50 PM the administrator, the DON and the facility consultant verified there was no evidence of treatment of the pressure ulcer from 9/18/14 until again on 9/22/14, no evidence that the physician was notified of the newly identified pressure ulcer from 9/18/14 until 9/22/14. The DON verified writing the nursing note 9/23/14 at 4:57 PM in which she referenced receiving new physician orders. In a telephone interview on 12/12/14 at 11:48 AM the primary physician stated she ordered interventions as soon as she became aware of a new pressure ulcer on Resident #53's right outer ankle and the delay in putting interventions in place could have contributed to the worsening of the pressure ulcer along with his co-morbidities. The primary physician stated her expectation would have been for the facility to use the wound care standing orders when the area was identified on Resident #53's right outer ankle. The primary physician further indicated that by using wound gel to the area, wound care would be indicated at minimum every other day but ideally daily to promote healing and she would have expected to be notified when the new facility acquired pressure ulcer was discovered.	F 157		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224		1/8/15

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F 224	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and physician interviews, the facility failed to treat a new stage 2 pressure ulcer found on 9/18/14 for 4 days; on 9/22/14, the wound was assessed as unstageable for 1 of 3 residents (Resident # 53) reviewed for pressures ulcers. Findings included: A review of the facility undated "Wound Care Standing Orders" indicated an intact or open/ruptured serum filled blister was considered a stage 2 pressure ulcer and the ordered treatment was to cleanse the area with Sea-Clens (saline based wound cleaning agent), pat dry and apply a regular hydrocolloid (biodegradable, non-breathable adherent) or foam dressing. This dressing should be changed on day 3, day 7 and then every week thereafter until healed. Resident #53 was admitted 4/20/12 with cumulative cerebral vascular accident (CVA), anemia, left sided hemiplegia, dysphagia, dementia and contractures. The 30 day Minimum Data Set (MDS) dated 11/24/14 indicated severe cognitive impairment, no behaviors and he was coded as extensive assistance with bed mobility and eating and total assistance with transfers, toileting, hygiene and bathing. Resident #53 was coded as non-ambulatory and incontinent of bladder and bowel. Record review revealed a nursing note dated 9/18/14 at 2:34 PM indicating Resident #53 developed an open are to the right outer ankle appearing to be a "busted blister." The area measured "3mm (millimeters) L (Length) and 2.3 W" Width). The unit manager gave instructions	F 224	F224 This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 12-11-14 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville 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 January 8, 2015. For the Resident affected: Resident #53 developed a wound on 9-18-2014, treatment was initiated at time of discovery per Wound Care Standing Orders. On 9-18-214 Physician was notified regarding the wound via entry in the communication book at the nurses□ station per physician□s request. During physician visit on 9-19-2014 physician initialed acknowledgment that she had	

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F 224	Continued From page 6 to apply wound gel (ointment use to hydrate damaged tissue) and cover with dry gauze, foam pad and wrap area. There was no indication in the nursing note how often the dressing was to be changed. Record review revealed the next mention of Resident #53's wound care needs was on 9/22/14 at 2:00 PM in a note labeled as a weekly wound assessment. The "dressing to the right leg was intact" and once removed the wound was described as an "unstageable pressure wound." The area was documented as measuring 2.0 cm (centimeters) L x 4 cm W with serous (thin, watery clear) drainage and the wound base was covered with soft yellow to black eschar (dead tissue). An "unstageable" pressure ulcer may be described as full thickness tissue loss with exposed bone, tendon or muscle. Necrosis/eschar may also be present. The note read treatment was changed to Santyl and a moisten gauze daily. A review of the Treatment/Procedure Administration Record for September 2014 indicated the first documented pressure ulcer treatment was 9/22/14. Record review revealed a nursing note stated 9/29/14 at 2:00 PM the wound care consultant physician conducted a bedside debridement and continued the treatments using Santyl. He described the wound as being "unstageable necrosis" measuring 1.9 cm L x 1.9 cm W and without drainage. In another interview on 12/11/14 at 9:35 AM, the treatment nurse stated she was not aware Resident #53 developed a blister to his right ankle on 9/18/14 until she received a copy of a skin alert sheet in her box dated 9/22/14. She	F 224	reviewed the entry and the treatment which was initiated per the Facility□s standing orders for pressure sores. Treatment of the affected resident has continued including both treatment of the initial wound and further interventions designed to promote healing and prevent additional wounds. These include alternating air pressure mattress, vascular surgeon referral regarding ABI results of left/right ankle, multi vitamin daily, vitamin C daily, zinc daily, lab work related to wound, and protective boots. Measures Put in Place/systems change: If a new wound is identified, the charge nurse is to immediately initiate Wound Care Standing Order Protocol. Facility updated Wound care Standing Orders to include Enter standing order in Electronic Medical Health Record. In-services held by DON and SDC 12-16-14, 12-20-14, and 1-7-15 which included that when initiating any standing orders a physician order sheet must be initiated and the order placed in the electronic medical health record. Physician or PA must be notified of any/all new wounds and/ or worsening of any existing wound. Wound Care Standing Orders updated on 1-6-15 to read notify physician at the time a wound is identified and/or worsening of wound and document physician notified in nursing progress note. Treatment orders are then initiated from the order placed into the Electronic Medical Health Record. Monitoring: the DON or her Designee will review 5 residents per week for 4 weeks then 2 residents a month for 2 months to ensure physician notification when Wound	

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F 224	Continued From page 7 recalled she assessed Resident #53's right out ankle and it was covered with eschar and considered an unstageable pressure ulcer at that time. In another interview on 12/11/14 at 10:25 AM, the facility nurse consultant confirmed there was no evidence of treatment in the electronic medical record for the blistered area to Resident #53's right outer ankle discovered 9/18/14 after the initial treatment the unit manager instructed the floor nurse to perform on 9/18/14 until again on 9/22/14. In another interview on 12/11/14 at 11:13 AM, the unit manager recalled being asked to assess the area to Resident #53's right outer ankle. She stated it appeared as an open blister and she told the nurse to put wound gel on it and wrap it with gauze until the primary physician could be contacted for additional orders. She stated she did not contact the primary physician to get treatment orders but thought Nurse #1 contacted the physician. The unit manager stated wound gel was used for areas such as an open blister to keep them moist and normally were ordered to be changed every day to maintain the moisture. She stated she did not recall telling the floor nurse how often the area should re-dressed. The unit manager state when a new area was discovered on any resident, the floor nurse completed a skin alert sheet letting the treatment nurse know there was a resident who needed to be assessed for wound care needs. The unit manager stated she was able to pull up a report of daily alerts based on the data entered into the computer. She confirmed if there was no order written regarding a new identified pressure ulcer, there would be no alert on the report for follow up.	F 224	Care Standing Order Initiated. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 224	Continued From page 8 In an interview on 12/11/14 12:18 PM, Nurse #1 recalled NA #2 informing her of an opened area to Resident #53's right outer ankle on 9/18/14. She recalled the unit manager assisting her with the assessment of the area. Nurse #1 stated the unit manager told her to put wound gel on the area and wrap it with gauze. She stated did not write any orders and was under the impression that the unit manager contacted the physician and wrote any orders given. Nurse #1 stated it was during her weekly skin assessment dated 9/22/14 she completed a skin alert form and put it in the treatment nurses box. She stated she did not think the area to Resident #53's right outer ankle had been redressed or assessed since its discovery on 9/18/14. In an interview on 12/11/14 at 12:50 PM the administrator, the DON and the facility consultant verified there was no evidence of treatment of the pressure ulcer from 9/18/14 until again on 9/22/14. In a telephone interview on 12/12/14 at 11:48 AM the primary physician stated she ordered interventions as soon as she became aware of a new pressure ulcer on Resident #53's right outer ankle and the delay in putting interventions in place could have contributed to the worsening of the pressure ulcer along with his co-morbidities. The primary physician stated her expectation would have been for the facility to use the wound care standing orders when the area was identified on Resident #53's right outer ankle. The primary physician further indicated that by using wound gel to the area, wound care would be indicated at minimum every other day but ideally daily to promote healing.	F 224		

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written documentation of verification of certification prior to employment for 2 of 5 employees (NA#3 and Nurse #2) reviewed for abuse prohibition. The findings included: 1a. A copy of the facility's policy on Abuse/Neglect dated 1/17/14 (revision date) was reviewed. The policy read in part "The facility believes each patient has the right to be free from verbal, sexual, physical, and mental abuse, corporate punishment, and involuntary seclusion, mistreatment, neglect, and misappropriation of property. The facility has developed policies that focus on seven components: screening, training, prevention, investigation, protection and reporting/response. "The policy also indicated "All licensed and/or certified applicants have license and certification verified prior to employment." A review of the employee file for NA #3 revealed a hire date of 6/13/14. Further review of the employee file revealed a verification of Nurse Aide 1 Registry dated 6/18/14. Review of the "Hours Worked Simplified Report" for NA #1	F 226	F226 This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 12-11-14 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville 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 January 8, 2015. For the residents affected, an audit was performed on 1-3-2015, of all licensed and/or certified staff, which included NA#3	1/8/15

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F 226	Continued From page 10 revealed the employee worked on 6/13/14, 6/16/14 and 6/17/14. On 12/11/4 at 2:00 pm in an interview, the Staff Development Coordinator (SDC) stated verification of licensure or certification was normally done before the first day of orientation. She further stated the first day of class orientation was the date of hire for the new employee. The SDC stated she do not know for sure why this was not done for NA #3 and Nurse #2. During an interview on 12/11/14 at 2:49 pm, the administrator stated it was his expectation for the Staff Development Coordinator to follow the facility's policy for verification of licensure and certification. 1b. A copy of the facility's policy on Abuse/Neglect dated 1/17/14 (revision date) was reviewed. The policy read in part "The facility believes each patient has the right to be free from verbal, sexual, physical, and mental abuse, corporate punishment, and involuntary seclusion, mistreatment, neglect, and misappropriation of property. The facility has developed policies that focus on seven components: screening, training, prevention, investigation, protection and reporting/response. "The policy also indicated "All licensed and/or certified applicants have license and certification verified prior to employment." A review of the employee file for Nurse #2 revealed a hire date of 8/22/14. Further review of the employee file revealed a "License Verification" dated 9/23/14. Review of the handwritten time worked form for Nurse #2	F 226	and Nurse #2, by DON and Administrator of current licensed and/or certified employees to ensure verification of license and/or certification. To ensure other residents are not affected, a log was created on 1-3-2015 listing all steps an employee must complete prior to employment including license and/or certification verification. SDC was in-serviced on 1-7-2015 by administrator. This log will be maintained by the facility□s staff development coordinator and must be completed prior to any employee being hired. For on-going compliance, an audit will be performed weekly, prior to orientation, by the administrator, or designee, to ensure any newly hired employee have licensure and/or certification verified prior to employment. The audits will be completed weekly for 4 weeks and then monthly for 2 months. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 226	Continued From page 11 revealed the employee worked on 8/22/14, 8/26/14, 8/27/14 and 8/28/14. On 12/11/4 at 2:00 pm in an interview, the Staff Development Coordinator (SDC) stated verification of licensure or certification was normally done before the first day of orientation. She further stated the first day of class orientation was the date of hire for the new employee. The SDC stated she do not know for sure why this was not done for NA #3 and Nurse #2. During an interview on 12/11/14 at 2:49 pm, the administrator stated it was his expectation for the Staff Development Coordinator to follow the facility's policy for verification of licensure and certification.	F 226		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 274		1/8/15

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F 274	Continued From page 12 Based on staff and provider interviews and record review the facility failed to complete and significant change Minimum Data Set (MDS) for 1 of 1 (Resident # 83) reviewed for hospice services. Findings included: Resident #83 was admitted to the facility with cumulative diagnoses of osteoarthrosis, congestive heart failure (CHF) and Parkinson's. The most recent Minimum Data Set (MDS) was a quarterly assessment dated 9/23/14. This MDS indicated Resident #83 had severe cognitive impairment and required extensive assistance with her activities of daily living, non-ambulatory, incontinent of bowel and bladder and coded as receiving hospice services with a prognosis of less than 6 months. Resident #83 care plan indicated a hospice care plan was initiated 12/13/13 and current with the next review of 12/30/14. Interventions included the assessment for changes in her ADL needs, provide assistance as needed, assessment of pain, ensuring that caregivers were aware of her wishes and keeping the family informed of changes in Resident #83 and in her medications. A review of the hospice provider care plan was current with recertification dates from 8/10/14 to 10/0814 and indicated Resident #83 was receiving nursing services twice weekly and aide services three times weekly. On 12/08/14 at 1:47 PM, the administrator provided entrance conference worksheet listed Resident #83 as receiving hospice services. This worksheet directed the survey process in the investigation of residents receiving specialized services. Record review of the hospice nurse visit note	F 274	F274 This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 12-11-14 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville 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 January 8, 2015. For the Resident affected: A Significant Change MDS Assessment was completed on Resident #83 with an ARD date of 12/10/14 and the assessment was submitted on 12/17/14 and accepted on 12/19/2014 For the Residents with the potential to be affected and measures put in place: Re-education was completed on 1-7-2015 by Regional QA Nurse with both MDS coordinators related to the requirement of a significant change being completed timely and according to the RAI Manual	

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F 274	Continued From page 13 dated 10/02/14 read Resident #83's responsible part (RP) was present at the facility to discuss the termination of hospice services next week and the RP reviewed and signed the notice of Medicare Non-coverage Form effective 10/8/14. The hospice nurse and RP explained the termination of hospice services to Resident #83 and to the facility staff. The note indicated the facility staff voiced understanding of the pending discharge next week. Record review of the hospice nurse visit note dated 10/6/14 read the facility staff was again reminded of Resident #83's discharge from hospice services on 10/8/14. Record review of the hospice nurse visit note dated 10/8/14 read Resident #83 was tearful when she was reminded that nurse and aide would no longer be visiting her at the facility. Emotional support was given and there was no new concerns reported by Nurse #1. Discharge teaching was done with the Nurse #1 and she verbalized understanding that effective 10/8/14 Resident #83's was discharged from hospice services. In an interview on 12/10/14 at 3:10 PM, the MDS nurse stated Resident #83 was on hospice services and if she was discontinued from hospice, she would have to complete a significant change MDS within 14 days and update her care plan. The MDS stated she was "certain" Resident #83 was currently receiving hospice services. In a telephone interview on 12/10/14 at 3:00 PM, the hospice nurse supervisor confirmed hospice services started on 12/13/13 and ended 10/8/14 for Resident #83. She stated the facility was	F 274	when an order is written to initiate or discontinue hospice services. A significant change assessment will be completed per RAI guidelines on all residents who are added or discontinued by hospice services in the future. Monitoring: An audit will be completed by MDS Coordinator or designee weekly for 3 months of all residents who have been added or discontinued from hospice services in the previous week. During audit MDS Coordinator or designee will confirm any resident who has been added or discontinued from hospice services since. Audits will monitored by Administrator weekly time 4 months and then monthly for 2 months to ensure residents who have been added or discontinued from Hospice services to ensure significant change assessment has been completed per RAI guidelines A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 274	Continued From page 14	F 274		

made aware on 10/2/14 of the services ending on 10/8/14 in a visit held at the facility with the family present.

In a interview on 12/10/14 at 4:50 PM Nurse #1 stated the hospice aide informed her and the unit manager the week before hospice services ended that she would not being providing services after 10/8/14 to Resident #83. She stated she assumed the unit manager or the hospice nurse wrote the order stopping hospice services. Nurse #1 confirmed her name as listed on the discharge hospice note dated 10/8/14 in which discharge teaching was done with her.

In another interview on 12/10/14 at 4:15 PM with MDS nurse along with the director of nursing, the MDS nurse stated she did not routinely review with hospice care plan completed by the providing hospice agency and was unaware Resident #83 was discharged from hospice services. She stated if an order was written discontinuing hospice services she would have completed a significant change MDS within 14 days after Resident #83's discharge on 10/8/14.

In an interview on 12/11/14 at 11:13 AM the unit manager stated she was aware that hospice was ending services but she did not recall the Nurse #1 or the hospice nurse providing a definite date. She stated the hospice nurse or Nurse #1 should have written the order stopping hospice services.

In an interview on 12/11/14 at 12:50 PM with the administrator, the DON and the facility nurse consultant, the facility nurse consultant stated a order should have been written discontinuing hospice services for Resident #83 and a significant change MDS should be completed

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F 274	Continued From page 15 within 14 days after any resident was admitted for discharged from hospice services.	F 274		
F 279 SS=G	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 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to address the potential for the development of a pressure ulcer in a resident identified as "high risk" (Resident # 53) for 1 of 3 residents reviewed for pressures ulcers. Findings included: Resident #53 was admitted 4/20/12 with cumulative cerebral vascular accident (CVA),	F 279	F279 This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 12-11-14 survey and does not	1/8/15

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F 279	Continued From page 16 anemia, left sided hemiplegia, dysphagia, dementia and contractures. His annual Minimum Data Set (MDS) completed 4/22/14 indicated Resident #53 triggered as "high risk" for the development of pressure ulcers. The Care Area Assessment (CAA) listed extrinsic risk factors as requiring staff assistance to move sufficiently to relieve pressure, he was coded as confined to bed or chair all or most of the time and as having a pressure relieving mattress to his bed. Intrinsic risk factors included cognitive loss, hemiplegia and incontinence. The CAA directed Resident #53 to be care planned for the risk potential with interventions. The weekly skin assessment completed 9/12/14, indicated no redness, no blisters or open areas to anywhere of Resident #53's body. The weekly skin assessment completed 9/15/14 indicated no redness, no blisters or open areas to anywhere to Resident #53's body. Record review revealed a nursing note dated 9/18/14 at 2:34 PM indicating Resident #53 developed an open area to the right outer ankle appearing to be a "busted blister." The area measured "3mm (millimeters) L (Length) and 2.3 W" Width). The unit manager gave instructions to apply wound gel (ointment use to hydrate damaged tissue) and cover with dry gauze, foam pad and wrap area. There was no indication in the nursing note how often the dressing was to be changed. Resident #53's current care plan included the onset of a right outer ankle unstageable wound effective 9/22/14 with interventions to include cleaning area with Sea Clens, pat dry, apply Santyl (enzymatic debriding ointment), cover with	F 279	constitute an agreement or admission of Autumn Care of Fayetteville 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 January 8, 2015. For the Resident affected: Resident #53□s care plan for wound treatment to right outer ankle was updated on 9-23-2014. For the Residents with the potential to be affected: In-service was completed on 1-6-2015 with MDS coordinators regarding updating resident□s care plans when a resident is identified as high risk. An Audit was completed by the DON, MDS Coordinators, and Regional QA nurse on 12-30-14, 1-5-15, and 1-6-15. Measures Put in Place/systems change: A Weekly Audit was initiated, on 1-5-15 to review/update resident□s Care Plan to ensure orders/interventions relating to wounds are included. This audit will be conducted by DON or Designee. Monitoring: the DON or her Designee will review 5 residents per week for 4 weeks then 2 residents a month for 2 months to ensure physician notification when Wound	

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F 279	Continued From page 17 gauze and plain foam and secure with tape daily and as needed. The only other indicated intervention dated 9/22/14 included a weekly wound measurement. There was no care plan for refusal of care regarding his lower extremities. Record review revealed the next mention of Resident #53's wound care needs was on 9/22/14 at 2:00 PM in a note labeled as a weekly wound assessment. The "dressing to the right leg was intact" and once removed the wound was described as an "unstageable pressure wound." The area was documented as measuring 2.0 cm (centimeters) L x 4 cm W with serous (thin, watery clear) drainage and the wound base was covered with soft yellow to black eschar (dead tissue). An "unstageable" pressure ulcer may be described as full thickness tissue loss with exposed bone, tendon or muscle. Necrosis/eschar may also be present. Physician orders revealed an alternating air mattress was ordered 9/24/14 and a review of the activities of daily living (ADLs) Administration Record for September 2014 indicated the alternating air mattress was in place as of 9/25/14. The current care plan was updated to include the alternating air mattress on 10/1/14. Review of the record revealed a nursing note stated 9/29/14 at 2:00 PM the wound care consultant physician conducted a bedside debridement and continued the treatments using Santyl. He described the wound as being "unstageable necrosis" measuring 1.9 cm L x 1.9 cm W and without drainage. This consult note recommended bunny boots. Record review revealed a physician order dated	F 279	Care Standing Order Initiated. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 279	Continued From page 18 10/1/14 for bunny boots to bilateral feet as tolerated with skin checks to the feet every shift and the care plan was updated 10/1/14 to include the bunny boots. In an interview and wound care observation on 12/10/14 at 9:15 AM the treatment nurse stated the area was considered a pressure ulcer and it developed at the facility. In an interview on 12/10/14 at 2:50 PM, the facility nurse consultant and the MDS nurse verified Resident #53 was identified as a "high risk" for pressure ulcers on his skin risk assessments dated 7/21/14, 10/27/14 and again on 11/3/14. The facility nurse consultant was unable to provide any policy or procedure for implementation of interventions for resident identified as a "high risk" for the development of a pressure ulcer.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record the facility failed to include hospice staff in scheduled care plan meeting and the facility failed to coordinate the planned hospice	F 309	F309 This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483,	1/8/15

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F 309	Continued From page 19 discontinuation of services for 1 of 1 (Resident # 83) reviewed for hospice services. Findings included: Resident #83 was admitted to the facility with cumulative diagnoses of osteoarthrosis, congestive heart failure (CHF and Parkinson's. The most recent Minimum Data Set (MDS) was a quarterly assessment dated 9/23/14. This MDS indicated Resident #83 had severe cognitive impairment and required extensive assistance with her activities of daily living, non-ambulatory, incontinent of bowel and bladder and coded as receiving hospice services with a prognosis of less than 6 months. Resident #83 care plan indicated a hospice care plan was initiated 12/13/13 and current with the next review of 12/30/14. Interventions included the assessment for changes in her ADL needs, provide assistance as needed, assessment of pain pain, ensuring that caregivers were aware of her wishes and keeping the family informed of changes in Resident #83 and in her medications. A review of the hospice provider care plan was current with recertification dates from 8/10/14 to 10/0814 and indicated Resident #83 was receiving nursing services twice weekly and aide services three times weekly. On 12/08/14 at 1:47 PM, the administrator provided entrance conference worksheet listed Resident #83 as receiving hospice services. This worksheet directed the survey process in the investigation of residents receiving specialized services. In an observation on 12/8/14 at 3:52 PM, Resident #83 was in bed. She appeared clean and reported no needs or discomfort. In another	F 309	Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 12-11-14 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville 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 January 8, 2015. For the resident affected: Order written on 12/11/14 to discontinue Hospice services for resident #83. For the resident with the potential to be affected: Hospice was contacted for all current residents receiving Hospice Services to confirm when each residents Hospice recertification to ensure coordination of planned discontinuation/continuation of Hospice Services. A Care Plan meeting will be scheduled at the time of recertification to include a Hospice Representative and at least quarterly. An order will be written timely by a licensed nurse for any resident who is discontinued from hospice services. This order will then be transcribed into the electronic health	

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F 309	Continued From page 20 observation on 12/9/14 at 9:50 AM, Resident #83 was again observed in bed. She was pleasantly confused and reported she did not wish to get out of bed today but reported no discomfort. Record review of the hospice nurse visit note dated 10/02/14 read Resident #83's responsible part (RP) was present at the facility to discuss the termination of hospice services next week and the RP reviewed and signed the notice of Medicare Non-coverage Form effective 10/8/14. The hospice nurse and RP explained the termination of hospice services to Resident #83 and to the facility staff. The note indicated the facility staff voiced understanding of the pending discharge next week. Record review of the hospice nurse visit note dated 10/6/14 read the facility staff was again reminded of Resident #83's discharge from hospice services on 10/8/14. Record review of the hospice nurse visit note dated 10/8/14 read Resident #83 was tearful when she was reminded that nurse and aide would no longer be visiting her at the facility. Emotional support was given and there was no new concerns reported by Nurse #1. Discharge teaching was done with Nurse #1 and she verbalized understanding that effective today, Resident #83 was discharged from hospice services. In an interview on 12/10/1414 at 9:53 AM, the unit manager stated Resident #83 was no longer receiving any hospice services and had not been receiving them for "awhile." The unit manager stated the floor staff was providing her care.	F 309	record. Measures put in place: Re-education completed on 1-6-15 by Regional QA and Administrator with both MDS coordinators regarding the responsibility of inviting the hospice representatives to all care plan conferences for all residents receiving hospice services. Monitoring: DON or designee will audit monthly for 3 months to ensure appropriate hospice company has been requested to attend meeting timely. DON or designee will also audit appropriate resident charts monthly for 3 months to ensure the facility appropriately coordinates the planned hospice discontinuation of services for each resident who is discontinued from hospice services in the future. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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In an interview on 12/10/14 at 12:30 PM, nursing assistant (NA) #4 confirmed she had worked with Resident #83 regularly and that she had not received any hospice services for a "couple of months."

In another interview on 12/10/14 at 12:40 PM, Nurse #2 stated she had only recently graduated from nursing school but since she worked with Resident #83 for past few months, she had not been receiving hospice services.

In a telephone interview on 12/10/14 at 3:00 PM, the hospice nurse supervisor confirmed hospice services started 12/13/13 and ended on 10/8/14 for Resident #83. She stated the facility was made aware on 10/2/14 of the services ending on 10/8/14 in a visit held at the facility with the family present. The hospice nurse supervisor also confirmed no documented evidence of the facility notifying hospice staff of any scheduled care plan conferences to discuss Resident #83's care while on hospice effective 12/13/13.

In an interview on 12/10/14 at 3:10 PM, the MDS nurse stated Resident #83 was on hospice services and if she was discontinued from hospice, she would have to complete a significant change MDS within 14 days and update her care plan. The MDS nurse stated she was "certain" Resident #83 was currently receiving hospice services.

In another interview on 12/10/14 at 4:15 PM with MDS nurse along with the director of nursing and the facility nurse consultant, the MDS nurse stated she did not routinely review with hospice care plan completed by the providing hospice agency. The MDS nurse also stated that when a

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care plan meeting was scheduled with a hospice resident, her expectation was that the responsible party to notify the hospice provider of the scheduled care plan meeting. The DON verified she was not aware that Resident #83 was no longer receiving hospice services.

In a interview on 12/10/14 at 4:50 PM Nurse #1 stated the hospice aide informed her and the unit manager the week before hospice services ended that she would not being providing services after 10/8/14 to Resident #83. She stated she assumed the unit manager or the hospice nurse wrote the order stopping hospice services. Nurse #1 confirmed her name as listed on the discharge hospice note dated 10/8/14 in which discharge teaching was done with her.

In an interview on 12/11/14 at 11:13 AM the unit manager stated she was aware that hospice was discontinuing hospice services but she did not recall Nurse #1 or the hospice nurse providing a definite date. She stated the hospice nurse or Nurse #1 should have written the order stopping hospice services.

In an interview on 12/11/14 at 12:50 PM with the administrator, the DON and the facility nurse consultant, the facility consultant stated that if an order was written, it would have identified Resident #83 as no longer on hospice caseload and there was no order discontinuing hospice services. The facility nurse consultant further stated the facility did not maintain any handwritten or hard copy of physician orders. She stated that once the order was written and entered into the electronic medical record, two nurses had to verify that the order was correct then the written order was no longer needed. The DON stated the

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F 309	Continued From page 23 facility has a daily stand up meeting and she implemented a communication board for any new changes regarding residents based on computer alerts, new orders, consults or incidents. She stated it would be her expectation that before hospice services were terminated, she would have been made aware of the upcoming end date in order to ensure the facility staff was providing the care no longer being provided by hospice. The facility nurse consultant stated it was the responsibility of the MDS nurse to invite hospice providers to care plan meetings in orders to facility communication between the agencies.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and physician interviews, the facility failed to implement pressure relief upon the discovery of a new stage 2 pressure ulcer on 9/18/14, failed to treat a new stage 2 pressure ulcer for 4 days; on 9/22/14, the wound was assessed as unstageable for 1 of 3 residents (Resident # 53) reviewed for pressures ulcers. Findings included:	F 314	F314 This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 12-11-14 survey and does not	1/8/15

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F 314	Continued From page 24 A review of the facility undated " Wound Care Standing Orders " indicated an intact or open/ruptured serum filled blister was considered a stage 2 pressure ulcer and the ordered treatment was to cleanse the area with Sea-Clens (saline based wound cleaning agent), pat dry and apply a regular hydrocolloid (biodegradable, non-breathable adherent) or foam dressing. This dressing should be changed on day 3, day 7 and then every week thereafter until healed. Resident #53 was admitted 4/20/12 with cumulative cerebral vascular accident (CVA), anemia, left sided hemiplegia, dysphagia, dementia and contractures. The 30 day Minimum Data Set (MDS) dated 11/24/14 indicated severe cognitive impairment, no behaviors and he was coded as extensive assistance with bed mobility and eating and total assistance with transfers, toileting, hygiene and bathing. Resident #53 was coded as non-ambulatory and incontinent of bladder and bowel. Resident #53 was coded as having a stage 3 pressure ulcer measuring 2.0 cm x 3.2 cm with slough present. He was coded for pressure relieving devices to his chair and bed. Record Review revealed evidence of weekly skin assessments. The weekly skin assessment completed 9/12/14, indicated no redness, no blisters or open areas to anywhere of Resident #53's body. The weekly skin assessment completed 9/15/14 indicated no redness, no blisters or open areas to anywhere to Resident #53's body. Record review revealed a nursing note dated 9/18/14 at 2:34 PM indicating Resident #53 developed an open area to the right outer ankle	F 314	constitute an agreement or admission of Autumn Care of Fayetteville 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 January 8, 2015. For the Resident affected: Resident #53 developed a wound on 9-18-2014, treatment was initiated at time of discovery per Wound Care Standing Orders. On 9-18-214 Physician was notified regarding the wound via entry in the communication book at the nurses□ station per physician□s request. During physician visit on 9-19-2014 physician initialed acknowledgment that she had reviewed the entry and the treatment which was initiated per the Facility□s standing orders for pressure sores. Treatment of the affected resident has continued including both treatment of the initial wound and further interventions designed to promote healing and prevent additional wounds. These include alternating air pressure mattress, vascular surgeon referral regarding ABI results of left/right ankle, multi vitamin daily, vitamin C daily, zinc daily, lab work related to	

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F 314	Continued From page 25 appearing to be a "busted blister." The area measured "3mm (millimeters) L (Length) and 2.3 W" Width). The unit manager gave instructions to apply wound gel (ointment use to hydrate damaged tissue) and cover with dry gauze, foam pad and wrap area. There was no indication in the nursing note how often the dressing was to be changed. Resident #53's current care plan included the onset of a right outer ankle unstageable wound effective 9/22/14 with interventions to include cleaning area with Sea Clens, pat dry, apply Santyl (enzymatic debriding ointment), cover with gauze and plain foam and secure with tape daily and as needed. The only other indicated intervention dated 9/22/14 included a weekly wound measurement. There was no care plan for refusal of care regarding his lower extremities. Record review revealed the next mention of Resident #53's wound care needs was on 9/22/14 at 2:00 PM in a note labeled as a weekly wound assessment. The "dressing to the right leg was intact" and once removed the wound was described as an "unstageable pressure wound." The area was documented as measuring 2.0 cm (centimeters) L x 4 cm W with serous (thin, watery clear) drainage and the wound base was covered with soft yellow to black eschar (dead tissue). An "unstageable" pressure ulcer may be described as full thickness tissue loss with exposed bone, tendon or muscle. Necrosis/eschar may also be present. The note read treatment was changed to Santyl and a moisten gauze daily. A review of the Treatment/Procedure Administration Record for September 2014 indicated the first documented pressure ulcer treatment was 9/22/14.	F 314	wound, and protective boots. Resident□s Care Plan updated on 12-10-14 to read encourage compliance with treatment related to wound care needs. For the Residents with the potential to be affected: All current residents with wounds were reviewed by DON and Administrator 1-6-15, 1-7-15, and 1-8-15, to ensure appropriate treatment orders are in place related to description of wound. All appropriate orders were found to be in place. Measures Put in Place/systems change: If a new wound is identified, the charge nurse is to immediately initiate Wound Care Standing Order Protocol. The Facility has updated its Wound Care Standing Orders to include Enter standing order in Electronic Medical Health Record. In-services held by DON and SDC 12-16-14, 12-20-14, and 1-7-15 that included instructing staff that when initiating any standing orders a physician order sheet must be initiated and the order placed in the electronic medical health record. The Physician or PA must be notified of any/all new wounds and/ or worsening of any existing wound. The Facility□s Wound Care Standing Orders were updated on 1-6-15 to include that staff must notify physician at the time a wound is identified and/or worsening of wound and document that the physician has been notified in the nursing progress note. Treatment orders are then initiated from the order placed into the Electronic Medical Health Record. Monitoring: the DON or her Designee will review 5 residents per week for 4 weeks then 2 residents a month for 2 months to	

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F 314	Continued From page 26 Physician orders revealed an alternating air mattress was ordered 9/24/14 along with a circulatory studies and vascular consult. Ankle brachial index (ABI) testing was completed 9/24/14 with inconclusive results and a referral to a vascular surgeon. A review of the activities of daily living (ADLs) Administration Record for September 2014 indicated the alternating air mattress was in place as of 9/25/14. Other ADL interventions documented on this record was heel checks every shift ongoing since 11/11/13. Review of the record revealed a nursing note stated 9/29/14 at 2:00 PM the wound care consultant physician conducted a bedside debridement and continued the treatments using Santyl. He described the wound as being "unstageable necrosis" measuring 1.9 cm L x 1.9 cm W and without drainage. This consult note recommended bunny boots and repositioning. Record review revealed a physician order dated 10/1/14 for bunny boots to bilateral feet as tolerated with skin checks to the feet every shift. The facility wound care consultant physician again saw Resident #53 on 10/6/14 and described the wound as "unstageable necrosis" measuring 1.8 cm L x 2.4 cm W. He documented no change in the wound condition. Record review revealed another wound consultant physician visit on 10/20/14 described the right outer ankle wound as infected and deteriorated. It was also described with unstageable necrosis measuring 2.5 cm L x 3.0 cm W with no drainage. The note read Resident #53's lies on his right side causing undue pressure on the wound and was noncompliant	F 314	ensure treatment order entered into electronic medical health record when Wound Care Standing Order Initiated. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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with wound care. There was deep tissue injury to the area surrounding the wound and the wound bed. It was documented that Resident #53 would "kick off" his boots and the wound physician discussed with Resident #53 the need to off load and keep off his right side. It was documented Resident #53

A nurses note dated 10/20/14 at 11:00 AM indicated the primary physician was at the facility and was made aware of the lack of improvement in the wound since the wound culture on 10/13/14 and subsequent ongoing antibiotic therapy. There was no change in orders.

Record review revealed Resident #53 was seen by a vascular surgeon on 11/6/14 to rule out impaired circulation and follow up of the results of the ABI completed on 9/24/14. The progress note from the vascular surgeon indicated the ABI studies were normal, the wound should heal spontaneously and there was no evidence of circulatory impairment to the right lower extremity.

In an interview and wound care observation on 12/10/14 at 9:15 AM the treatment nurse stated the area was considered a pressure ulcer and it developed at the facility. She recalled it started as a blister measuring 2cm L x 4 cm W x 0.8 cm D (depth) with undermining noted at the 2 o'clock position. There was yellowish slough noted to the right upper edge of the wound bed and the drainage appeared watery, pale red/pink. There was no evidence of odor or pain. The treatment nurse verified he preferred to be on his right side in bed and in his reclining chair.

In a telephone interview on 12/10/14 at 5:30 PM, the wound consultant physician stated the area

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on Resident #53 right outer ankle was a pressure ulcer and he had no history of any other pressure ulcers anywhere other than a few incidental areas to his left hand prior to the development of the area to his right outer ankle. He noted Resident #53's tendency to lie on his right side along with his dementia and total assistance for ADL assistance were contributing factors to the development of the pressure ulcer. He was unable to recall documenting Resident #53 understood his instructions to stay off of his right side during his bedside visit on 10/20/14.

In another interview on 12/11/14 at 9:35 AM, the treatment nurse stated she was not aware Resident #53 developed a blister to his right ankle on 9/18/14 until she received a copy of a skin alert sheet in her box dated 9/22/14. She recalled she assessed Resident #53's right out ankle and it was covered with eschar and considered an unstageable pressure ulcer at that time. The treatment nurse stated she was unsure when the protective boots were actually ordered but the staff had been floating Resident #53's heels in the bed and reclining chair for as long as she could recall.

In another interview on 12/11/14 at 10:25 AM, the facility nurse consultant confirmed there was no evidence of treatment in the electronic medical record for the blistered area to Resident t#53's right outer ankle discovered 9/18/14 after the initial treatment the unit manager instructed the floor nurse to perform on 9/18/14 until again on 9/22/14. She also confirmed the treatment done to the blister on 9/18/14 was not consistent with the facility's standing wound care orders, no pressure relieving mattress ordered until 9/25/14.

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In a telephone interview on 12/11/14 at 10:55 AM, the vascular surgeon recalled seeing Resident #53 in his office on 11/6/14 to rule out vascular versus mechanical compromise. He stated Resident #53's ABI studies were normal and the area was pressure related but contributing factors to the development of the area was his dementia and left sided weakness.

In another interview on 12/11/14 at 11:13 AM, the unit manager recalled being asked to assess the area to Resident #53's right outer ankle. She stated it appeared as an open blister and she told the nurse to put wound gel on it and wrap it with gauze until the primary physician could be contacted for additional orders. She stated she did not contact the primary physician to get treatment orders but thought Nurse #1 contacted the physician. The unit manager stated wound gel was used for areas such as an open blister to keep them moist and normally were ordered to be changed every day to maintain the moisture. She stated she did not recall telling the floor nurse how often the area should re-dressed. The unit manager state when a new area was discovered on any resident, the floor nurse completed a skin alert sheet letting the treatment nurse know there was a resident who needed to be assessed for wound care needs. The unit manager stated she was able to pull up a report of daily alerts based on the data entered into the computer. She confirmed if there was no order written regarding a new identified pressure ulcer, there would be no alert on the report for follow up.

In an interview on 12/11/14 12:18 PM, Nurse #1 recalled NA #2 informing her of an opened area to Resident #53's right outer ankle on 9/18/14. She recalled the unit manager assisting her with

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F 314	Continued From page 30 the assessment of the area. Nurse #1 stated the unit manager told her to put wound gel on the area and wrap it with gauze. She stated did not write any orders and was under the impression that the unit manager contacted the physician and wrote any orders given. Nurse #1 stated it was during her weekly skin assessment dated 9/22/14 she completed a skin alert form and put it in the treatment nurses box. She stated she did not think the area to Resident #53's right outer ankle had been redressed or assessed since its discovery on 9/18/14 In an interview on 12/11/14 at 12:50 PM the administrator, the DON and the facility consultant verified there was no evidence of treatment of the pressure ulcer from 9/18/14 until again on 9/22/14. In a telephone interview on 12/12/14 at 11:48 AM the primary physician stated she ordered interventions as soon as she became aware of a new pressure ulcer on Resident #53's right outer ankle and the delay in putting interventions in place could have contributed to the worsening of the pressure ulcer along with his co-morbidities. The primary physician stated her expectation would have been for the facility to use the wound care standing orders when the area was identified on Resident #53's right outer ankle. The primary physician further indicated that by using wound gel to the area, wound care would be indicated at minimum every other day but ideally daily to promote healing.	F 314		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334		1/8/15

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F 334	Continued From page 31 that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal	F 334		

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	345553	A. BUILDING _____ B. WING _____	C 12/11/2014

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F 334	Continued From page 32 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer the pneumococcal vaccination to 1 of 5 Residents (Resident #53) with a signed consent reviewed for immunizations. The findings included: A review of the facility policy on "Influenza and Pneumococcal Disease" dated 10/01/2006 was reviewed. The policy read in part "It is the policy of this facility to minimize the risk of patients acquiring, transmitting or experiencing	F 334	F334 This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 12-11-14 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is	

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F 334	Continued From page 33 complications from influenza and pneumococcal pneumonia by assuring that each patient is informed about the benefits and risks of immunizations and has the opportunity to receive (unless medically contraindicated or refused or already immunized) the influenza and pneumococcal immunization. Before offering the pneumococcal immunization, each patient, or the patient's legal representative receives education regarding the benefits and potential side effects of the immunization. (This information will be obtained from the current data on the CDC web site). Upon admission each patient will be offered a pneumococcal immunization, unless the immunization is medically contraindicated or the patient has already been immunized in the past 5 years. The patient or the patient's legal representative has the opportunity to refuse the immunization." The policy also indicated "the patient's medical record will include documentation that indicates, at a minimum, the following: the patient or patient's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. The patient either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal." Resident # 53 was readmitted to the facility on 10/27/14. The most recent 30 day Minimum Data Set (MDS) assessment dated 11/24/14 documented Resident #53 was severely cognitively impaired. A review of the medical record revealed a signed consent for the influenza and pneumococcal vaccination dated 10/28/14. Further review of the medical record revealed Resident # 53 received the influenza vaccination on 11/10/14.	F 334	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 January 8, 2015. For the residents affected, resident was given pneumococcal vaccination on 12-11-2014. To ensure other residents are not affected, an audit was completed of the entire facility on1-6-15, 1-7-14, and 1-8-15 to ensure all residents who wish to receive the pneumococcal vaccine received it For on-going compliance, a log was created to track pneumococcal consent forms. These logs will be maintained by DON or designee. When consent is received it will be given to DON. It will then be recorded onto the log and administered according to consent form. An in-service with unit managers completed 1-7-15 regarding pneumonia vaccine consent/declination, to administer as applicable. An audit will be performed weekly by DON or designee to ensure log was completed and verify pneumococcal vaccine was given via resident□s medical record. This audit will be weekly for 4 weeks, then monthly for 2 months.	

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F 334	Continued From page 34 During an interview on 12/11/14 at 11:45am, Nurse Manager #1 stated she overlooked the consent for the pneumococcal vaccination. She further stated "I was told today by the Regional QA nurse that I need to give (Resident # 53) the pneumonia shot today." In an interview on 12/11/14 at 12:07 pm, the Director of Nursing (DON) stated it was her expectation for the nurse to administer the pneumococcal vaccination at the time the consent was received. She further stated it was her expectation for the nurse to document in the medical record if the vaccination was not administered for any reason. On 12/11/14 at 12:09 pm during an interview, the Regional QA Nurse stated she advised the Nurse Manager to administer the pneumonia vaccination today.	F 334	A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		1/8/15

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F 431	Continued From page 35 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to remove and/or dispose of two tubes of prescribed ointment for Resident #124 (who was discharged on October 9, 2014) from 1 of 7 medication storage areas. The findings included: The facility's policy on "Returning Meds to the Pharmacy" undated was reviewed. The policy read in part "All medications for discharged or expired residents should be returned to the pharmacy in 3 days." An observation of the treatment cart on 12/10/14 at 10:23 am revealed two tubes of prescribed santyl ointment for Resident #124. A review of the	F 431	F431 This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 12-11-14 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville 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	

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F 431	Continued From page 36 medical record discharge summary for Resident #124 revealed she was discharged to home on October 9, 2014. On 12/11/14 at 12:52 pm during an interview, the Director of Nursing stated it was her expectation for the nurse to return the medication to the pharmacy when the resident was discharged.	F 431	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 January 8, 2015. For the residents affected, for the medication found in treatment cart was returned to the pharmacy on 12-10-14 To ensure other residents are not affected, all nurses were in-serviced on, 12-15-14, 12-16-14, 12-20-14, 1-6-15, and 1-7-14 on timeliness of sending back medication on when residents are discharged. All nursing carts were audited on 1-7-14 Regional QA Nurse to ensure there was no other medication in need of being sent back to pharmacy. The audit did not find any medication needing to be sent back to the pharmacy. For on-going compliance an audit will be completed by Director of Nursing or designee, five days a week for one month, then weekly for two months to check all nursing carts for medication from residents who have been discharged. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to	

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F 431	Continued From page 37	F 431	determine if further systems modifications and/or training are in order.	