

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

PRINTED: 11/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2016
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to change the bath water prior to providing perineum care, failed to change the water after washing the rectal area and before proceeding to complete the bath and failed to remove facial hair for 1 of 1 residents (Resident #2) whose bed bath was observed. Findings included: Resident #2 was admitted to the facility on 9/21/16 with diagnoses that included generalized muscle weakness, diabetes, depression, glaucoma and anemia. Review of the 10/11/16 Admission Minimum Data Set (MDS) indicated Resident #2 was cognitively intact and required extensive assistance for bed mobility, transfer, dressing, toilet use and personal hygiene. The care plan, reviewed on 10/19/16, indicated Resident #2 had a self-care deficient. Bathing and personal hygiene would be accomplished with assistance from staff. An observation was made of Resident #2 on 10/30/16 at 2:55 PM. She was sitting in her wheelchair. The resident stated she had been bathed. She was dressed in street clothes. Chin hair was present. The resident stated she would have liked for the hair to be removed, but no one had offered.</p>	F 312	<p>For the resident affected: On 10/31/16, surveyor observed a CNA provide a bed bath to one resident. Surveyor observed CNA wash resident starting with her face proceeding to her upper body, then to rectum area, then proceeded to residents' legs and feet using the same water and wash cloth for entire bed bath given. Resident was also seen with facial hair. Facial hair was removed by nursing staff with residents consent. 1:1 observation and re-education provided with CNA observed providing bed bath to resident.</p> <p>For the residents with the potential to be affected: All nursing staff will be re-educated and in-serviced by DON and/or designee beginning on 11/1/16 and will be completed by 11/21/16 regarding facilities policy and procedure for personal care to ensure appropriate steps are being followed as well as grooming related to facial hair. All certified nursing assistants will be observed one on one by DON and/or designee to ensure personal care policy was retained and performed accurately. This will be completed by 11/21/16. DON and/or designee will</p>	11/21/16	

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

TITLE

(X6) DATE

Electronically Signed

11/14/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2016
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 1</p> <p>On 10/31/16 at 8:15 AM, Resident #2 was observed dressing and sitting up in her wheelchair. She stated she had not received her morning bath. The chin hair remained visible. An observation was made of Resident #2 receiving her morning bed bath from Nursing Assistant (NA) #1 on 10/31/16 at 11:00 AM. The NA acknowledged she had provided care for Resident #2 the previous day. After preparing the bath water, the NA cleansed the resident 's face and upper body. Using the same washcloth and water, NA #1 provided perineum care to the resident, including cleaning her indwelling urinary catheter. After turning Resident #2 on her left side, NA #1 washed the resident 's back, buttocks and rectal area. Without changing the water, the NA completed Resident #2 's bath by washing her legs and feet. Hair care was provided and the NA assisted the resident with oral care. Removal of Resident #2 's chin hair was not offered or observed.</p> <p>NA #2 was interviewed on 10/31/16 at 1:52 PM. The NA stated Resident #2 had not refused any type of personal hygiene. She stated she had not been taught to change the bath water during a bath, before perineum care or catheter care, but added she thought it may be important to change the water to prevent infection. The NA stated she had noticed Resident #2 's chin hair and intended to shave her later. She again acknowledged she had cared for Resident #2 the previous day and gave no reason why the chin hair had not been removed</p> <p>On 10/31/16 at 11:55 AM, Nurse #1 was interviewed. The nurse acknowledged she had been assigned to care for Resident #2 that day. The nurse stated when bathing a resident, bath water should be changed before perineum care or catheter care was given. She added after the</p>	F 312	<p>conduct a facility wide audit of all residents to ensure free of facial hair. If resident so chooses to have facial hair, care plan will be updated to reflect wishes. This will be completed by 11/21/16. All new hires will be educated upon orientation of policy and procedures of personal care and grooming. Measures put into place: All nursing staff were re-educated and in-serviced by DON and/or designee beginning on 11/1/16 and will be completed by 11/21/16 regarding facilities policy and procedure for personal care to ensure appropriate steps are being followed as well as grooming related to facial hair. All certified nursing assistants will be observed one on one by DON and/or designee to ensure personal care policy was retained and performed accurately. This will be completed by 11/21/16. DON and/or designee will conduct a facility wide audit of all residents to ensure free of facial hair. If resident so chooses to have facial hair, care plan will be updated to reflect wishes. This will be completed by 11/21/16. All new hires will be educated upon orientation of policy and procedures of personal care and grooming. Monitoring: Personal care pertaining to bed bath/ADL care/grooming including facial hair will be audited weekly x 4 weeks of 5 random certified nursing assistants per week then monthly x 2 months by DON and/or designee. This plan of correction and monitoring will be reviewed by QAPI Committee until deemed no longer necessary.</p>		

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

PRINTED: 11/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2016
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 2 rectal area was cleansed, the water should be changed before cleansing the rest of the resident ' s body. The Director of Nursing (DON) was interviewed on 10/31/16 at 2:26 PM. The DON stated NAs were taught to change the bath water prior to providing perineum or catheter care to help prevent urinary tract infections. She added the water should be changed after washing the rectal area and prior to completing the resident ' s bath. The DON stated residents were usually shaven on shower days and as needed. She stated NA #1 should have changed the water prior to providing perineum care to Resident #2.	F 312			