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	345129	A. BUILDING _____ B. WING _____	C 05/20/2017

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AUTUMN CARE OF MOCKSVILLE	1007 HOWARD STREET MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility to accurately code the minimum data set	F 278	F278 Steps Taken in regards to those residents	6/15/17

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

Electronically Signed | 06/15/2017

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F 278	Continued From page 1 to reflect a resident's height for 1 of 9 residents sampled (Resident #115). The findings included: Resident #115 was admitted to the facility on 04/12/17 and discharged on 04/30/17. Resident #115's diagnoses included osteoarthritis, weakness, dementia, and bilateral below knee amputations. Review of Resident #115's most recent comprehensive minimum data set (MDS) dated 04/19/17 revealed that Resident #115 was moderately impaired for daily decision making and required extensive assistance to total assistance with activities of daily living (ADLs). The MDS also revealed that Resident #115 had impairments to bilateral upper and lower extremities and had Resident #115's height as 65 inches. An interview with the Dietary Manger (DM) was conducted on 05/18/17 at 5:42 PM. The DM stated she had completed the comprehensive MDS dated 04/19/17 for Resident #115. The DM stated she used the medical record to gain most of the information that she coded on the MDS. She stated that she would ask the resident how tall they were and if they did not know then should would measure the resident with them lying flat on the bed. The DM stated that the 65 inches that she coded on the MDS was her mistake and when she had visited with Resident #115 she did not realize the resident was a double amputee. Resident #115 had told her 65 inches and that was what she recorded without verifying the information.	F 278	found to be affected: Resident #115 MDS was modified for height accuracy on 5/20/2017 and transmitted on 5/23/2017 by the MDS Coordinator. Steps Taken in regard to those Residents having the potential to be affected: All otherCurrent residents were audited by the Dietary Manager for accuracy of height that were entered on the MDS since 10/1/2016 on 5/23/2017. No other issues were identified. Measures put in place to ensure the deficient practice does not recur: The DON/Administrator provided re-education on MDS height accuracy to the Dietary Manager, MDS nurses, Social Worker, and Activities Director on 5/26/2017. New admissions and re-entry MDS assessments will be audited for height accuracy by the DON and/or designee times eight weeks. Monitoring effectiveness of corrective action: The MDS (height accuracy) audits will be brought by the DON to the Quality Assurance Committee for two months for review. Any areas of concern will be brought back to the Quality Assurance Committee for further action plan.	

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F 278	Continued From page 2 An interview with the MDS Coordinator was conducted on 05/19/17 at 11:39 AM. The MDS coordinator stated that each department was responsible for completing their assigned sections of the MDS and making sure that it was coded accurately. She stated that she did briefly review the MDS for accuracy but did not review each and every question for accuracy that would be up to the individual that was completing the section. The MDS Coordinator stated she would speak the DM and take care of correcting the MDS for Resident #115. An interview with Director of Nursing (DON) was conducted on 05/19/17 at 11:50 AM. The DON stated she expected all MDS's to be coded accurately and to verify the information given to the staff by the residents before coding it on the MDS.	F 278		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to thoroughly clean a female resident's perineal area during incontinence care to prevent the potential for skin breakdown or infection for 1 of 3 residents sampled for activities of daily living (Resident #72). Findings included:	F 312	F312 Steps Taken in regards to those residents found to be affected: Upon notification by surveyor to DON, two RNs were directed to provide adequate peri-care to the resident #72. Resident #72 was evaluated by a licensed nurse for any signs and symptoms of infection. None were identified. Steps Taken in regard to those Residents	6/15/17

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F 312	Continued From page 3 Resident #72 was admitted to the facility on 03/24/15 with diagnoses which included muscle weakness and history of a stroke with paralysis. A review of the most recent quarterly Minimum Data Set (MDS) dated 03/05/17 indicated Resident #72 was cognitively intact for daily decision making. The MDS also indicated Resident #72 required extensive staff assistance with toileting but required total care with personal hygiene and bathing and was always incontinent of bladder and bowel. A review of a care plan dated 03/16/17 indicated a focus statement Resident #72 was at risk for self-care deficit due to poor motivation and declined to get out of bed. The goals indicated in part Resident #72 would have activities of daily living met daily and the interventions were listed in part to provide incontinent care as necessary. During an observation of incontinence care on 05/20/17 at 9:30 AM NA #3 and the MDS Coordinator washed their hands and put on gloves. NA #3 removed Resident #72's brief which was wet and soiled with stool and Resident #72 was turned to her right side. NA #3 then took a wet wash cloth and applied soap and wiped Resident #72's buttocks in a circular motion and wiped stool from inside Resident #72's buttocks back and forth. She then took a wet washcloth and wiped inside Resident #72's buttocks again and the MDS Coordinator told NA #3 to dry the resident's skin with a towel. NA #3 placed a clean brief under Resident #72 and she was turned onto her back. NA #3 attempted to spread Resident #72's legs apart but had difficulty so she wiped down inside Resident #72's right and left groin with a wet washcloth and soap and then wiped down the front of Resident #72's vaginal	F 312	having the potential to be affected: Residents dependent on staff to provide/assist with peri-care were identified by RN on 5/22/2017. Licensed nurses completed bi-weekly skin checks on 5/22/2017 to ensure no areas of infection were identified. None were identified with signs and symptoms of infection related to improper peri-care. Measures put in place to ensure the deficient practice does not recur: DON and/or designee re-educated nursing staff on proper peri-care to prevent infection. All nursing assistants were required to complete a return demonstration to an RN which was completed on 5/31/2017. RN/ADON, RN treatment nurse will observe 5 nursing assistants weekly for 6 weeks to ensure adequate/proper peri-care is provided to prevent infection. Monitoring effectiveness of corrective action: The peri-care audits will be brought by the DON and/or designee to the Quality Assurance Committee for two months to ensure continued compliance.	

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area but did not separate the labial folds to clean the resident. She then took a wet washcloth and wiped down inside each groin and the front of Resident #72's vaginal area and wiped her with a towel and fastened her brief. NA #3 placed soiled linens into a clear plastic bag, removed her gloves and washed her hands and carried the soiled linen bag out of the resident's room.

During an interview on 05/20/17 at 9:43 AM with NA #3 she confirmed the incontinence care she had provided to Resident #72 was her usual technique when she provided incontinence care to Resident #72 as well as other residents. NA #3 stated Resident #72 was hard to clean because her legs were tight and were hard to get open. She confirmed it was difficult to clean inside Resident #72's labial folds in front but she thought she had cleaned them some. She further acknowledged she probably could have cleaned Resident #72 more thoroughly but she had cleaned what she could.

During an interview on 05/20/17 at 9:45 AM with the MDS Coordinator she stated she did not think NA #3 had cleaned Resident #72 as thoroughly as she should have. She further stated NA #3 did not separate labial skin folds and clean thoroughly in the front and she had cleaned Resident #72's buttocks in a random fashion. She also stated she probably should have intervened and told NA #3 to clean Resident #72 more thoroughly but didn't because it was not her routine to assist Nurse Aides during incontinence care.

During an interview and observation on 05/20/17 at 10:02 AM with a weekend Nursing Supervisor she stated she was going to repeat the

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incontinence care for Resident #72 because she had been told Resident #72 had not been thoroughly cleaned. The weekend Nursing Supervisor and the MDS Coordinator washed their hands and put on gloves and Resident #72 was positioned on her back and her brief was opened. The weekend Nursing Supervisor and the MDS Coordinator separated Resident #72's legs and the weekend Nursing Supervisor used a wet wash cloth from a bath basin that contained soap and water and wiped inside Resident #72's labial folds and the wash cloth was soiled with black stool. She then used 2 more washcloths with soap and water to clean stool from Resident #72's labial folds, then rinsed her skin with water and dried her skin with a towel. Resident #72 was turned onto her right side and black stool was visible on her buttocks. The MDS Coordinator used wet washcloths with soap and water to clean Resident #72's buttocks, then rinsed and dried her skin. A clean brief was placed on Resident #72 and she was repositioned in bed and was covered in a blanket. The weekend Nursing Supervisor and MDS Coordinator removed their gloves, washed their hands and removed soiled linens from Resident #72's room.

During an interview 05/20/17 at 10:26 AM with the weekend Nursing Supervisor she confirmed Resident #72 had stool in her labial folds that had not been cleaned during the incontinence care that was provided by NA #3. She stated she felt incontinence care should have been done more thoroughly because it increased the risk of urinary tract infections and skin breakdown.

During an interview on 05/20/17 at 12:16 PM with the Director of Nursing she stated it was her

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F 312	Continued From page 6 expectation for a resident to be cleaned and dried during incontinence care. She stated if the NA could not thoroughly clean a resident she expected for them to report to the nurse so it would be done thoroughly. She stated if a resident was not cleaned thoroughly, it was unacceptable because it put the resident at risk for urinary tract infections and skin breakdown.	F 312		
F 369 SS=D	483.60(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS (g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and family interviews and record review the facility failed to provide a two handled drinking cup with spouted lid for 1 of 2 sampled residents reviewed for assistive eating devices. (Resident #44) The findings included: Resident #44 was admitted to the facility on 02/22/16 and had current diagnoses including; muscle weakness, cancer and congestive heart failure. Review of Resident #44's care plan, which was last reviewed and updated on 04/19/17, revealed he was at increased nutrition and hydration risk due to diagnoses of congestive heart failure and cancer. A care plan approach directed staff to	F 369	F369 Steps Taken in regards to those residents found to be affected: Resident #44 was interviewed by the MDS nurse on 5/19/2017 and his preference for a cup with a handle, lid and straw for his coffee was determined. The care plan was updated on 5/19/2017. Steps Taken in regard to those Residents having the potential to be affected: All other current residents' care plans/kardex were reviewed and updated as indicated related to assistive devices by the Dietary Manager MDS nurse. A device list was completed on 5/26/17 for all residents to include any assistive devices. The device list will be updated with changes during morning risk meeting	6/15/17

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F 369	Continued From page 7 provide the resident with adaptive equipment as needed/ordered. Review of Resident #44's quarterly Minimum Data Set assessment of 05/06/17 revealed he was cognitively intact, understood what was being said to him and was able to make himself understood and required supervision and oversight with eating and drinking. Observations of Resident #44 on 05/18/17 at 1:12 PM revealed he was in his room with his lunch meal. Review of the tray slip served with the resident's meal revealed a two handled mug with spouted lid was to be served with his meal. However, observations of the resident's meal tray revealed he was not provided with a two handled mug or the spouted lid. Continued observations of Resident #44 on 05/18/17 from 1:12 PM to 1:27 PM revealed he made attempts to independently drink fluids by placing a straw in beverages and soup that were served, but his hand was very unsteady when he placed the straw in the liquids and he was observed to only be able to consume minimal fluids using the straw. On 5/18/17 at 1:35 PM a staff member was observed to provide the resident with assistance and encouragement to consume foods and fluids provided at this meal which the resident accepted. Observations of Resident #44 on 05/18/17 at 6:17 PM revealed he was in his room with his evening meal tray. Review of the tray slip served with this resident's meal revealed a two handled mug with spouted lid was to be served with his meal. Observations of the resident's meal tray revealed the two handled mug was on his tray, but the mug's spouted lid was not available. A family member was observed assisting the resident with	F 369	Monday - Friday by the interdisciplinary team. Measures put in place to ensure the deficient practice does not recur: 5 residents on the device list will be audited weekly times three months to ensure devices are in place on the care plan and kardex updated as appropriate by the DON and/or designee. All nurses, CNAs, and dietary staff members were inserviced on ensuring that the kardex/care plans matches the adaptive devices listed on the tray. Monitoring effectiveness of corrective action: The device list audit will be brought by the DON and/or designee to the Quality Assurance Committee for three months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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his meal. Interview with the resident's family member at the time of this observation revealed, the two handled cup with lid was beneficial for the resident because he was able to use it to independently drink fluids and it prevented him from spilling fluids onto himself.

Observations of Resident #44 on 05/19/17 at 1:00 PM revealed he was in his room with his lunch meal tray. Review of the tray slip served with this resident's meal revealed a two handled mug with spouted lid was to be served with his meal. Observations of the resident's meal tray revealed the two handled mug was on his tray, but the spouted lid was not available. The resident was observed to use both of his hands to bring the two handled mug to his mouth and consume tea independently. The resident's hands were shaking while drinking from the two handled cup, but he did not spill any fluids onto himself. Interview with the resident at the time of this observation revealed, he liked to use the two handled cup to consume his beverages.

Nursing Assistant (NA) #4, who provided care to Resident #44, was interviewed on 05/19/17 at 1:15 PM. NA #4 stated that when Resident #44 used the two handled cup with spout lid to drink liquids he was more independent and it prevented spills. NA #4 stated the two handled cup and spout lid were usually on the resident's meal trays.

Interview with the Dietary Manager (DM) on 05/19/17 at 1:25 PM revealed Resident #44 should have a two handled cup with spouted lid on his meal trays to allow him to independently drink fluids and prevent spills. The DM stated the resident spilled coffee on himself 6 to 8 months

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F 369	Continued From page 9 ago, so the two handled cup and spouted lid was implemented to prevent further spills. The DM checked the kitchen and stated she was unable to find the spouted lid for the resident's two handled cup, so she would have therapy order another lid.	F 369		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 514	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to document a pressure ulcer wound treatment for a resident with a stage 4 pressure ulcer on the sacrum (Resident #115).

Findings included:

Resident #115 was admitted to the facility on 04/12/17 with diagnoses which included diabetes, heart disease, anxiety, depression and Alzheimer's disease. A review of the admission Minimum Data Set dated 04/19/17 indicated Resident #115 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #115 required extensive assistance with bed mobility and had a stage 4 pressure ulcer on her sacrum.

A review of a hospital discharge summary dated 04/12/17 indicated Resident #115 had sepsis (presence of bacteria spread in the blood stream throughout the body) due to an infected sacral pressure ulcer. A section

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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labeled plan indicated in part to continue with local wound care and turn every 2 hours.

A review of a Weekly Wound Assessment electronically signed by the Wound nurse dated 04/14/17 indicated Resident #115 had a stage 4 pressure ulcer on her sacrum which was 5.5 centimeters (cm) length by 5 cm width and 0.9 cm depth, had no drainage, no odor and the wound bed was pink, yellow and had necrotic (dead tissue). A section labeled comments indicated a Wound Physician would evaluate the pressure ulcer on his next round at the facility on 04/18/16.

A review of a facility document labeled Physician's Order Sheet dated 04/14/17 indicated to clean sacral wound with wound cleaner, apply Dakin's moist gauze and cover with an absorbent dressing daily.

A review of a Treatment Administration Record (TAR) dated 04/14/17 revealed there were no staff initials to indicate wound treatments had been done.

A review of a care plan dated 04/17/17 indicated Resident #115 had actual skin breakdown to her sacrum. The goals were listed in part the wound to sacrum would show decreased size through next review and would show no signs or symptoms of infection and interventions were listed in part to provide treatment as ordered.

During an interview on 05/20/17 at 11:55, MDS Nurse #1 stated Resident #115 had a pressure ulcer on her sacrum when she was admitted to the facility. After review of the TAR she confirmed the orders for wound treatments for Resident #115's pressure ulcer were not documented on 04/14/17.

During an interview on 05/20/17 at 12:12 PM, the Wound Treatment Nurse stated the nurse who admitted the resident was responsible for putting in the admission treatment orders. She stated she did Resident #115's wound assessment on 04/14/17 and verified she wrote a paper order on 04/14/17 to clean sacral wound with wound cleaner, apply Dakin's moist gauze and cover with an absorbent dressing daily but there was no documentation treatments had been done on 04/14/17.

During an interview on 05/20/17 at 12:53 PM, the weekend Nursing Supervisor confirmed there was no documentation of the treatments on 04/14/17.

During an interview on 05/20/17 at 1:12 PM, the Director of Nursing stated it was her expectation for staff to document wound treatments on the TAR according to physician's orders.

During a telephone call received on 05/20/16 at 2:06 PM, a wound technician stated she remembered Resident #115 had a wound on her sacrum. She further stated she thought someone had told her to put a wet to dry dressing on Resident #115's sacral wound on 04/14/17 but was not sure why it wasn't documented.