

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTER'S FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2011
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2011
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 360 BALSM ROAD WAYNESVILLE, NC 28786	
(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=B	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to ensure that the Registered Nurse Assessment Coordinator certified the overall completion of a Minimum Data Set only after all individual assessors had completed and signed their portions for four (4) of</p>	F 278	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.</p> <p>A 100% audit for all current residents was completed on 02/28/2011. Fifteen residents were identified and had modification MDS's completed and sent to CMS.</p> <p>Residents numbers 54,82, 98 & 105 have modification MDS's completed and sent to CMS.</p> <p>MDS (Minimum Data Set) nurses were reinserviced by the Regional MDS Nurse Consultant 02/28/2011 for completion RN signature dates.</p>	2/28/11

RECEIVED
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 BY: ORN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Barbara Dias* TITLE: *Administrator* (X6) DATE: *4/5/11*

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.

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F 278	<p>Continued From page 1</p> <p>fifteen (15) residents (Residents # 54, 82, 98, and 105).</p> <p>The findings are:</p> <p>1. Resident # 54 was admitted to the facility on 03/03/06. Review of a quarterly Minimum Data Set (MDS) revealed that facility observations of Resident # 54 were completed on 12/20/10 (Assessment Reference Date). Review of Section Z revealed that the Registered Nurse Assessment Coordinator (AC) # 1 signed the MDS on 12/31/10, certifying that all sections of the MDS had been completed. Review of dated signatures of individual assessors revealed that Sections A, O, and Q had not been completed until 01/02/11.</p> <p>On 02/24/11 at 1:40 p.m. AC # 2 was interviewed. She stated that AC # 1 was unavailable for interview as she was currently out of the country. She stated AC # 1 had started in this position 11/01/10 and AC # 2 had trained AC # 1. AC # 2 examined the MDS for Resident # 54 and stated that AC # 1 should not have signed and certified that the MDS had been completed until individual assessors had all signed indicating they had completed their respective sections.</p> <p>2. Resident # 82 was admitted to the facility on 09/06/10. Review of a quarterly Minimum Data Set (MDS) revealed that facility observations of Resident # 82 were completed on 12/08/10 (Assessment Reference Date). Review of Section Z revealed that the Registered Nurse Assessment Coordinator (AC) # 1 signed the MDS on 12/13/10, certifying that all sections of the MDS had been completed. Review of dated signatures of individual assessors revealed that</p>	F 278	<p>The DON (Director of Nurses) audits 10 MDS's per week for 4 weeks to monitor compliance of signatures to ensure the RN completion signature date is on or after the last section signature date. The DON audits 5 MDS's weekly for 2 weeks to monitor compliance for signatures to ensure the RN signature date is on or after the last section signature date.</p> <p>The DON performs random audits on a prn (as needed) basis to monitor compliance of signatures to ensure the RN signature date is on or after the last section signature date .</p> <p>The DON is responsible to monitor compliance and reports findings to the QA (Quality Assurance) committee quarterly.</p>	
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F 278	<p>Continued From page 2</p> <p>Sections A, G, J, M, and O had not been completed until 12/14/10.</p> <p>On 02/24/11 at 1:40 p.m. AC # 2 was interviewed. She stated that AC # 1 was unavailable for interview as she was currently out of the country. She stated AC # 1 had started in this position 11/01/10 and AC # 2 had trained AC # 1. AC # 2 examined the MDS for Resident # 54 and stated that AC # 1 should not have signed and certified that the MDS had been completed until individual assessors had all signed indicating they had completed their respective sections.</p> <p>3. Resident # 98 was admitted to the facility on 06/27/09. Review of a quarterly Minimum Data Set (MDS) revealed that facility observations of Resident # 98 were completed on 01/21/11 (Assessment Reference Date). Review of Section Z revealed that the Registered Nurse Assessment Coordinator (AC) # 1 signed the MDS on 01/28/11, certifying that all sections of the MDS had been completed. Review of dated signatures of individual assessors revealed that Section I had not been completed until 01/31/11.</p> <p>On 02/24/11 at 1:40 p.m. AC # 2 was interviewed. She stated that AC # 1 was unavailable for interview as she was currently out of the country. She stated AC # 1 had started in this position 11/01/10 and AC # 2 had trained AC # 1. AC # 2 examined the MDS for Resident # 54 and stated that AC # 1 should not have signed and certified that the MDS had been completed until individual assessors had all signed indicating they had completed their respective sections. She stated that initially she reviewed the work of AC # 1 but had stopped because she was too busy with her own work.</p>	F 278			

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F 278	Continued From page 3 4. Resident # 105 was admitted to the facility on 01/11/10. Review of a quarterly Minimum Data Set (MDS) revealed that facility observations of Resident # 105 were completed on 01/25/11 (Assessment Reference Date). Review of Section Z revealed that the Registered Nurse Assessment Coordinator (AC) # 1 signed the MDS on 02/03/11, certifying that all sections of the MDS had been completed. Review of dated signatures of individual assessors revealed that Section M had not been completed until 02/04/11. On 02/24/11 at 1:40 p.m. AC # 2 was interviewed. She stated that AC # 1 was unavailable for interview as she was currently out of the country. She stated AC # 1 had started in this position 11/01/10 and AC # 2 had trained AC # 1. AC # 2 examined the MDS for Resident # 54 and stated that AC # 1 should not have signed and certified that the MDS had been completed until individual assessors had all signed indicating they had completed their respective sections. She stated that initially she reviewed the work of AC # 1 but had stopped because she was too busy with her own work.	F 278			
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	F 309	Resident's number 98 and 136 experienced no negative outcomes. Facility bowel protocols were initiated for each of the residents (during annual survey) with positive results.	3/15/11	

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F 309	<p>Continued From page 4</p> <p>by: Based on staff interviews and record reviews the facility failed to manage and implement planned measures for adequate bowel elimination patterns for two (2) of eleven (11) sampled residents. (Resident #s 98 and 136).</p> <p>The findings are:</p> <p>The facility's house standing orders revised 2/24/10 specified, "If no bowel movement times 2 days 3-11 shift will give 30 cc (cubic centimeters) of Milk of Magnesia (laxative) in the evening. Please sign off on MAR (Medication Administration Record). If no bowel movement by the next day, 7-3 shift will give Fleets enema. Please sign off on MAR, if no results with Fleets enema, give 1000cc soap suds enema. If no results from soap suds enema after eight hours, notify Medical Doctor as soon as possible. For occasional constipation and those who have muscle control give a suppository as needed."</p> <p>1. Resident #98 was admitted to the facility on 6/27/09 with diagnoses that included constipation, history of colon cancer and dementia. The most recent Minimum Data Set (MDS) dated 1/28/11 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily decision making. The MDS also specified the resident required extensive assistance with Activities of Daily Living (ADLs) and was frequently incontinent of bowel.</p> <p>Resident #98's bowel elimination and constipation care plans updated 11/3/10 specified the resident will have a bowel movement at least every three (3) days and outlined interventions such as, (1) Initiate HSO (house standing orders) protocol</p>	F 309	<p>A 100% audit was completed 02/24/2011 for all residents to monitor bowel elimination. No other residents were identified in need of intervention.</p> <p>Licensed nurses were reinserviced in reviewing the bowel elimination report on a daily basis and initiating the bowel protocol as indicated for the 3 day look back period, when a resident is without a bowel movement. 03/10/2011</p> <p>Certified Nurse Assistants reinserviced to document all BM's on a daily basis, each shift. 03/10/2011</p> <p>House Standing orders are amended so a bowel protocol is initiated every 3 days. The amendments are placed in each medical record 03/15/2011.</p> <p>The DON and ADON (Assistant Director of Nursing) audit bowel elimination summary 5 days a week for 4 weeks to monitor compliance</p>	
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F 309	<p>Continued From page 5</p> <p>after two days without bowel movement and (2) monitor and chart bowel movements.</p> <p>Resident #98's bowel elimination records were reviewed and revealed the following:</p> <p>a. Starting 8/26/10 and continuing for five (5) days no bowel movements were documented.</p> <p>b. Starting 9/7/10 and continuing for eight (8) days no bowel movements were documented.</p> <p>c. Starting 10/24/10 and continuing for five (5) days no bowel movements were documented.</p> <p>d. Starting 11/1/10 and continuing for five (5) days no bowel movements were documented.</p> <p>e. Starting 11/21/10 and continuing for five (5) days no bowel movements were documented.</p> <p>f. Starting 12/16/10 and continuing for four (4) days no bowel movements were documented.</p> <p>g. Starting 1/12/11 and continuing for five (5) days no bowel movements were documented.</p> <p>h. Starting 2/11/11 and continuing for six (6) days no bowel movements were documented.</p> <p>A review of nursing notes for Resident #98 for the periods of 8/26/10 through 8/31/10; 9/7/10 through 9/14/10; 10/20/10 through 10/24/10; 11/1/10 through 11/5/10; 11/21/10 through 11/24/10; 12/16/10 through 12/19/10; 1/12/11 through 1/16/11 and 2/11/11 through 2/16/11 revealed no documentation of assessment for constipation or implementation of the "House Standing Orders" for constipation.</p> <p>The Medication Administration Record (MAR) for 8/10, 9/10, 10/10, 11/10, 12/10, 1/11 and 2/11 were reviewed and revealed an original physician order for Colace (laxative) 100 milligrams (mg) by mouth daily for constipation. Further review of the MAR and physician orders revealed no additional</p>	F 309	<p>The DON and ADON audit bowel elimination summaries weekly for 8 weeks, then perform random audits prn to monitor compliance.</p> <p>The DON and ADON are responsible for monitoring compliance and report findings to the QA committee quarterly,</p>		

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F 309	<p>Continued From page 6</p> <p>orders and/or interventions to address the eight (8) episodes of constipation.</p> <p>On 2/23/11 at 9:10 a.m. the Director of Nursing (DON) was interviewed and reported incidents of bowel movements were documented in the resident 's computerized medical record and on an assignment sheet kept at the nurses ' station. The DON stated the assigned licensed nurse was responsible for reviewing the assignment sheets to ensure all residents had a bowel movement in the last two days. She stated she would expect the nurse to initiate the house standing orders for a resident who had not had a bowel movement after the second day. The DON confirmed this was the only system the licensed nurses utilized to ensure residents maintained an adequate bowel elimination regimen. The DON reviewed Resident #98 ' s bowel elimination record and confirmed measures should have been implemented for the eight episodes of no bowel movement greater than two days.</p> <p>2. Resident #136 was admitted to the facility on 2/14/11 with diagnoses that included delirium, adult failure to thrive and chronic kidney disease. No Minimum Data Set (MDS) had been completed for the resident. The hospital discharge summary dated 2/13/11 specified the resident required extensive assistance with Activities of Daily Living (ADLs). Resident #136 ' s initial care plan dated 2/16/11 specified to monitor and chart bowel movements.</p> <p>Resident #136's bowel elimination record was reviewed and revealed:</p> <p>a. Starting 2/19/11 and continuing for five (5) days no bowel movements were documented.</p>	F 309		

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F 309	Continued From page 7 A review of nursing notes for Resident #136 for the period of 2/19/11 through 2/23/11 revealed no documentation of assessment for constipation or implementation of the "House Standing Orders" for constipation. Review of the Medication Administration Record (MAR) and physician orders revealed no additional orders and/or interventions to address the episode of constipation. On 2/23/11 at 9:10 a.m. the Director of Nursing (DON) was interviewed and reported all bowel movements were documented in the resident's computerized medical record and on an assignment sheet kept at the nurses' station. The DON stated the assigned licensed nurse was responsible for reviewing the assignment sheets to ensure all residents had a bowel movement in the last two days. She stated she would expect the nurse to initiate the house standing orders for a resident who had not had a bowel movement after the second day. The DON confirmed this was the only system the licensed nurses utilized to ensure residents maintained an adequate bowel elimination regimen. The DON reviewed Resident #136's bowel elimination record and confirmed measures should have been implemented for the episode of no bowel movement.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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.	F 312	Resident's number 54 and 15 were immediately shaved on 02/24/2011. Resident's #54 care plan reviewed and amended to remove facial hair as needed.	3/11/11

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F 312	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility failed to remove facial hair for two (2) of fifteen (15) residents (Resident # 54 and 15). The findings are: Resident # 54 was admitted to the facility on 03/03/06 with diagnoses of Alzheimer ' s Disease and general muscle weakness, among others. The latest Minimum Data Set dated 12/13/10 revealed the resident had severe cognitive impairment and required extensive assistance of one person for most activities of daily living including personal hygiene. A review of the resident ' s care plan effective through 03/21/11 revealed a problem entitled " Personal Hygiene, extensive assist needed. " One intervention for the problem was to remove facial hair every week day morning. On 02/22/11 at 9:22 a.m. Resident # 54 was observed sitting in her wheelchair in her room. The resident was observed to have facial stubble approximately ¼ inch long covering her chin. On 02/23/11 at 1:30 p.m. and on 02/24/11 at 10:30 a.m. Resident # 54 was again observed sitting in her wheelchair. The resident ' s facial stubble remained untrimmed. On 02/24/11 at 11:05 a.m. Nursing Assistant # 2 was interviewed. She stated she was usually assigned to care for Resident # 54, including	F 312	A 100% audit was conducted for facial hair 02/24/2011 and no other residents were identified. Licensed nurses and certified nurse assistants reinserviced in grooming/removal of facial hair 03/11/2011 The QA (Quality Assurance) nurse completes audits 2 times weekly x 3 months to monitor facial hair on all residents, then randomly weekly. The QA nurse is responsible for monitoring compliance and reporting findings to the QA committee quarterly.	

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F 312	<p>Continued From page 9</p> <p>today. She stated the resident was cooperative and did not resist care. NA # 2 stated part of her daily routine was to check female residents for facial hairs and remove them. An observation was made of the resident with NA # 2 who stated she had not noticed the resident ' s facial hairs.</p> <p>On 02/24/11 at 11:13 a.m. the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that nursing assistants should monitor dependent female residents for facial hairs and remove them. The ADON observed the facial hairs on Resident # 54 and stated they should have been cut.</p> <p>2. Resident #15 was admitted to the facility on 4/7/09 with diagnoses that included diabetes mellitus, hypertension, lung disease, constipation and hypothyroidism. The most recent Minimum Data Set (MDS) dated 2/15/11 specified the resident was moderately impaired with cognitive skills for daily decision making. The MDS also specified the resident required extensive assistance with Activities of Daily Living (ADLs).</p> <p>Resident #15's ADL care plan updated 8/30/10 specified the resident would have personal hygiene needs met daily. The resident's shower schedule revealed she received bi-weekly showers on Mondays and Thursdays.</p> <p>On 2/21/11 at 11:40 a.m. Resident #15 was observed in her bed to have approximately ¼ inch long facial stubble that covered her chin.</p> <p>On 2/24/11 at 10:50 a.m. Resident #15 was observed up sitting in her recliner chair with approximately ¼ inch long facial stubble that covered her chin. She reported that she just</p>	F 312		

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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 360 BALSM ROAD WAYNESVILLE, NC 28786		
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F 312	<p>Continued From page 10 received her shower that morning.</p> <p>On 2/24/11 at 11:00 a.m. nurse aide (NA) #1 was interviewed and reported she gave Resident #15 her shower earlier that morning. She stated she observed Resident #15 to have chin stubble and confirmed she did not offer to shave the resident.</p> <p>On 2/24/11 at 11:15 a.m. the Assistant Director of Nursing (ADON) observed Resident #15's facial hair and confirmed the nurse aide should have shaved the resident. The ADON asked Resident #15 how she dealt with her facial hair when she lived at home and Resident #15 reported she shaved. The ADON stated nurse aides are expected to remove facial hair as needed during their shifts.</p>	F 312			