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 _____	01/17/2014

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 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 interview, the facility failed to include in the abuse policy that all allegations of abuse would be reported to the appropriate state agency. The findings included: The facility' policy entitled Abuse/Neglect Policy dated on 11/1/13, read in part "Abuse and/or Patient Neglect Investigation - 6. Should the investigation reveal that abuse occurred; the administrator/designee will submit a 24-hour initial report to the appropriate state agencies and submit the 5 working days report upon completion of the investigation." During an interview with the Administrator on 01/17/14 at 11:00 am he stated that he would follow his abuse policy, figure out what was going on and investigate the alleged abuse allegation and make sure it was a true allegation of abuse before he reported it.	F 226	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 HCFA 2567 for the 1-13-2014 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 February 10, 2014. F226 The policy was changed on January 24, 2014 to read When an incident or	2/10/14

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

Electronically Signed | 02/10/2014

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 226	Continued From page 1	F 226	suspected incident of patient abuse or neglect is reported, the Administrator the administrator/designee investigates the incident& The Administrator or designee will submit a 24-hour initial report to the appropriate state agencies and submit a 5 working day report upon the completion of the investigation. To ensure other residents are not affected, Staff was in-serviced on the change in abuse policy by the Staff Development Coordinator or designee on 1/21/2014, 1/22/2014, 1/24/2014, 1/27/2014, 1/28/2014, 1/29/2014, 1/30/2014, 1/31/2014, 2/3/204, 2/4/2014, and 2/6/2014. For on-going compliance, staff will be in-serviced yearly on the facility□s abuse policy, and all new staff will be in-serviced on the policy during orientation by the Staff Development Coordinator or designee. A comprehensive review of the systematic changes will be discussed and monitored through our quality assurance meetings at least quarterly.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		2/10/14

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F 371	Continued From page 2 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of facility records, the facility failed to eliminate the risk of cross-contamination during meal tray preparation by not washing hands or changing gloves as dietary employees transitioned between touching appliance handles and touching ready to eat foods in 2 of 4 dining areas observed for dining. The findings included: 1. A lunch meal observation that began on 1/13/14 at 12:30 pm revealed the dietary staff setting up the meal tray line on the steam table in the 400 hall dining area. The dietary aide #1 was observed with gloved hands to touch the refrigerator handle and then picked up the cooked chicken patty and placed it on a bun. In an interview on 1/16/14 at 3:29 pm with the Dietary Aide #1, she stated she was not supposed to touch the refrigerator and then touch the ready to eat foods. She further stated she is supposed to use tongs to handle the ready to eat foods. During an interview on 1/16/14 at 5:21pm, the Eastern district dietitian stated she expected the staff to not handle edible food items with bare hands or gloved hands. She further stated "They should handle the ready to eat foods with any sort	F 371	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 HCFA 2567 for the 1-23-2014 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 February 10, 2014. F371 For the residents affected, during the meal service on 01-14-14, the dietary staff members were directed by the administrator and the dietician to stop serving until tongs were brought to the	

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F 371	Continued From page 3 of barrier." 2A.During a dinner meal observation on 1/14/14 at 5:39 pm revealed the dietary staff preparing the meal tray line on the steam table in the 400 hall dining area. The dietary aide #2 was observed touching the refrigerator with gloved hands and then he picked up a biscuit and placed it on a resident's meal tray. The administrator was informed on 1/14/14 at 5:40 pm of the observation and he immediately walked over and stopped the tray line and sent the staff to get tongs. The tongs was placed in the biscuit compartment on 1/14/14 at 5:42 pm. The dietary aide #2 was not available for interview for the remainder of the survey. An attempt was made to contact the dietary aide #2 on 1/16/14 at 12:54 pm. A second attempt to contact the dietary aide #2 was made on 1/16/14 at 2:05 pm. The Eastern district dietitian was notified on 1/16/14 at 2:07 pm of the inability to reach the dietary aide #2 by phone for interview. 2B.During an evening meal observation on 1/14/14 at 5:44 pm, dietary aide #3 was observed opening the drawer with gloved hands in the food prep area of the 600 hall dining area to retrieve cup lids and then picked up a biscuit and placed it on a resident's meal tray. The facility's dietitian was notified on 1/14/14 at 5:45 of the observation. The dietitian immediately went and stopped the serving line and sent the dietary staff to get a set of tongs. The tongs were placed in the biscuit compartment on 1/14/14 at 5:48 pm. On 1/15/14 at 10:24 am in an interview with the dietary aide #3, he stated he was not aware of touching the drawer and then touching the	F 371	service line. To ensure other residents are not affected, All dietary staff was in-serviced on 1-20-2014. Dietician in-serviced on the proper way to serve foods using utensils, and staff should not at any point use hands to serve foods. For on-going compliance, Dietician or designee will monitor Dietary Aides while serving lines for five days a week for one month, then weekly for three months. Any area of identified concern will be addressed at the time identified A comprehensive review of our audits and systematic changes will be discussed and monitored through our quality assurance meeting at least quarterly.	

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F 371	Continued From page 4 biscuits with the same gloved hands. He further stated he went to get the tongs because he should have had them from the beginning to handle the bread. During an interview on 1/16/14 at 5:21pm, the Eastern district dietitian stated she expected the staff to not handle edible food items with bare hands or gloved hands. She further stated "They should handle the ready to eat foods with any sort of barrier."	F 371		
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 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	F 431		2/10/14

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F 431	Continued From page 5 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 observations, staff interviews and record review, the facility failed to store Schedule II medications in a locked, permanently affixed compartment for 1 of 2 medication rooms observed for storage. The findings included: Review of the facility's policy entitled "Pharmacy Services" section for Medication Access and Storage version dated 11/1/13 states in part "Schedule II medications must be maintained in separately locked, permanently affixed compartments." On 1/16/14 at 4:40 pm an observation of the Nurse's station 2 medication room revealed two cards of Marinol 2.5 mg with a total of 62 capsules for Resident #18 located on the bottom shelf of an unlocked refrigerator. During an interview on 1/16/14 at 4:54 pm, Nurse #2 stated the narcotics should be stored under two locks at all times. She further stated she do not know why the medication refrigerator was not locked.	F 431	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 HCFA 2567 for the 1-13-2014 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 February 10, 2014. F431 For the medication refrigerator which	

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F 431	Continued From page 6 In an interview on 1/16/14 at 4:59 pm with the Director of Nursing, DON, she expected the narcotics to be double locked. She further stated the refrigerator lock was broken and she was not aware. The DON immediately called maintenance to the medication room. The DON returned on 1/16/14 at 5:23 pm to indicate the lock on the refrigerator was currently working. On 1/17/14 at 11:48 am, an observation revealed the Marinol medication for Resident #18 was located in the permanently affixed locked compartment box in the refrigerator on Nurse's station 1.	F 431	found not properly locked, it was locked immediately. To ensure other residents are not affected, a larger lock box was installed 2-3-2014 in medication room refrigerator so medication cards will fit in the lock box. The nurses will have to only lock the lock box instead of the refrigerator. Nurses were in-serviced on by Staff Development or designee on 2/3/2014, 2/4/2014, 2/5/2014, and 2/6/2014. For on-going compliance and audit will be completed by Director of Nursing or designee, five days a week for one month, then weekly for two months to ensure the narcotics lock box in the refrigerator is locked at all times. Any area of identified concern will be addressed at the time identified. A comprehensive review of our audits and changes will be discussed and monitored through our quality assurance meeting at least quarterly.	

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	345553	A. BUILDING 01 - MAIN B. WING _____	02/18/2014

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type V prot ectedconstruction with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	MAR 1 1 2014 This plan of correction will serve as the facility's allegation of compliance. Preparation and submission of this plan of correction is in response to HCFA 2567 for the 2-28-2014 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 4-3-2014.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation on Tuesday 2/18/2014 at approximately 8:30 AM onward the following deficiencies were noted: 1) There are penetrations in the smoke walls located on the rear cross corridor attic smoke walls that were not properly sealed in order to maintain the required fire resistance rating of the	K 025	K025 On or before April 3, 2014, all penetrations in the smoke walls located on the rear cross corridor attic smoke walls will be properly	4-3-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE

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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K 025	Continued From page 1 smoke wall. There are PVC penetrations in the smoke wall that were not equipped with approved UL rated assemblies and unapproved foam insulation on lines penetrating the smoke wall. CFR#: 42 CFR483.70 (a)	K 025	sealed in order to maintain the required fire resistance rating of the smoke wall. The proper UL rated assemblies will be placed around the PVC piping. The unapproved foam will be removed and fiberglass insulation and fire caulking will be applied to the refrigerant lines penetrating the smoke wall.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.	K 056	On 2-24-2013, the other smoke walls were inspected for additional penetrations not properly sealed and/or fire caulked. Any areas identified have been noted and will be corrected by April 3, 2014 To ensure on-going compliance, the environmental director or his designee will audit the building monthly for three months to ensure any future penetrations are properly sealed and/or fire caulked. If no deficient areas are noted, this audit will be conducted during periodic safety rounds to ensure on-going compliance. The results of these audits and any subsequent repairs will be taken to the quality assurance committee for monitoring purposes.	4-3-14
	This STANDARD is not met as evidenced by: Based on observation on Tuesday 2/18/2014 at approximately 8:30 AM onward the following deficiencies were noted: 1) The sprinkler heads located in front of the kitchen hood are rated for Intermediate Temperature Classification, Glass Bulb Color of Green temperature rating of (200°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red (155°F). 2) The sprinkler heads located in the laundry room are covered in lint and not maintained in			

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K 056	Continued From page 2 good condition. 3) The sprinkler head located in the shower room on 500 hall has paint on the glass bulb and not maintained in good condition. 42 CFR 483.70	K 056	K056 Autumn Care of Fayetteville has contracted with an outside sprinkler vendor to install an appropriate sprinkler heads in front of the kitchen hood and in the shower room. The sprinkler heads will be replaced on or before April 3, 2014. On March 5, 2014 the environmental services staff inspected the entire facility to identify any additional areas requiring replacement sprinkler heads. On March 6, 2014, the administrator reviewed the results of the audit conducted on March 5, 2014. The work or an update of its progress will be reviewed at our next quality assurance committee meeting. Autumn Care of Fayetteville cleaned the sprinkler heads located in the laundry. This was completed February 18, 2014.	4-3-14
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4:1. This STANDARD is not met as evidenced by: Based on observation on Tuesday 2/18/2014 at approximately 8:30 AM onward the following deficiencies were noted: 1) The generator annunicator panel did not show emergency power supplying load when power was transfered from normal to emergency connected load. 42 CFR 483.70	K 144		

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K			To ensure the heads to not build up lint in the future, the sprinkler heads will be cleaned on a weekly basis and PRN. Audits will be performed weekly for one month, then monthly for three months. Results of these audits will be brought to the quarterly QA meeting for monitoring. K144 On February 21, 2014, a outside contractor came to inspect the annunciator panel. Wire will be run from the transfer switches to the annunciator panel by April 3, 2014. The annunciator will then indicate when the generator is supplying power to the facility. To ensure on going compliance, the emergency power supply indicator light will be monitored monthly during the monthly load test. This will become part of the	4-3-14

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

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K			monthly routine inspection of the generator panel.	

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

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.