DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COM	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	AUTUMN CARE OF MARION			12	264 AIRPORT ROAD		
				М	ARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	nurse aide threw a m an object from that m she was propelling he Immediate Jeopardy when the facility prov Credible Allegation of Removal. The facility at a scope and sever actual harm with the minimal harm that is complete employee e monitoring systems p 2. 483.12 and 483.95 Immediate Jeopardy nurse aide threw a m an object from that m she was propelling he missed hitting Reside permitted to continue during the meal. Imm removed on 11/19/17 and implemented a C Immediate Jeopardy remains out of compl severity level of D (Is the potential for more not Immediate Jeopardy place are effective. 3. 483.21 (F281) at J Immediate Jeopardy staff failed to monitor	began on 10/23/17 when a eal tray into the hallway and eal tray hit Resident #71 as er wheelchair nearby. was removed on 11/19/17 ided and implemented a f Immediate Jeopardy remains out of compliance ity level of D (Isolated no potential for more than not Immediate Jeopardy) to education and ensure out into place are effective. (F226) at J began on 10/23/17 when a eal tray into the hallway and eal tray hit Resident #71 as er wheelchair nearby and ent #23. The nurse aide was working with residents nediate Jeopardy was when the facility provided redible Allegation of Removal. The facility					
		SUPPLIER REPRESENTATIVE'S SIGNATURE		_	TITLE		(X6) DATE
Electroni	cally Signed						12/15/2017

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURV COMPLETED		
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUTUMN	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)					(X5) COMPLETION DATE
F 000	milligrams (mg) once physician's standing of transcribing Resident orders staff did not m clotting time on 10/21 10/27/17. Immediate 11/19/17 when the fac implemented a credib The facility remains of scope and severity le harm with the potentia harm that is not Imme monitoring of systems completion of employ 4. 483.45 (F329) at J Immediate Jeopardy staff failed to monitor Resident #139, who w milligrams (mg), per t orders. Immediate Je 11/19/17 when the fac implemented a credib The facility remains o scope and severity le harm with the potentia harm that is not Imme monitoring of systems completion of employ 5. 483.35 (F353) at J Immediate Jeopardy I nurse aide threw a m to staffing frustrations meal tray hit Residen her wheelchair nearby permitted to continue during the meal. Imm	a day per, per the resident's orders. Due to staff not #139's physician's standing onitor the resident's blood /17, 10/23/17, 10/25/17 and Jeopardy was removed on cility provided and de allegation of compliance. ut of compliance at a lower vel of D (Isolated no actual al for more than minimal ediate Jeopardy) to ensure s put in place and ee training. began on 10/21/17 when the blood clotting time of vas on Warfarin 10 he resident's standing opardy was removed on cility provided and de allegation of compliance. ut of compliance at a lower vel of D (Isolated no actual al for more than minimal ediate Jeopardy) to ensure s put in place and	F	000			

Facility ID: 922951

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	MEDICAID SERVICES					APPROVED . 0938-0391	
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED	
	345165	B. WING _			C 11/15 TE, ZIP CODE		
ROVIDER OR SUPPLIER					-		
CARE OF MARION							
(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					(X5) COMPLETION DATE	
the facility provided an Allegation of Immedia tag was left out of com and severity of E (Pat potential for more that Immediate Jeopardy) examples #4, #5, and severity level D (Isola potential for more that Immediate Jeopardy). 6. 483.70 (F490) at J Immediate jeopardy b Resident #71 was stru- meal tray thrown by a permitted the nurse at on that unit due to sho Jeopardy was remove facility provided and in Allegation of Immedia facility remains out of severity level of E (Pat the potential for more not Immediate Jeopar education and ensure place are effective an	hd implemented a Credible te Jeopardy Removal. This npliance at a lower scope tern no actual harm with the n minimal harm that is not due to example #3, and #6 are at the scope and ted no actual harm with the n minimal harm that is not egan on 10/23/17 when uck by a flying object from a nurse aide. Nurse #1 de to continue to pass trays ort staffing. Immediate ed on 11/19/17 when the mplemented a Credible te Jeopardy Removal. The compliance at a scope and ttern no actual harm with than minimal harm that is rdy) to complete employee monitoring systems put into d sufficient to meet the care	FC	000				
facility's survey from 7 ID# 9KIX11 FREE FROM ABUSE SECLUSION CFR(s): 483.12(a)(1) 483.12	11/13/17 to 11/19/17. Event	F 2	223			12/22/17	
	CORRECTION ROVIDER OR SUPPLIER CARE OF MARION SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page the facility provided ar Allegation of Immedia tag was left out of con and severity of E (Pat potential for more than Immediate Jeopardy) examples #4, #5, and severity level D (Isolar potential for more than Immediate Jeopardy). 6. 483.70 (F490) at J Immediate jeopardy b Resident #71 was stru- meal tray thrown by a permitted the nurse ai on that unit due to sho Jeopardy was remove facility remains out of severity level of E (Pat the potential for more not lmmediate Jeopardy b Resident #71 was stru- meal tray thrown by a permitted the nurse ai on that unit due to sho Jeopardy was remove facility remains out of severity level of E (Pat the potential for more not Immediate Jeopar education and ensure place are effective and needs of the residents An extended survey w facility's survey from 1 FREE FROM ABUSEL SECLUSION CFR(s): 483.12(a)(1)	CORRECTION IDENTIFICATION NUMBER: JUDINIFICATION NUMBER: 345165 SOUDER OR SUPPLIER SARE OF MARION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. This tag was left out of compliance at a lower scope and severity of E (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) due to example #3, and examples #4, #5, and #6 are at the scope and severity level D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy). 6. 483.70 (F490) at J Immediate jeopardy began on 10/23/17 when Resident #71 was struck by a flying object from a meal tray thrown by a nurse aide. Nurse #1 permitted the nurse aide to continue to pass trays on that unit due to short staffing. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity level of E (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to complete employee education and ensure monitoring systems put into place are effective and sufficient to meet the care needs of the residents. An extended survey was conducted as part of the facility's survey from 11/13/17 to 11/19/17. Event ID# 9KIX11 FREE FROM ABUSE/INVOLUNTARY SECLU	CORRECTION IDENTIFICATION NUMBER: A. BUILDII 345165 B. WING_ COVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. This tag was left out of compliance at a lower scope and severity of E (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) due to example #3, and examples #4, #5, and #6 are at the scope and severity level D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy). 6. 483.70 (F490) at J Immediate jeopardy began on 10/23/17 when Resident #71 was struck by a flying object from a meal tray thrown by a nurse aide. Nurse #1 permitted the nurse aide to continue to pass trays on that unit due to short staffing. Immediate Jeopardy was removed on 11/19/17 when the facility remains out of compliance at a scope and severity level of E (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to complete employee education and ensure monitoring systems put into place are effective and sufficient to meet the care needs of the residents. F 2 An extended survey was conducted as part of the facility's survey from 11/13/17 to 11/19/17. Event ID# 9KIX11 F 2 FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) F 2	CORRECTION IDENTIFICATION NUMBER: A. BUILDING	CORRECTION IDENTIFICATION NUMBER: A BULDING 345165 B. WING COULDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SARE OF MARION STREET ADDRESS, CITY, STATE, ZIP CODE IEACH DEFICIENT OF DEFICIENCIES D IEACH DEFICIENT OR SUPPLIER D SUMMARY STATEMENT OF DEFICIENCIES D IEACH DEFICIENT ON USE THE PROCEEDED BY FULL RECULATORY OR LSC IDENTIFYING WFORMATION) PREPX CONTINUE FOR DEPICIENCY F000 Continued From page 2 F 000 Continued From page 2 F 000 Continued From page 2 F 000 A severity of E (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) due to example #3, and examples #4, #5, and #6 are at the scope and severity level D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) due to example #3, and examples #4, #5, and #6 are at the scope and severity level D (solated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy at J Immediate Jeopardy at J Immediate Jeopardy Removal. The facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity level of C (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy Removal. The facility remains out C completer employee education and ensure monitoring systems put into place are effective and sufficient to meet the care needs of the residents.	CORRECTION IDENTIFICATION NUMBER: A BUILDING 11/ 345165 B WING 11/ COMPER OF SUPPLER STREET ADDRESS (DTY, STATE, ZIP CODE 124 ARPORT ROAD SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE GEACH DEFICIENCY MIST PROCEDED BY FULL PREFX PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE Continued From page 2 ID PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE Continued From page 2 F 000 The facility provided and implemented a Credible PREFX Allegation of Immediate Jeopardy Removal. This Tag and severity (JC (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy beg on actual harm with the potential for more than minimal harm that is not Immediate Jeopardy beg on a clubular minimal harm that is not Immediate Jeopardy J. 6. 483.70 (F490) at J Immediate Jeopardy beg on a lof23/17 when Resident #71 was struck by a fiving object from a meal tray thrown by a nurse aide. Nurse #1 Jeopardy Was removed on 11/19/17 when the facility provided and implemented a Credible Allegation of more than minimal harm that is not Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity loc4 and implemented a Credible Allegator of the nurse aide to continue to pass trays on that unit due to short staffing. Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity loc4 (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy Removal. The facility remains	

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/21/20 [;] RM APPROVE IO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE SURVEY COMPLETED		
		345165	B. WING			1	1/19/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	•		
	CARE OF MARION				AIRPORT ROAD RION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 223	Continued From page	e 3	F	223				
	neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.							
	abuse, corporal punis seclusion; This REQUIREMENT	must- , mental, sexual, or physical shment, or involuntary f is not met as evidenced						
	staff interviews, the fa environment that main right to be free from a Immediate Jeopardy nurse aide threw a man an object from that man she was propelling he	iew, resident interview, and acility failed to provide an ntained 1 of 3 residents' abuse (Resident #71). began on 10/23/17 when a eal tray into the hallway and real tray hit Resident #71 as er wheelchair nearby.		F C Ii C	Disclaimer Preparation and submission of th Correction is required by state ar aw. This Plan of Correction doe constitute an admissiion for purp general liability, professional mal or any other court proceeding.	nd federal es not oses of		
	when the facility prov Credible Allegation of Removal. The facility at a scope and sever with the potential for is not Immediate Jeo	and ensure monitoring		E 1 c v F	2223 During annual survey ending 11/ he Self-Reported Incident initiate 10/23/17 was reviewed and it wa determined that the abuse invest was incomplete by not following policy and procedures. Due to the mmediate Jeopardy was cited for event that occurred on 10/23/20	ed on as tigation the facility nis, and or the		
	The findings included	:			1/19/2017.			
	06/30/14. Her diagno following a cerebral in and hemiplegia and h			s a N	Reeducation was completed for staff on 11/17/2017 concerning fabuse policy and procedures and Manager on Duty process. Reed	acility d the new ducation		
	Resident #71's annua	al Minimum Data Set (MDS)		v	vas performed by the Administra	ator, the		

Event ID: 9KIX11

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/21/201 MAPPROVEI D. 0938-039
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		345165	B. WING			C / 19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1264 AIRPORT ROAD		
AUTUMN	CARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 223	The Care Area Asses cognition dated 07/23 scored an 11 out of 1 Mental Status (BIMS) confusion, forgetfulne age related cognitive diagnoses of dementi scored varied. She w changes. On 11/13/17 at 10:07 Resident #71 denied denied she had been anything. A follow up 11/17/17 at 9:46 AM, again about a tray ind tray being thrown but anything. She stated not know what to thin little. She further stat involved was a good	d her with moderately ad requiring extensive activities of daily living skills. sment (CAA) related to 3/17 stated Resident #71 5 on the Brief Interview for 0. The CAA noted she had ess and she showed signs of loss although she had no ia. It was noted her BIMS vas at risk for cognitive AM during an interview, she had been abused and hit by a meal tray or o interview was conducted on Resident #71, when asked cident, stated she recalled a denied being hit by it happened so fast she did k and thinks it scared her a ted that the nurse aide	F 22	 Regional Vice President of Ope the Director of Nursing, and the Director of Clinical Services. Any hired staff from November 17th forward will receive education of Policy and Procedure. The Administrative Department will complete abuse policy and questionnaires on 3 staff memb week x4 weeks, then monthly x Any negative findings will be ad immediately by Administrator or of Nursing. Administrator/designee will com resident questionnaires with 3 r 3x weekly x4 weeks, then mont months related care and service negative findings will be addres immediately by Administrator or of Nursing. The facility will have a Manager every Saturday and Sunday fro 3pm. The 300 hall charge nurs designated nurse in charge in th absence of the Administrator, D 	Regional y newly 2017 on Abuse Managers procedure ber, 3x a 2 months. Idressed Director aplete esidents hly x2 es. Any sed Director	
	Health Care Personnel Investigations on 10/23/17 at 7:44 PM, revealed that a staff member reported that Nurse Aide (NA) #2 tossed a meal tray on 10/23/17 at 5:30 PM and that Resident #71 was wet with water. Review of the investigation revealed written statements were obtained by the nurse on duty (Nurse #1), the Nurse Aide (NA) #1 who witnessed the incident, and NA #2 who was alleged to throw the tray. The written statement from NA #1 dated 10/23/17			 Nursing, or the Manager on Dut Manager on Duty or the designation in charge will report negative fir the Administrator immediately. information gathered will be shat the Administrator in the next mo- meeting. Results of the questionnaires w forwarded to the facility Quality Performance Improvement com 3 months for further review and 	ty. The ated nurse ndings to General ared with orning ill be Assurance mittee for	

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/21/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE S COMPLE	
		345165	B. WING _				C / 19/2017
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	264 AIRPORT ROAD		
AUTUMN	CARE OF MARION			М	IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	Continued From page	5		223			
1 220		ately at 5:30 PM, NA #2		223	recommendations.		
		use out of the nurse's					
	station and across the resident. NA #2 then the tray cart and NA # then "grabbed a tray	e hall barely missing a went to the kitchen to obtain #1 told her to "chill." NA #2 off the cart and flung it went flying everywhere			The title of the person responsible for implementing the acceptable plan of correction is the Administrator.		
	problem was, NA #2	of water that hit face. When asked what her grabbed her stuff and or. After (NA #1) checked on					
	(Resident #71) (NA # who heard the incide	1) reported it to the nurse nt."					
	11/15/17 at 8:23 AM. 10/23/17 she and NA	ducted with NA #1 on She recalled that on #2 worked a 12 hour shift. an announcement over the					
	ready. Then a nurse	at the trays for this hall were called the nursing station to d the announcement. Then					
	NA #2 threw a mouse the tray cart. Upon re	e into the hall and left to get eturn NA #1 told NA #2 to 2 then threw a tray off the					
	the unit and NA #2 to	Resident #71. NA #2 left Id Nurse #1. A phone follow #1 on 11/16/17 at 4:17 PM					
	revealed Resident #7 away from NA #2 who #1 saw a cup of wate	1 was about an arms length en she threw the tray and NA r hit Resident #71's left					
	not injured. NA #1 st telling Nurse #1 abou	#71 never reacted and was ated she was intending on it the mouse being thrown in					
	leave the floor, NA $#2$	wever, before she could 2 had thrown the tray.					
	stated NA #2 "had go	t from NA #2 dated 10/23/17 tten very frustrated at work, .' I was about to pass out					

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		D HUMAN SERVICES //EDICAID SERVICES					FORM	D: 12/21/2017 APPROVED D: 0938-0391	
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		345165	B. WING _			_	C 11/19/2017		
NAME OF PROVID	DER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
AUTUMN CARI				12	264 AIRPORT ROAD				
AUTUWIN CARI	E OF MARION			М	IARION, NC 28752				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	((EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
tray whi or b too hall bec stat cau stat to t to t to t to t to t to t take pro at t bec she sho stat to t t to t t t to t t to t t to t t to t t to t t to t t to t t t to t t t to t t t to t t t to t t t to t t t to t t t to t t t to t t t to t t t t	ich set me over the being aware of who k a tray from the ca l. I did not know it a cause she kept rolli tement also include used them any more ff has, by not being the fullest. It was no cake care of 50 peo en care of. It's bar we the care that is a cause she felt as if e could not handle a build have to work u ff are expected to v whone interview was 16/17 at 9:54 AM. S ides on the 100 hal en a nurse called a nouncement that the ted she threw the no get the trays. Her cover veral times she sho orimanding way. Af #2 stated she took ew it into the hall. S ted she was frustra inths and not being care that was need h NA #2 on 11/16/1 ubably knew Reside	cold me I 'needed to chill', edge. So, without thinking or what was around me, I art and flung it across the affected (Resident #71), ng by." The written ed that she did not think she e trouble than what all the able to care for their needs ot possible for two people ple like they should be ely possible for 3 people to necessary for the residents ated she was frustrated there was too much that and she didn't think anyone nder the conditions that the vork under at this facility. s conducted with NA #2 on She stated there were only II. NA #2 got frustrated fter the overhead e trays were ready. She nouse into the hall and went coworker (NA #1) told her uld chill out in a ter being told several times, a tray off the cart and She then left the hall. She ted due to short staffing for able to give the residents ded. A follow up interview 7 at 4:29 PM revealed she ent #71 was rolling by but ose she was. She found out ent #71.	F 2	223					

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/21/2017 / APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		DNSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345165	B. WING _			C 11/19/2017		
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				1264	AIRPORT ROAD			
AUTUMN	CARE OF MARION			MAI	RION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 223	10/23/17 stated at 5:3 noise from the main of came from the day ro started walking down purse and Nurse #1 at happened. NA #2 sta done.' Nurse #1 wrol and Resident #71's s Resident #71 stated ' stuff.' Resident #71's and she was wet. Re- checked and found no statement continued DON and informed he Nurse #1 was intervite at 10:04 AM. Nurse #1 noise and started to h passed her with her of had enough and was tray and food all over shirt was 'soaked'. R hurt a little but she wa really mad. Nurse #1 mess and tried to obt happened. NA #2 the 30 minutes and Nurse information before ca stated she had not im showed remorse and returned from the bre she did not think NA # NA #2 apologized and she would call her bo asked to continue wo as long as she did no Nurse #1 called the A was instructed to take	30 PM she heard a loud dining room. The sound oom on the 100 hall. NA #2 the hall with her coat and asked NA #2 what ated 'you can have this I'm te she went down the hall hirt and pants were wet. that girl's mad and throwing stated a plate hit her knee sident #71's skin was o bruising or redness. The "at 5:37 I called (name of) er of the situation." ewed via phone on 11/16/17 #2 stated that she heard a head up the hall when NA #2 coat and purse saying she leaving. Nurse #1 saw the the floor and Resident #71's esident #71 stated her knee as alright and that girl was helped NA #1 pick up the ain information about what en came back in after about e #1 tried to gather lling administration. NA #2 tended to hit anyone. NA #2	F 2	223				

Facility ID: 922951

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES					FORM): 12/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION			LETED
		345165	B. WING			_	(11/	C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF MARION			1	264 AIRPORT ROAD			
AUTOMIN				N	MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	and fax it to the Healt Investigations unit and #1 stated that in hinds her home immediately there had been more assist on the floor. No During a follow up pho 3:57 PM, Nurse #1 sta #2 throwing the mous statement. She stated thrown a mouse earlie home immediately aft despite short staffing. tray incident was an is stated NA #2 worked incident for approxima DON spoke to her on her to leave. Interview with the Adm 11:59 AM revealed sh abuse following the in discussion with corpo do with burnout. Educ #2. The Administrato have been permitted to throwing the tray. Interview with the DO revealed she received Nurse #1 around 5:30 that NA #2 was frustra the building. Nurse # NA #2 returned, withir what she should do no #1 to put NA #2 in an	h Care Personnel d send NA #2 home. Nurse sight she would have sent y and would have done so if aides to pass 30 trays and to one was available to help. One interview on 11/16/17 at ated she learned about NA e when she took NA #1's d if she knew NA #2 had er, she would have sent her er she threw the tray She stated she thought the solated incident. Nurse #1 on the floor after the tray ately 10 minutes before the the phone and instructed	F	223				

	-	ID HUMAN SERVICES				FORM	M APPROVED D. 0938-0391
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Per the undated Sum the 10/23/17 incident was removed from the educated on employed handle work related s return to work. The a unsubstantiated "due The Administrator and were informed of Imm 11/16/17 at 6:18 PM. The facility provided a allegation of immedia 11/19/17 at 11:57 AM The Plan of Correctin The original allegation #71 was investigated Incident was submitte area of concern ident (NA) #2 was not remo Nurse #1 when she b objects including a co resident's meal tray. #71 being hit with an allowed to continue to Director of Nursing. A by the Administrator at 10/23/17. An investigation was Administrator and Dir Reportable Incident s Day on 10/27/17.	mary of the investigation of written by the DON, NA #2 e hall immediately, was e burnout and how to tress prior to allowing her to llegation of abuse was to no intent of harm." d Regional Clinical Nurse hediate Jeopardy on an acceptable credible te jeopardy removal on as follows: g the specific deficiency. n on 10/23/17 for Resident and a Facility Reportable ed by the administrator. The ified on 10/23/17 Nurse Aide oved from her duties by ecame upset and threw imputer mouse and a This resulted in Resident object and NA#2 was o work before calling the an investigation was initiated and Director of Nursing on conducted by the ector of Nursing and Facility ubmitted on 10/23/17 and 5	F	22:	3		

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		LE CONSTRUCTION	(X3) DATE COMP	
		345165	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					1264 AIRPORT ROAD		
AUTUWIN	CARE OF MARION				MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 223	Continued From page	e 10	F	223	3		
		lent was assessed for injury d had no negative outcome					
	resident #71 occurrer during state survey in conducted by the Adr Drexel. It was identifie immediately suspend while Director of Nurs the Nurse#1 on duty. On 11/16/17 the Nurs 10/23/17 occurrence investigation.	o incident of 10/23/17 for ince due to additional findings iterviews. This was ninistrator of Autumn Care of ed that NA#2 was not ed and returned to care sing was being notified by we#1 and NA#2 from were suspended pending					
		obtained for those staff in					
		plementing the Acceptable the specific deficiency cited.					
	All residents have the	potential to be affected.					
	the Administrator on t (MOD) process and ir beginning on 11/19/1 facility and provides for /administrative covera scheduled and at rand the center, to include addressing concerns	ment staff was educated by he new Manager-On-Duty mplemented on weekends 7. This process is new to or management age on weekends both dom based on the needs of management rounds and or allegation of abuse which diately by the Manager on					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		345165	B. WING				C 19/2017		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•			
AUTUMN	CARE OF MARION	MARION, NC 28752							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ECTIVE ACTION SHOULD BE COM ENCED TO THE APPROPRIATE			
F 223	Duty who will notify A Nursing. The Nurse a designated nurse in of Administrator or Direct the Director of Nursin immediately of any all concerns. To prevent this from r and Regional Clinical immediate in-house e related to F223 Abuse and implementation of (screening/training/pr investigation/protection burnout. This educat ensure staff was prop aware that abuse wou facility. 11/16/17 the Adm department heads on procedures Department heads on procedures Department heads on procedures Department heads staff on duty and the through 11/17/17 Education will co staff will not be permi is received. New hires will be and procedure upon h The Regional Vice Pr re-educated the Licer Administrator on abus and conducting a proj on 11/17/17	dministrator and Director of essigned to 300 Hall is the charge in the absence of the ctor of Nursing and will notify g and Administrator legations of abuse or ecurring the Administrator Consultant started education on 11/16/17 e and F226 development of policy and procedures evention/ identification/ on/ reporting response and ion was performed to perly trained on abuse and uld not be tolerated at the hinistrator re-educated abuse and policy and ds completed education for education will continue ntinue via telephone and tted to work until education e educated to abuse policy hire.	F	22:					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	by Nursing Home Adr abuse/reporting/ withe knowledge of abuse p On 11/17/17 the Busin completed an employ appropriate pre-emplo completed for NA#2 a new hires. Resident council minu forms for the last 3 m Administrator of NA # On 11/17/17 Facility r conducted by Departr residents that are inter There were new negative those residents that a completed by License negative findings. The monitoring proce Correction is correcte regulatory requirement To monitor and maintat The facility Administrative will start abuse questi 11/17/17 related to ab procedures (7 element	ministrator related to essing abuse and procedure. Iness office manager ee file audit to ensure byment screening was and all other staff, including utes and resident concern onths were reviewed by the 2. No negative findings. esident interviews were ment Managers for those erviewable related to abuse. ative findings. ecks were completed for ire not interviewable ed Nurses. There were new dure to assure the Plan of d and the specific deficiency ed and in compliance with nts. ain ongoing compliance: ative/Department Managers ionnaires with all staff on puse and policy and nts). The audits will be 3x weekly. Any negative ssed immediately	F	223			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345165	B. WING				C 19/2017
	ROVIDER OR SUPPLIER			126	REET ADDRESS, CITY, STATE, ZIP CODE 64 AIRPORT ROAD ARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 223 F 224 SS=D	On 11/17/17 resident conducted with 3 resid abuse. Any negative immediately by Admir Nursing. The facility will condur Assurance Performan on 11/17/17 with the f the Regional Team an review. The title of the person the acceptable plan o Administrator. Date of Alleged Comp PROHIBIT MISTREATMENT/NE CFR(s): 483.12(b)(1)- §483.12 The resident abuse, neglect, misap property, and exploita subpart. This includes freedom from corpora seclusion and any phy not required to treat th 483.12(b) The facility implement written pol (b)(1) Prohibit and pre	questionnaires will be dents 3x weekly related to findings will be addressed histrator of Director of ct an Ad HOC Quality nee Improvement meeting facility Interdisciplinary team, nd the Medical Director to n responsible for implanting of correction is the bliance is: 11/19/17 GLECT/MISAPPROPRIATN -(3) thas the right to be free from opropriation of resident ation as defined in this is but is not limited to al punishment, involuntary ysical or chemical restraint he resident's symptoms. must develop and icies and procedures that: event abuse, neglect, and nts and misappropriation of es and procedures to		223			12/22/17

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345165	B. WING		C 11/19/2017	
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MARION			264 AIRPORT ROAD		
			I	MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETI	
F 224	Continued From page	e 14	F 224			
	§483.95,	g as required at paragraph Γ is not met as evidenced				
	interviews, the facility incontinence care wh	ons, record reviews and staff / neglected to provide nen needed to 3 of 12 Residents #27, #28, and 79).		F224 Due to lack of clear and consice assignments for NA's Residents #2 and #28 were found to have not bee		
	sampled residents (Residents #27, #28, and 79). The findings included: 1. Resident #27 was originally admitted to the facility on 10/31/15 and recently readmitted on 10/15/17. His diagnoses included muscle weakness, atrial fibrillation, diastolic heart failure, adult failure to thrive and dementia.		provided incontinence care. Their of plans have been updated by MDS r to reflect incontinence care during N Aide rounds and AM/PM care, and a indicated.Assignment sheets have b implemented to include room #'s for staff member along with dining and shower assignments.	nurse Nurse as been		
	10/22/17 coded him of cognition, having no extensive assistance toileting and hygiene	with bed mobility, transfers, , and being frequently and bladder. The MDS		Incontinent residents have been ide by the Nursing Management staff of 12/1/17. MDS has updated residen care plans related to incontinence of during Nurse Aide rounds, AM/PM of and as indicated.	n ts' are as	
	The Care Area Asses dated 11/03/17 stated episodes of incontine complications. The c 05/05/16 included a g assisted with elimina through 01/02/18. In monitor and assist wi provide assistance w	ssment for incontinence d he was at risk for increased		The Director of Nursing (DON)/ Administrator/ designee provided education on 12/8/17 to the Nurse A regarding incontinence care during aide rounds and dignity related to incontinence care prior to meals.Ne assignment sheets have been implemented to include room numb dining and shower assignments for Certified nurse assistants. Any new or agency staff will be educated on prior to taking assignment.	nurse w daily ers, staff	

Facility ID: 922951

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ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE	CONSTRUCTION	(X3) D.	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				· · · ·	OMPLETED
							С
		345165	B. WING	÷			11/19/2017
AME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				12	264 AIRPORT ROAD		
UTUMN	CARE OF MARION			м	IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREI TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 224	Continued From page	ne 15	Í	224			
	· · · · · · · · · · · · · · · · ·	esident care needs, revealed		224	compliance the		
		e was to be provided as			compliance, the DON/Administrator/Designee will a	audit	
		ould offer toileting with care			incontinence care for interviewable		
	rounds.				non-interviewable residents.Audit		
					include 4 residents randomly prior	to meal	
		bserved on 11/13/17 at 11:24			service (to include rounds and mo	•	
		ne odor. On 11/14/17 at 8:10			patients in the dining room) 2x we	-	
		ed wheeling himself down the			4 weeks and then once a week x 2	2	
		ing room. He was wearing			months.		
	light blue thin pants which were observed to have a wet area around his crotch and darker dried						
		of the wet area. A urine odor			The results of the audits will be for to the facility monthly Quality Assu		
		e passed the surveyor in the			Performance Improvement commi		
		A #6 pushed him to the dining			months for further review and		
		ained in the dining room			recommendations.		
		Then at 9:35 AM, Resident			The title of the person responsible	for	
	#27 was observed in	n his room in his wheelchair			implementing the acceptable plan	of	
		ined light blue pants and the			correction is the Administrator.		
		seen on his outer right thigh					
		knee toward his bottom.					
		bserved again on 1/14/17 at					
		otch was very wet from his					
		n the inner thigh. A urine odor entered the room across the					
		e odor of urine was strong in					
		ime and the surveyor could					
		om the hall. At 9:48 AM the					
	wound physician an	d Nurse #8 entered the room					
	-	are to Resident #27's					
		e physician and Nurse #8 left					
		n at 9:56 AM and continued					
		nt #27 was still visibly wet from #27 remained with the same					
		ness observed under the right					
	-	d at 10:04 AM. The urine					
	-	from the hallway at 10:07 AM.					
			1				

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/21/201 MAPPROVEI D. 0938-039	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE COMF	SURVEY	
		345165	B. WING		C 11/19/2017		
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	•		
	CARE OF MARION		1264	4 AIRPORT ROAD			
AUTUMIN	CARE OF MARION		MA	RION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 224	they had not planned at this time. They pu bathroom and remove pants and socks were and his pants had dri NA #9 stated "this is li- wet clothing. On 11/14/17 at 10:46 conducted with NA # orientee NA #12, who Resident #27 resided had no specific assign room/resident assign and helped everyone assignment sheet wh showers to be given a room numbers were the assignments depr aides present. Some care for residents at of others start at the other	A. NA #9 and NA #11 stated on caring for Resident #27 shed Resident #27 into the ed his clothes. His blue e soaked through with urine ed urine stains on the legs. bad" when she removed his AM, interviews were 7, NA #8, NA #10, and an o were on the hall where I. They all stated that they	F 224				
	further stated there w the far end of the hall resided. NA #7, NA # stated they had not p care this morning. NA #6 stated at 11/14 not notice Resident # pushed him down the On 11/14/17 at 10:53 not given him care th assignment sheet on revealed NA #9 was	ere 2 other nurse aides at					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345165	B. WING _				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		_ _		TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 224	stated she was not as and just came in to he rooms as of 5 minutes She stated they usual rooms. She stated the enough coverage for the shift on time. Interview with NA #11 revealed she was from her 3rd day in this fac no specific assignmen from room to room to #11 stated she had re NA that Resident #27 further stated that she morning and it would an actual resident assistant. NA #4 was interviewe 5:45 AM. NA #4 states before (11/13/17 into had dressed Residen him back to bed the n stated Resident #27 f past 2 to 3 months an although he could trat and take himself to th however, he was less to do care himself. N he told the oncoming needs. During an interview of Assistant Director of 1 Nursing stated regard	er interview with NA #9 ssigned to work this date elp. She had no assigned s prior to this conversation. Ily do not have assigned ere should have been those who actually started on 11/14/17 at 11:09 AM m an agency and this was ility. She stated there was nt of rooms, they just went provide resident care. NA eceived report from 3rd shift took care of himself. She e had not given him care this make it easier if there was signment provided to the d via phone on 11/15/17 at ed he had worked the night 11/14/17). NA #4 stated he t #27 in khaki pants and put norning of 11/14/17. NA #4 had been declining over the id needed more assistance insfer himself out of the bed	F2	224			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	nursing staff. Other th timely manner, it was provide incontinent ca they were doing round 11/19/17 at 5:12 PM r aides to have and kno provide the necessary including checking an residents as needed. 2. Resident #28 was diagnoses including c Review of a care plan Resident #28 was add incontinence of bowe for complications rela Interventions included routine and as neede rounds during the nig Review of the Care A Urinary Incontinence Resident #28 had epi both bowel and bladd with activities of daily her risk factors she ha to incontinence. Review of a quarterly dated 09/15/17 revea severely impaired cog extensive assistance personal hygiene, and MDS indicated Reside incontinent of bowel a	han answering call lights in a his expectation for NAs to are immediately even when ds. Follow up interview on revealed he expected nurse by their assignments to y care and services id changing incontinent admitted on 06/09/17 with lementia. A dated 06/13/17 revealed mitted with a history I and bladder and was a risk ted to incontinent episodes. I to check and change per d; and check for wetness on ht and as needed. Trea Assessment (CAA) for dated 06/22/17 revealed sodes of incontinence of er and required assistance living. It was noted despite ad no complications related Minimum Data Set (MDS) led Resident #28 had gnition and required with transfer, dressing, d toilet use. The quarterly ent #28 was always and bladder and noted no am had been attempted.	F	224			

Facility ID: 922951

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/21/201 [°] RM APPROVEI IO. 0938-039 [°]
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		345165	B. WING		C 11/19/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	CARE OF MARION			1264 AIRPORT ROAD		
AUTUMIN	CARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 224	revealed at 4:20 PM s self-propelling in the l pants. The crotch are wet and a faint urine 5:05 PM Resident #2 and the crotch area o wet. Nurse #11 enter 5:24 PM and Residert headache. Resident and a faint urine odor PM Nurse #11 wheel dining room and aske Nurse #11 returned to and administered me Her pants remained w was noticeable when wheelchair. Nurse Ai up Resident #28's su exited the dining roor An interview with NA revealed she was one the 200 hall that ever there until 4:00 PM. worked together and resident or room assi other NAs had alread arrived but they typica everyone on the hall. checking on Residen continuous observatio PM when she was wh by Nurse #11. An interview with NA revealed she did not rounds that afternoor	dent #28 on 11/14/17 she was observed hall wearing a pair of pink ea of the pants were visibly odor was noted as well. At 8 was observed in her room of her pants remained visibly red Resident #28's room at nt #28 stated she had a #28's pants were visibly wet r was noted as well. At 5:25 ed Resident #28 to the ed her to rate her pain. o the dining room at 5:31 PM dication to Resident #28. <i>v</i> isibly wet and the urine odor standing next to her ide (NA) #16 served and set pper tray at 5:33 PM and	F 22	24		

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF PI	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 224	observation from 4:20 she was wheeled into #11. During an interview o #16 was asked which and changed before s had checked and char were in bed and the r call lights. NA #16 wa Resident #28 at any to observation from 4:20 she was wheeled into #11. An interview with Nur PM revealed she did pants were wet with u incontinence before ta An interview was con Administrator on 11/1 Administrator on 11/1 Administrator stated i resident to be taken to a meal wearing pants Administrator further NAs to check every re beginning of the shift. revealed the Administ given the NAs a room 3. Resident #79 was 06/18/13 with diagnos anxiety, depression, a above knee.	ime during a continuous PM until 5:25 PM when the dining room by Nurse n 11/14/17 at 5:44 PM NA residents were checked supper. NA #16 stated they inged the residents that esidents that turned on their as not observed checking on ime during a continuous PM until 5:25 PM when the dining room by Nurse se #11 on 11/14/17 at 5:50 not notice Resident #28's urine or check her for aking her to the dining room. ducted with the 4/17 at 5:54 PM. The t was not acceptable for a o the dining room or served wet with urine. The stated she expected the esident on rounds at the The interview further trator thought the nurse had assignment. admitted to the facility on ses including hypertension, and amputation of right leg	F	224	4		
	Review of care plan c	lated 05/18/17 revealed pendent on staff for toileting					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	assistance. Interventi toileting assistance of as needed and encou- for assistance at the f Review of the Minimu 09/13/17 revealed Re- intact and able to mal care. She required ex- more staff for transfer dressing, personal hy #79 was coded with in lower extremities. The Resident #79 was fre bladder and occasion Review of care area a Resident #79 required her activities of daily l above knee amputation for decline in her funct Review of daily staffir revealed Nurse Aide assigned to work on t and NA #4 was assig However, because th in sick, NA #3 was re- 100 Hall with NA #4. During an interview o Resident #79 stated s 11/14/17 at around 5: soaking wet in bed. It to answer her call ligh she was soaking wet NA #3 replied he had promised her to come	ons included providing r incontinence care routinely uraging Resident #79 to call first urge. Im Data Set (MDS) dated esident #79 was cognitively ke decisions about daily tensive assistance of two or r, toileting, bed mobility, rgiene and bathing. Resident mpairment on right upper & e MDS further indicated quently incontinent with hally incontinent with bowel. assessments revealed d assistance with most of living (ADL) due to right on (AKA). She was at risk etional ADL abilities.	F	224	4		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/21/2017 RM APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DAT	E SURVEY IPLETED	
		345165	B. WING			1.	C I/ 19/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MARION			126	64 AIRPORT ROAD		
AUTOWIN	CARE OF MARION			MA	ARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 224	room. Resident #79 s one hour without hav addressing her incon activated the call ligh NA #3 came back and needed. NA #3 then p and apologized indica Resident #79 stated s embarrassed, disrega had to wait in a soaki an hour. During an interview of Nurse #4 stated all N complete their assign manner. However, as to provide incontinent rounds as resident ca During a phone interv PM, NA #3 confirmed Hall that ended on the was not familiar with second week working time working on the 1 started the last morni AM and he was over there were only 2 NA provide care for arour not recall answering a care at around 5:00 A to come back when h #3 stated if he knew I wet that morning, he incontinent needs imp	said she waited for almost ing any nursing staff tinent needs. When she t again at around 6:00 AM, d asked her what she provided incontinent care ating they were short of staff. she was upset, felt arded and forgotten as she ng wet condition for almost on 11/15/17 at 12:05 PM, As were required to need rounds in a timely a nurse, she expected NAs t care as needed during the are had a higher priority. <i>view</i> on 11/15/17 at 12:43 I he worked third shift on 100 e morning of 11/14/17. He the residents as it was his g in the facility and his first 100 Hall. NA #3 said he ng rounds at around 5:00 whelmed with call lights as s working on the 100 Hall to nd 50 residents. He could any call light for incontinent AM or promising any resident ne was doing his rounds. NA Resident #79 was soaking would have addressed her mediately. on 11/16/17 at 8:28 AM, NA working with NA #3 on third	F	224			
	#3 stated if he knew l wet that morning, he incontinent needs im During an interview o #4 confirmed he was	Resident #79 was soaking would have addressed her mediately. n 11/16/17 at 8:28 AM, NA			16 and		

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	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	A. BUILDING		
		345165	B. WING		C 11/19/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLET THE APPROPRIATE DATE	
F 224		e 23 ot remember seeing NA #3 #79's call light at around	F 22	4		
	care. He stated if a re care during his round resident first, then co was NA #3's first nigh With only 2 NAs work shift, the work load w He agreed resident co over the rounds at all During an interview of Assistant Director of	n 11/17/17 at 4:14 PM, the Nursing (DON)/Acting DON				
F 226 SS=J	was always the first p Other than answering manner, it was his ex resident care immedia doing rounds. He also resident call lights on provide the assistance DEVELOP/IMPLMEN	IT ABUSE/NEGLECT, ETC	F 22	6	12/22/17	
	written policies and p					
		ent abuse, neglect, and nts and misappropriation of				
	(2) Establish policies investigate any such	-				
	(3) Include training as	required at paragraph				

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345165	B. WING			C / 19/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 226	 §483.95, 483.95, 483.95, (c) Abuse, neglect, and the freedom from aburequirements in § 483 provide training to the educates staff on- (c)(1) Activities that calculate staff on- (c)(1) Activities that calculate staff on- (c)(1) Activities that calculate staff on- (c)(2) Procedures for neglect, exploitation, and missip property as set forth a field to implemente a management on the educate staff on- (c)(3) Dementia management of the educate staff on this REQUIREMENT by: Based on record revisif acility failed to implement of the educate staff on the educate staff on	ad exploitation. In addition to ise, neglect, and exploitation 3.12, facilities must also eir staff that at a minimum onstitute abuse, neglect, appropriation of resident at § 483.12. reporting incidents of abuse, or the misappropriation of agement and resident abuse is not met as evidenced ew, and staff interviews, the ment their abuse policy and the prevention, protection 1 of 3 residents who were vestigations. Immediate 0/23/17 when a nurse aide the hallway and an object t Resident #71 as she was hair nearby and missed The nurse aide was working with residents hediate Jeopardy was when the facility provided redible Allegation of Removal. The facility	F 2	 F226 F226 During annual survey ending 11/19 the Self-Reported Incident initiated 10/23/17 was reviewed and it was determined that the abuse investiga was incomplete by not following the policy and procedures. Due to this, Immediate Jeopardy was cited for t event that occurred on 10/23/2017 11/19/2017. Reeducation was completed for cur staff on 11/17/2017 concerning faci abuse policy and procedures and th Manager on Duty process. Reeduc was performed by the Administraton Regional Vice President of Operatio 	on ation e facility , and he to rrent lity ne new cation r, the		

Facility ID: 922951

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/21/20 FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345165	B. WING		C 11/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE COMPLETIC D THE APPROPRIATE DATE
F 226		rdy) to complete employee e monitoring systems put into	F 2:	26 the Director of Nursing, a Director of Clinical Servic hired staff from 11-17-20 receive education on Abu procedure.	es.Any newly I7 forward will
	03/03/17, revealed A including such action of injury. The policy of used in this definition individual must have the individual must have the section of deployment of staff o numbers to meet the Under the section of allegations included i The policy also indica accused or suspecter immediately remove resident care area ar will remain under dire statement is complete there should be docu notes including the re of motion, body asse notification of the phy Resident #71 was ad 06/30/14. Her diagno	s such as the willful infliction continued stating "Willful, as of abuse, means the acted deliberately, not that ave intended to inflict injury." prevention was the n each shift in sufficient needs of the residents. how to investigate nterview of all witnesses. ated that if a staff member is d of abuse, the Facility will staff member from the nd the accused staff member ect supervision until e. The policy also noted that mentation in the nurses' esults of the resident's range ssment, vital signs, and visician and responsible party.		The Administrative Depar will complete abuse polic questionnaires on 3 staff week x4 weeks, then mon Any negative findings will immediately by Administr of Nursing. Administrator/designee w resident questionnaires w 3x weekly x4 weeks, ther months related care and negative findings will be a immediately by Administr of Nursing. The facility will have a Ma every Saturday and Sund 3pm. The 300 hall charg designated nurse in charg absence of the Administra Nursing, or the Manager Manager on Duty or the o in charge will report nega the Administrator immedia information gathered will the Administrator in the n meeting.	y and procedure member, 3x a hthly x2 months. be addressed ator or Director ill complete vith 3 residents in monthly x2 services. Any addressed ator or Director anager on Duty lay from 11am to e nurse is the ge in the ator, Director of on Duty. The lesignated nurse tive findings to ately. General be shared with
	dated 07/12/17 codec impaired cognition ar	al Minimum Data Set (MDS) d her with moderately nd requiring extensive activities of daily living skills.		Results of the questionna forwarded to the facility C Performance Improvemen 3 months for further revieurecommendations.	uality Assurance nt committee for

Event ID: 9KIX11

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/21/201 RM APPROVE IO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIFICATION NUMBER: A. BUILDING			STRUCTION		E SURVEY IPLETED
		345165	B. WING			C 11/19/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET	ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION			1264 AI	RPORT ROAD		
				MARIC	ON, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	Continued From page	e 26	F 2	226			
	 Review of a 24 hour initial report sent to the Health Care Personnel Investigations on 10/23/17 at 7:44 PM, revealed that a staff member reported that Nurse Aide (NA) #2 tossed a meal tray on 10/23/17 at 5:30 PM and that Resident #71 was wet with water. Review of the investigation revealed written statements were obtained by the nurse on duty (Nurse #1), the Nurse Aide (NA) #1 who witnessed the incident, and NA #2 who was alleged to throw the tray. The written statement from NA #1 dated 10/23/17 stated that approximately at 5:30 PM, NA #2 threw a computer mouse out of the nurse's station and across the hall barely missing a resident. NA #2 then went to the kitchen to obtain the tray cart and NA #1 told her to "chill." NA #2 then "grabbed a tray off the cart and flung it across the hall. Items went flying everywhere including a glass full of water that hit (Resident#71) in the face. When asked what her problem was, NA #2 grabbed her stuff and 			im	e title of the person responsible f olementing the acceptable plan o rrection is the Administrator.		
	who heard the incide An interview was con 11/15/17 at 8:23 AM. 10/23/17 she and NA Around supper time, speaker was made th ready. Then a nurse make sure staff heard NA #2 threw a mouse the tray cart. Upon re calm down and NA #2 cart with a cup hitting	1) reported it to the nurse nt." ducted with NA #1 on She recalled that on #2 worked a 12 hour shift. an announcement over the nat the trays for this hall were called the nursing station to d the announcement. Then e into the hall and left to get eturn NA #1 told NA #2 to 2 then threw a tray off the Resident #71. NA #2 left Id Nurse #1. After 10 to 15					

Facility ID: 922951

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345165	B. WING				C / 19/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 226	minutes, NA #2 came trays. A phone follow 11/16/17 at 4:17 PM r about an arms length threw the tray and NA Resident #71's left low never reacted and wa stated NA #2 continue minutes until NA #2 w statement. NA #1 sta telling Nurse #1 about the hall by NA #2, how leave the floor, NA #2 The written statement stated NA #2 "had go to the 'breaking point. trays when someone which set me over the or being aware of who took a tray from the ca hall. I did not know it Resident #23), becau After the tray, I got was done, and went i intentions of clocking room, I came to my se back and finish the sh A phone interview wa 11/16/17 at 9:54 AM. 2 aides on the 100 ha when a nurse called a announcement that the stated she threw the r to get the trays. Here several times she sho	back and finished passing up interview with NA #1 on evealed Resident #71 was away from NA #2 when she A #1 saw a cup of water hit wer jaw. Resident #71 is not injured. She again ed to pass trays for about 20 vas instructed to write a ited she was intending on it the mouse being thrown in wever, before she could e had thrown the tray. if from NA #2 dated 10/23/17 tten very frustrated at work, " I was about to pass out told me I 'needed to chill', e edge. So, without thinking p or what was around me, I art and flung it across the affected (Resident #71 and se they kept rolling by my things, told (Nurse #1) I in the break room with out. When I got to the break enses and decided to go iff." s conducted with NA #2 on She stated there were only ull. NA #2 got frustrated after the overhead he trays were ready. She mouse into the hall and went coworker (NA #1) told her	F	226	3			

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/2017 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345165	B. WING		_		C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
A 1 17 1 1 A A 1			1	264 AIRPORT ROAD			
AUTUMN	CARE OF MARION		N	MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 226	went to the break root to pay and did not was she finished her shift feeling a resident unti she was then placed days and allowed to re the Director of Nursing stated she was frustra months and not being the care that was nee with NA #2 on 11/16/1 probably knew Reside (Resident #23) were re how close they were. hit Resident #71. NA pass trays which she work on the hall for ap She was interviewed (DON) via phone that A written statement fre 10/23/17 stated at 5:3 noise from the main d came from the day roo started walking down purse and the nurse a happened. NA #2 stated done.' Nurse #1 wrot and Resident #71's st Resident #71 stated 'f stuff.' Resident #71's st Resident #71 stated 'f stuff.' Resident #71's st Resident #71 stated 'f stuff.' Resident #71 stated 'f statement continued 'f back in the facility and her shift stating 'f don abandonment.' I calle	She then left the hall and m but decided she had bills nt to abandon her duties so via passing out trays and I her shift ended. She stated on burn out leave for two eturn to work. She recalled g meeting with her. She ated due to short staffing for able to give the residents ded. A follow up interview I7 at 4:29 PM revealed she ent #71 and her roommate rolling by but did not realize She found out later an item #2 stated Nurse #2 let her did so and continued to oproximately 45 minutes. by the Director of Nursing day and in person later. om Nurse #1 dated 80 PM she heard a loud lining room. The sound om on the 100 hall. NA #2 the hall with her coat and asked NA #2 what tted 'you can have this I'm e she went down the hall nirt and pants were wet. that girl's mad and throwing tated a plate hit her knee sident #71's skin was o bruising or redness. The 'at 5:37 PM (NA #2) came d asked if she could finish 't want to be got for d (name of) DON and	F 226				
	her shift stating 'I don	't want to be got for d (name of) DON and					

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ID PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	· · ·	E SURVEY	
NAME OF PR			A. BUILDIN	G	CON	IPLETED	
NAME OF PR						С	
NAME OF PR		345165	B. WING		11	/19/2017	
	345165 ME OF PROVIDER OR SUPPLIER NTUMN CARE OF MARION X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
аитими с	ARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE	
F 226	Continued From page	29	F 22	26			
		•					
		•					
	-						
	shirt was "soaked". R	Resident #71 stated her knee					
	•						
		-					
I							
		d Nurse #1 informed NA #2					
		ss. Nurse #1 stated NA #2					
	asked to continue wo	rking and Nurse #1 agreed					
	as long as she did no	t throw anymore trays.					
	Nurse #1 called the A	dministrator and DON and					
		e statements, not write up an					
	-	complete the 24 hour form					
	and fax it to the Healt						
	-	d send NA #2 home. Nurse					
		2 finished her shift. Nurse sight she would have sent					
		y and would have done so if					
	-	aides to pass 30 trays and					
		o one was available to help.					
		one interview on 11/16/17 at					
	÷	ated she learned about NA					
		e when she took NA #1's					
	-	d if she knew NA #2 had					
		er, she would have sent her					
	home immediately aft	er she threw the tray She stated she thought the					

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 226	tray incident was an is stated NA #2 worked incident for approxima DON spoke to her on her to leave. Interview with the Adr 11:59 AM revealed sh not the other witnesse the facility unsubstant the investigation after discussed it and felt it Education was provid Administrator stated N permitted to work on the tray. Interview with the DO revealed she received Nurse #1 around 5:30 that NA #2 was frustrat the building. Nurse # NA #2 returned, within what she should do n #1 to put NA #2 in an statement and then es The DON stated she what happened and the interviewed NA #1. Review of the time clo NA #1 clocked out on Review of the nursing regarding Resident #7 from a tray thrown by assessment of the residocumentation of noti	solated incident. Nurse #1 on the floor after the tray ately 10 minutes before the the phone and instructed ministrator on 11/16/17 at he only interviewed NA #2 es. She further stated that tiated the abuse following corporate and they thad to do with burnout. ed to NA #2. The NA #2 should not have been the floor after throwing the N on 11/16/17 at 12:11 PM d a call on 10/23/17 from 0 to 6:00 PM. She learned ated, threw a tray and left 1 called the DON back after n 7 to 8 minutes, asking ext. DON instructed Nurse office and obtain a written scort her out of the building. did not talk to NA #1 about hought the Administrator Dock documentation revealed 10/23/17 at 6:48 PM.	F	220			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	there should have been documentation of the Resident #71 after the during telephone inter PM that when she cal 10/23/17 to obtain gui should write an incide incident somewhere a Administrator and the she did not need to du administration later in Administration just wa faxed to the Health ca Record review reveal completed on 10/24/1 which stated no curre specify anything abour relating to her knee of being struck). The DO obtaining an interview assessment. The Add interview on 11/16/17 should have document following the incident. Nurse #1 on 11/16/17 was told not to make additional documenta fill out an incident rep and the DON. Per the Summary of t the DON, NA #2 was immediately, was edu and how to handle wo allowing her to return	PM, the Administrator stated en a nursing note or nurse's assessment of e incident. Nurse #1 stated rview on 11/16/17 at 3:57 lled administration on idance, she asked if she ent note or document the and was told by both the Director of Nursing (DON) ocument anything unless structed her to. anted the 24 hour report are Personnel Investigations. ed a skin assessment was 7 at 12:56 AM by the DON nt skin issues but did not at the incident or specifics r face (which were noted as ON resigned prior to <i>v</i> relating to the skin ministrator stated during at 2:41 PM that the nurse nted her skin assessment . A telephone interview with <i>i</i> at 3:57 PM revealed she	F	226			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345165	B. WING				C 19/2017
NAME OF PF	ROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page	32	F	226			
	The Administrator and were informed of Imm 11/16/17 at 6:18 PM.	d Regional Clinical Nurse nediate Jeopardy on					
		an acceptable credible te jeopardy removal on as follows:					
	F226 Development/in procedures	nplementation of policy and					
	The Plan of Correctin	g the specific deficiency.					
	#71 was investigated Incident was submitter instruction of the Dire concern identified on #2 was not removed f when she became up including a computer meal tray. This resulter with an object and NA to work before calling This investigation did interviews of all witne documentation in the investigation was initia and Director of Nursin	mouse and a resident's ed in Resident #71 being hit #2 was allowed to continue the Director of Nursing. not include documented sses and lacked medical record. An ated by the Administrator ng on 10/23/17.					
	Reportable Incident s Day on 10/27/17.	ector of Nursing and Facility ubmitted on 10/23/17 and 5					
	The Marion Police we 10/23/17 and no char	ere notified of the incident on ges filed					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345165	B. WING				U /19/2017
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	by licensed nurse and On 11/16/17 the facili investigation related to Resident #71 occurrent findings, during state conducted by the Adr Drexel. It was identified immediately suspend while Director of Nurse the Nurse#1 on duty. On 11/16/17 statement in original investigation On 11/16/17 the Nurse 10/23/17 occurrence investigation. NA #2 and Nurse #1 or removed from payroll The Procedure for Imm Plan of correction for All residents have the On 11/13/17 manage the administrator on to (MOD) process and in beginning on 11/19/17 facility and provides for /administrative coverar scheduled and at ran- the center, to include	lent was assessed for injury d had no negative outcome ty started another o incident of 10/23/17 for ence due to additional survey interviews. This was ninistrator of Autumn Care of ed that NA#2 was not ed and returned to care sing was being notified by nts obtained for those staff on we #1 and NA #2 from were suspended pending was terminated and system on 11/17/17 plementing the Acceptable the specific deficiency cited. e potential to be affected. ment staff was educated by he new Manager-On-Duty mplemented on weekends 7. This process is new to or management age on weekends both dom based on the needs of management rounds and	F	220			
	will be handled imme	or allegation of abuse which diately by the Manager on dministrator and Director of					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 226	Nursing. The Nurse a designated nurse in c Administrator or Direct the Director of Nursin immediately of any all Nurse will remove the To prevent this from m and the Regional Clin started immediate in-1 11/16/17 related to At implementation of pol (screening/training/pri- investigation/protection burnout. This educat ensure staff was prop aware that abuse wou facility. - 11/16/17 the Admini- department heads on procedures - Department heads on procedures - Department heads of on duty and the educa 11/17/17 - New Hires will contin abuse policy and proo - Education will contin will not be permitted to received. - The Regional Vice F re-educated the Licer Administrator on abus and conducting a prop on 11/17/17 The monitoring proce Correction is correcter	ssigned to 300 Hall is the harge in the absence of the ctor of Nursing and will notify g and Administrator legations of abuse. Also the a alleged abuser. ecurring the Administrator nical Services Director house education on buse and development and icy and procedures evention/ identification/ on/ reporting response and ion was performed to erly trained on abuse and uld not be tolerated at the strator re-educated abuse and policy and completed education for staff ation will continue through nue to be educated on cedure upon hire. nue via telephone and staff o work until education is President of Operation hsed Nursing Home se, policy and procedures per/thorough investigation	F	226			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/21/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	1264 AIRPORT ROAD		
AUTUMN	CARE OF MARION			r	MARION, NC 28752		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI	IX	(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
					DEFICIENCY)		
F 226	Continued From non			~~~			
F 220	Continued From page	50		226			
	To monitor and maint	ain ongoing compliance:					
		ative/Department Managers					
		ionnaires with all staff on					
	11/17/17 related to at						
		nts). The audits will be					
		members 3x weekly. Any					
		be addressed immediately					
	by the Administrator of	or Director of Nursing.					
	The results of the auc	tits will be forwarded to the					
	facility Quality Assura	nce Performance					
	Improvement commit	tee for further review and					
	recommendations.						
	The facility will condu	ct an Ad HOC Quality					
	-	nce Improvement meeting					
		acility Interdisciplinary team,					
		nd the Medical Director to					
	review.						
	The title of the percor	n responsible for implanting					
	the acceptable plan o						
	Administrator.						
	Date of Alleged Comp	bliance is: 11/19/17					
	Immediate Jeopardv	was removed on 11/19/17					
		direct and supervisory staff					
		een inserviced and knew the					
		and procedures including					
		ad to be removed from					
		ately, witnesses had to be					
	interviewed, and docu						
		g notes including event					
	information, assessm						
		n. The staff knew signs of					
	burnout and what to c	to if they were feeling					

Facility ID: 922951

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY MPLETED
		345165	B. WING		1	C 1/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				1264 AIRPORT ROAD		
	CARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 226	Continued From page	e 36	F 22	6		
		ed other coworkers with				
F 241 SS=D	DIGNITY AND RESP CFR(s): 483.10(a)(1)	ECT OF INDIVIDUALITY	F 24	1		12/22/17
	resident in a manner promotes maintenand her quality of life reco individuality. The faci promote the rights of					
	interviews, the facility incontinence care to resulting in 2 resident eating while wet with	ns, record reviews and staff failed to provide 3 of 12 sampled residents ts (Resident #27 and #28) urine and 1 resident's st for incontinence care		F241 During the survey process the caring for residents #27, 79 not provide incontinent care Kardex due to confusion relation	and 28 did per the	
	forgotten by staff. The findings included			specific assignments. Reside plans have been updated by to reflect incontinence care of	MDS nurse	
	Resident #27 was ori on 10/31/15 and rece	ginally admitted to the facility ntly readmitted on 10/15/17. ed muscle weakness, atrial		Aide rounds and AM/PM car indicated and new assignme have been implemented.	e, and as	
	fibrillation, diastolic h	e Minimum Data Set dated		Incontinent residents have b by the Nursing Management 12/1/17. MDS has updated	staff on	
	10/22/17 coded him v cognition, having no l	vith severely impaired behaviors, requiring		care plans related to incontin during Nurse Aide rounds, A	nence care as	
	extensive assistance toileting and hygiene,	with bed mobility, transfers,		and as indicated.		
	incontinent of bowel a			The Director of Nursing (DO Administrator/ designee prov	/ided	
		sment for incontinence I he was at risk for increased		education on 12/8/17 to the regarding incontinence care aide rounds and dignity relat	during nurse	

Facility ID: 922951

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				E CONSTRUCTION		OMB NO. 09	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		(X3) DATE SURV COMPLETE	
			A. BOILDING			С	
		345165	B. WING			11/19/2	017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, (CITY, STATE, ZIP CODE		
A 				1264 AIRPORT ROA	AD		
AUTUWIN	CARE OF MARION			MARION, NC 287	752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) MPLETION DATE
F 241	Continued From page	27					
1 241			F 24		aana anian ta maala Naw de	-:!. <i>.</i>	
		n initiated 05/05/16 included 27 to be assisted with			care prior to meals.New da	any	
		needed through 01/02/18.		-	sheets have been I to include room numbers,		
		d to monitor and assist with			hower assignments. Any ne		
		des, provide assistance with			cy staff will be educated on		
	toileting, pericare and	l clothing management as			o taking assignment.		
	indicated and per res	ident request.					
					nd maintain ongoing		
		a care guide for nurse aides		compliance,			
		ident care needs, revealed			strator/Designee will audit		
		was to be provided as uld offer toileting with care			care 4 residents randomly service (to include rounds		
	rounds.	and other tolleting with care			ng patients in the dining		
					eekly for 4 weeks and then		
	Resident #27 was ob	served on 11/13/17 at 11:24		once a week	-		
		odor. On 11/14/17 at 8:10					
		d wheeling himself down the		The results o	of the audits will be forwarde	ed	
	hall towards the dinin	g room. He was wearing		to the facility	monthly Quality Assurance	•	
	light blue thin pants w	which were observed to have		Performance	e Improvement committee x	3	
	a wet area around his	s crotch and darker dried		months for fu	urther review and		
		the wet area. A urine odor		recommenda	ations.		
		passed the surveyor in the					
		#6 pushed him to the dining			ne person responsible for		
		ined in the dining room			g the acceptable plan of		
	-	hen at 9:35 AM, Resident		correction is	the Administrator.		
		his room in his wheelchair					
	-	ed light blue pants and the					
		een on his outer right thigh nee toward his bottom.					
	•	served again on 1/14/17 at					
		ts were very wet from his					
		the inner thigh. A urine odor					
		ntered the room across the					
	hall at 9:46 AM. The	odor of urine was strong in					
		ne and the surveyor could					
		m the hall. At 9:48 AM the					
	wound physician and	Nurse #8 entered the room					
	to provide wound car	e to Resident #27's					
	roommate. Both the	physician and Nurse #8 left					

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	-	D HUMAN SERVICES					FORM): 12/21/2017 APPROVED
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345165	B. WING			_		C 19/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				1:	264 AIRPORT ROAD			
AUTUMIN	CARE OF MARION			N	IARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	on rounds. Resident #2 wet blue pants, wetnet thigh when observed for odor was observed for Incontinence care was 10:39 AM after NAs # care to his roommate. they had not planned at this time. They pus bathroom and remove pants and socks were and his pants had drie When Resident #27's NA #9 stated "This is On 11/14/17 at 10:46 conducted with NA #7 orientee NA #12, who hall where Resident # that they had no spec room/resident assign and helped everyone. assignment sheet whi showers to be given a room numbers were r stated there were 2 of end of the hall where #7, NA #8, NA #10 an not provided Resident #2 pushed him down the On 11/14/17 at 10:53	at 9:56 AM and continued #27 was still visibly wet from P7 remained with the same ess observed under the right at 10:04 AM. The urine om the hallway at 10:07 AM. s observed on 11/14/17 at 9 and #11 had provided . NA #9 and NA #11 stated on caring for Resident #27 shed Resident #27 into the ed his clothes. His blue e soaked through with urine ed urine stains on the legs. wet clothing was removed, bad." AM, a group interview was 7, NA #8, NA #10, and an were on the far end of the 27 resided. They all stated ific assignment regarding ments they just pitched in . NA #7 produced the ich listed the staff and the and who was to pass ice but not assigned. She further ther nurse aides at the far Resident #27 resided. NA id NA #12 all stated they had t #27 any care this morning. /17 at 10:51 Am that she did 27 was wet when she hall toward the dining room. AM, NA #9 stated she had	F	241				
	not notice Resident #2 pushed him down the On 11/14/17 at 10:53	27 was wet when she hall toward the dining room.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	NA #9 stated she was date and just came in (after 8 AM). Review 11/14/17 at 10:57 AM assigned to Resident had been added next Interview with NA #11 revealed she was from her 3rd day in this fac no specific assignmen from room to room to #11 stated she had re NA that Resident #27 further stated that she morning. Administrator stated of at 5:54 PM it was not eat with wet pants and check everyone on ro shift. She also though assignments. Interview on 11/19/17 Assistant Director of N revealed he expected know their assignmen care and services inci changing incontinent 2. Resident #28 was diagnoses including of Review of a care plan Resident #28 was add incontinence of bower for complications rela	a not assigned to work this to help later in the shift of the assignment sheet on revealed NA #9 was now #27, as room assignments to staff names. on 11/14/17 at 11:09 AM m an agency and this was sility. She stated there was not of rooms, they just went provide resident care. NA eceived report from 3rd shift took care of himself. She had not given him care this during interview on 11/14/17 acceptable for a resident to d would expect staff to bunds at the beginning of the at the nurse had given room f at 5:12 PM with the Nursing (DON)/Acting DON I nurse aides to have and hts to provide the necessary luding checking and residents as needed. admitted on 06/09/17 with lementia.	F	241			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		COMF	PLETED
							С
		345165	B. WING			11/	19/2017
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD		
	1				MARION, NC 28752		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	3F	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 241	Continued From page		F	241	1		
		d; and check for wetness on					
	rounds during the nig	nt and as needed.					
	Review of the Care A	rea Assessment (CAA) for					
		dated 06/22/17 revealed					
	Resident #28 had epi	sodes of incontinence of					
		ler and required assistance					
		living. It was noted despite					
	her risk factors she ha	ad no complications related					
	to incontinence.						
	Review of a quarterly	Minimum Data Set (MDS)					
		led Resident #28 had					
	severely impaired coo						
		with transfer, dressing,					
		d toilet use. The quarterly					
	MDS indicated Resid	and bladder and noted no					
		am had been attempted.					
	Rejection of care was	•					
	Observations of Resid						
	revealed at 4:20 PM						
		hall wearing a pair of pink ea of the pants were visibly					
	-	odor was noted as well. At					
		8 was observed in her room					
	and the crotch area o	f her pants remained visibly					
		ed Resident #28's room at					
		nt #28 stated she had a					
		#28's pants were visibly wet was noted as well. At 5:25					
		ed Resident #28 to the					
		ed her to rate her pain.					
	-	the dining room at 5:31 PM					
	and administered me	dication to Resident #28.					
		visibly wet and the urine odor					
	was noticeable when						
	wheelchair. Nurse Al	de (NA) #16 served and set					

Facility ID: 922951

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	-	D HUMAN SERVICES				FORM): 12/21/2017 APPROVED
STATEMENT C	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345165	B. WING		_	(11/	C 19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		10/2011
A				1264 AIRPORT ROAD			
AUTUMIN	CARE OF MARION			MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page up Resident #28's sup exited the dining room An interview with NA a revealed she was one the 200 hall that even there until 4:00 PM. N worked together and o resident or room assig other NAs had already arrived but they typica everyone on the hall. checking on Resident continuous observatio PM when she was wh by Nurse #11. An interview with NA a revealed she did not a rounds that afternoon showers. NA #18 was Resident #28 at any to observation from 4:20 she was wheeled into #11. During an interview of #16 was asked which and changed before s had checked and cha were in bed and the ro call lights. NA #16 was Resident #28 at any to observation from 4:20	41 oper tray at 5:33 PM and	F 24				
		se #11 on 11/14/17 at 5:50 not notice Resident #28's					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					INTED: 12/21/2017 FORM APPROVED IB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345165	B. WING				C 11/19/2017	
NAME OF PI	ROVIDER OR SUPPLIER		I	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE	
F 241	Continued From page	- 12		241				
1 2 7 1	pants were wet with u			241				
		aking her to the dining room.						
	An interview was con	ducted with the 4/17 at 5:54 PM. The						
		t was not acceptable for a						
	resident to be taken t	o the dining room or served						
	a meal wearing pants	s wet with urine. The stated she expected the						
		esident on rounds at the						
		. The interview further						
	given the NAs a room	trator thought the nurse had n assignment.						
	06/18/13 with diagnor anxiety, depression, a right leg above knee. Data Set (MDS) date Resident #79 was co make decisions about extensive assistance transfer, toileting, bed hygiene and bathing, with impairment on ri- extremities. The MDS #79 was frequently in occasionally incontine Review of care area a Resident #79 require	gnitively intact and able to t daily care. She required of two or more staff for d mobility, dressing, personal Resident #79 was coded ght upper & lower S further indicated Resident icontinent with bladder and ent with bowel. assessments revealed d assistance with most of						
	her activities of daily	living (ADL) due to right on (AKA). She was at risk						
	Resident #79 was de assistance. Interventi	dated 05/18/17 revealed pendent on staff for toileting ons included providing r incontinence care routinely						

Facility ID: 922951

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DEPARTMENT OF HEALTH ANI CENTERS FOR MEDICARE & N					FORM	: 12/21/2017 APPROVED . 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
	345165	B. WING		_	(11/*) 19/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
AUTUMN CARE OF MARION			1264 AIRPORT ROAD			
AUTOMIN CARE OF MARION			MARION, NC 28752			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
for assistance at the fine of the second sec	raging Resident #79 to call rst urge. g sheet dated 11/13/17 NA) #3 was initially nird shift on the 200 Hall hed to work on the 100 Hall. e NA on the 100 Hall called assigned to work on the n 11/15/17 at 10:51 AM, he activated the call light on 00 AM because she was took NA #3 about 5 minutes t. When she told NA #3 that and needed to be changed, to finish the round and back in a few minutes. NA ight before leaving the aid she waited for almost ng any nursing staff inent needs. When she again at around 6:00 AM, d asked her what she provided incontinent care ting they were short of staff. he was upset, felt rded and forgotten as she ng wet condition for almost of units in a timely a nurse, she expected NAs care as needed during the	F 24		DEFICIENCY		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 241	During a phone interv PM, NA #3 confirmed Hall that ended on the was not familiar with the second week working time working on the 1 the last morning round was overwhelmed with only 2 NAs working of care for around 50 res answering any call lig around 5:00 AM or pr come back when he w stated if he knew Res wet that morning, he w incontinent needs imr During an interview of #4 confirmed he was third shift on 100 Hall of 11/14/17. He could #3 respond to Reside 5:00 to 6:00 AM as he care. He stated if a re care during his round resident first, then con NA #3's first night wor only 2 NAs working of the work load was ow agreed resident care the round at all times. During an interview of Assistant Director of the stated regardless of s was always the first p Other than answering manner, it was his ext	iew on 11/15/17 at 12:43 he worked third shift on 100 e morning of 11/14/17. He the residents as it was his in the facility and his first 00 Hall. He said he started d at around 5:00 AM and he h call lights as there were n the 100 Hall to provide sidents. He could not recall ht for incontinent care at omising any resident to vas doing his round. NA #3 ident #79 was in soaking would address her nediately. n 11/16/17 at 8:28 AM, NA working with NA #3 during that ended on the morning not remember seeing NA nt #79's call light at around e was busy with resident sident asked for incontinent , he would take care the ntinue with the round. It was rking on the 100 hall. With n the 100 Hall for third shift, erwhelming for NA #3. He should be prioritized over	F	24			

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/20 [.] / APPROVE). 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345165	B. WING) 19/2017
NAME OF PI	ROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MARION				64 AIRPORT ROAD ARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 241		expected NAs to leave the until they could actually	F	241			
F 242 SS=D	SELF-DETERMINAT CHOICES CFR(s): 483.10(f)(1)-	ION - RIGHT TO MAKE (3)	F	242			12/22/17
	schedules (including health care and provi consistent with his or	s a right to choose activities, sleeping and waking times), ders of health care services her interests, assessments, other applicable provisions					
		s a right to make choices or her life in the facility that resident.					
	members of the comic community activities facility.	s a right to interact with munity and participate in both inside and outside the					
	by: Based on record rev interviews, the facility with their preferred no	is not met as evidenced iews and resident and staff failed to provide residents umber of showers a week for ved for choices (Resident			F242 During Survey it was identified that Residents #46, #66, and #174 were no receiving their perfered number of showers per week.The shower	t	
	The findings included				assignments did not reflect resident choice and were not performed accordingly due to insufficient staffing.		
	diagnoses including h ramus fracture.	admitted on 09/23/16 with neart failure and left pubis			Director of Nursing completed an audit all Admission Questionnaires related to resident preference for showers and		
		nt change Minimum Data Set 7 revealed Resident #66's			showers were scheduled based upon resident choice on 12/13/17.		

Event ID: 9KIX11

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12 FORM AP OMB NO. 09	PROVE
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
		345165	B. WING		C 11/19/2	017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 1264 AIRPORT ROAD MARION, NC 28752)E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE CC	(X5) MPLETION DATE
F 242	physical assistance w change MDS indicate important to Resident shower, bed bath, or Review of the Care A Summary for Activitie 02/09/17 revealed Re independent to limited and tended to require bedtime. The CAA S was still weak and ha on her left lower extre was walking with a ro Review of a care plan Resident #66 had a s advanced age, decre diagnoses. Intervent assistance as needed ensure her needs we schedule and as need needed. Review of a quarterly dated 10/18/17 reveat was intact and she w known. The quarterly required one person and no rejection of care Review of the 100 ha Resident #66 was sci on Tuesday and Frida	and she required one person with bathing. The significant ed it was somewhat t #66 to choose between a sponge bath. rea Assessment (CAA) es of Daily Living dated esident #66 varied from d assistance with most care e more assistance at ummary noted Resident #66 ed some limited movement emity from her fracture but elling walker. In dated 02/09/17 revealed self-care deficit related to ased mobility and other ions included to provide daily d to complete all care and re met; and showers per ded with assistance as	F 24	2 The DON/ADON in-serviced (CNA and Licensed Nursing) 12/8/2017 regarding docume giving showers and identifyin shower on Nurse Aide assign sheet. Any newly hired staff fr 12-08-2017 forward will recei on the above. To monitor and maintain ongo compliance, the Director of Nursing/Designee will audit F documentation and Nurse Aid assignment sheets 6 random x week x one month and ther two months to validate compl showers. The results of the audits will B to the facility monthly Quality Performance Improvement comonths for further review and recommendations. The title of the person respon- implementing the acceptable correction is the Administrato	on ntation of g schedule of iment om ve education bing Point of Care de residents 2 h 1 x week x etion of be forwarded Assurance ommittee x 3 d sible for plan of	

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 242	and this was a proble further explained she but only one the week An interview with Nur- 11/15/17 at 9:00 AM r the "long" section of ti other NA on the 100 r her second day worki stated showers were they don't have time of A follow up interview of Resident #66 on 11/1 #66 stated she had no a week consistently d Resident #66 indicate month and there were hall. An interview was com- Director of Nursing (A 11/17/17 at 5:03 PM. expectation was for th preferred number of s indicated Resident #6 and if she said she was stated he felt showers consistently due to sta 2. Resident #174 was diagnoses including v congestive heart failu diabetes mellitus, and Review of an "Admiss Questionnaire" dated	m for her. Resident #66 had two showers last week a before. se Aide (NA) #12 on revealed he was assigned to he 100 hall that day and the hall was agency and it was ing at the facility. NA #12 not getting done because due to the staffing. was conducted with 5/17 at 10:39 AM. Resident of been getting two showers ue to staffing problems. ed a lot of staff quit last e not enough NAs for the ducted with the Assistant DON)/Acting DON on The ADON stated his he residents' to receive their showers a week. The ADON 66 was alert and oriented as not getting showers twice not. The ADON further s were not being given affing issues. s admitted on 11/01/17 with rentricular tachycardia, re, respiratory failure,	F	24:	2		

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345165	B. WING				C 19/2017		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>			
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 242	have a preference wh Review of the admiss (MDS) dated 11/08/17 cognition was intact a needs known. The ad required extensive as bathing. No rejection admission MDS indica- important to Resident shower, bed bath, or Review of the Care A Summary for Activitie 11/14/17 revealed Re following a hospitaliza- including ventricular t failure, respiratory fail muscle weakness. The required assistance we eating and was at risk functional ADL or the functional ADL or the functional ADL or the functional ADL abilitie Review of the 300 ha Resident #174 was se on Tuesday and Frida An interview with Res (Tuesday) at 9:54 AW would get two showed admitted and expected #174 stated he had o and had not had a sh Review of a care plan rehabilitation potentia	ion Minimum Data Set 7 revealed Resident #174's nd he was able to make his dmission MDS noted he sistance with transfers and of care was noted. The ated it was somewhat #174 to choose between a sponge bath. rea Assessment (CAA) s of Daily Living (ADL) dated sident #174 was admitted ation with diagnoses achycardia, congestive heart ure, diabetes mellitus, and he CAA Summary noted he vith all of his ADL except for a for a decline in his inability to improve his s. Il shower schedule revealed cheduled to receive showers by during the second shift. ident #174 on 11/14/17 revealed he was told he s a week when he was d to get them. Resident nly one shower last week ower so far this week.	F	242	2				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345165	B. WING				C / 19/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 242	the assistance of one During an interview o Nurse Aide (NA) #19 the 300 hall from 6:45 11/14/17 because the cover the hall. NA #1 list for the hall and sh #174 was scheduled until 9:30 PM and he indicated she typically NAs on the next shift do all her showers. N the night shift staff or residents that did not NA #19 stated staffing she was not always a completed due to staff An interview with NA revealed she worked because there were r hall. NA #18 stated it hall after they put ever residents, including R showered. NA #18 fu stayed late and finish but she did not leave and was too tired. The the facility had been s months and NA #18 v herself a few days thi An interview with the (ADON) on 11/15/17 a told by the Director of	d bathing and hygiene with person. n 11/15/17 at 12:01 PM confirmed she worked on 5 AM until 11:00 PM on ere were no agency NAs to 9 stated there was a shower e did not notice Resident for a shower on 11/14/17 was asleep. NA #19 y notified the nurse and the when she was not able to VA #19 thought NA#18 told left a note about the get showers on 11/14/17. g was not getting better and ble to get all her showers ffing. #18 on 11/15/17 at 4:00 PM 17 hours on 11/14/17 to agency NAs to cover the got really busy on the 300 eryone to bed and two male tesident #174, did not get urther stated she usually ed her showers if needed until 11:30 PM on 11/14/17 he interview further revealed short staffed for the last 3 vas assigned the 300 hall by s month. Assistant Director of Nursing at 4:01 PM revealed he was f Nursing (DON) that two	F	242				
		hall did not gets showers the (14/17). The ADON noted						

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	
		345165	B. WING				0 /19/2017
	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	they did not have age NA #18 and NA #19 v yesterday (7:00 AM to explained he texted N were very busy and d Resident #174 his sho An interview with the PM revealed she was #174's family membe shower the previous of DON stated she expen- nurses if they could n The DON explained to assignments or a sho came two months ago that. A follow up interview on 11/17/17 at 5:00 P the NAs were not able shower on 11/14/17 of expect residents to ge showers per week. 3. Resident #46 was 03/11/17 with current artery disease, respira non-Alzheimer's dem Review of the care pla Resident #46 had an deficit related to limited deficits secondary to traumatic brain injury, obstructive pulmonar	ncy staff to cover the hall so vorked a double shift o 11:00 PM). The ADON IA #18 and she told him they id not have time to give ower on 11/14/17. DON on 11/15/17 at 4:06 at the desk when Resident r reported he did not get a evening (Tuesday). The oted the NAs to tell the ot complete all the showers. the facility did not have wer schedule when she o and she had worked on with the ADON/Acting DON M revealed he was aware e to give Resident #174 his lue to staffing and would et their preferred number of admitted to the facility on diagnoses of coronary atory failure and entia. an dated 08/16/17 revealed activity of daily living (ADL) ed mobility and cognitive dementia, history of bladder cancer, chronic y disease, osteoarthritis, d debility. The goal was for cipate in care as able	F	242	2		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 242	with showers per sche Review of the annual dated 10/03/17 revea severely cognitively in understand and make MDS further revealed extensive assistance important for him to cl shower. Review of the facility is through 11/2017 reve received 1 shower pe 09/04/17 to 09/10/17, 10/23/17 to 10/29/17, 11/06/17 to 11/12/17. An interview conducted with Nurse Aide (NA) worked at the facility is never worked anywhe He stated 7 or 8 NAs with the shower team to get his showers do stayed after his shift w was too busy with rou he didn't get to them. given Resident #46 a him and one other NA how they could get sh further stated he repo didn't get the showers just as under staffed a done either.	tensive to total assistance edule and as needed. Minimum Data Set (MDS) led Resident #46 was npaired but could this needs understood. The Resident #46 required with bathing and it was very hoose between a bath or shower sheets from 09/2017 aled Resident #46 only r week for the weeks of 10/02/17 to 10/08/17, 10/30/17 to 11/05/17, and ed on 11/15/17 at 9:00 AM #12 revealed he has for two months and has ere that staffing was this low. quit at the same time along . He stated he did his best	F	242			
		ed on 11/15/17 at 9:05 AM she was an Agency NA and					

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	
		345165	B. WING			/19/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)				
F 242 F 253 SS=E	this was her 3rd day we stated she had not do 3 days at the facility a staff about showers the short staffed to give the short staffed to give the short staffed to give the per week should be here week should be here week should be given. Here showers weren't given low staffing. HOUSEKEEPING & I CFR(s): 483.10(i)(2) (i)(2) Housekeeping a necessary to maintain comfortable interior; This REQUIREMENT by: Based on observation facility failed to unclog drainage on 1 of 3 ha affected on 100 hall (failed to repair broker splintered wood on 2 was affected on 100 halls.	working at the facility. She one any showers during her and when she asked other ney told her they were too nem. ed on 11/17/18 at 5:03 PM ector of Nursing	F 24		14, ilets /116,	12/22/17

I

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				D: 12/21/20 MAPPROVE 0. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	Сом	E SURVEY PLETED	
		345165	B. WING _		C 11/19/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE		
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 253	Continued From page	e 53	F 2	253			
F 203	to repair or replace bastained caulking on 3 bathrooms were affect 113/114, #115/116, # bathrooms were affect #202/203, #204/205), were affected on 300 314/315). The facility pan, wash basin and floor near commode of bathrooms were affect #113/114, # 123/124) affected on 300 hall (facility failed to repair tiles on 1 of 3 halls. 2 affected on 200 hall (The facility failed to re dirty stains on 1 of 3 I affected on 200 hall (The facility failed to re (AC) unit and bathroot away from the wall in was affected on 200 l bathrooms was affect #202/203). The facilit found on the floor near hall. 1 of the 5 bathr hall (Bathroom #204/2 bathrooms were affect #304/305, #316/317). failed to control odors	athroom with broken or of 3 halls. 3 of 13 cted on 100 hall (Bathroom # 121/122), 2 of the 5 cted on 200 hall (Bathroom and 2 of the 9 bathrooms hall (Bathroom #304/305, # failed to label and cover bed fracture pan found on the on 2 of 3 halls. 2 of 13 cted on 100 hall (Bathroom and 1 of 9 bathrooms was Bathroom # 304/305). The bathroom floor with broken of 5 bathrooms were Bathroom #201, #204/205). lean bathroom floor with nalls. 2 of 5 bathrooms were Bathroom #201, # 202/203). epair heater/air conditional om sink that were pulling 1 of 3 halls. 1 of 13 rooms hall (Room #203) and 1 of 5 cted on 200 hall (Bathroom y failed to cover plungers ar the commode on 2 of 3 ooms was affected on 200		 Covers with residents' name on bedpan, fracture pan are in Rooms 113/114 and 123 Broken tiles in bathroom of and 204/205 were replaced. The air conditioning unit are 202/203 were repaired. Plungers in Rooms 304/300 were covered. The elevated toilet seat in 304/305 was cleaned by he staff. Resident #27's room was cleaned by he staff. Resident #27's room was cleaned matters was replaced. The Maintenance Director, Manager and Administrato completed rounds of facility bathrooms to identify any cleaned House. The Administrator in-service Maintenance Director and Supervisor on the cleaning rooms and bathrooms and maintenance of toilets/sink on 12/11/2017. The Admir Housekeeping Manager had deep cleaning schedule of and bathrooms. 	nd wash basin 3/124. f Room 201 d. nd sink in Room 95 and 316/317 bathroom ousekeeping deep cleaned d. , Housekeeping r have y rooms and other resident tified concerns. II be addressed ekeeping. ced the Housekeeping g of resident the ss and A/C units histrator and ave initiated a		
	÷	: rvations were related to log resident sink with poor		Department Heads/Design cleanliness of rooms, bath appropriate storage of bed basins, condition of doors, base of toilet and sinks and secured to the wall by man	rooms and I pans and wash caulking at d AC units		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/ FORM APP OMB NO. 093	ROVE	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		345165	B. WING		C 11/19/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COM	(X5) PLETION DATE	
F 253	PM revealed the sink drainage. Subsequent 11/15/17 at 10:32 AM the sink remained clo 2. The following obset facility's failure to rep and bathroom doors of at the lower edges: a. Observation of Roo PM revealed the lower and the bathroom doo splintered wood. Sub on 11/15/17 at 10:32 the doors remained in b. Observation of Roo PM revealed the lower door was broken with Subsequent observat 10:47 AM and at 4:03 remained in disrepair 3. The following obset facility's failure to rep holes: a. Observation of Bat at 3:31 PM revealed at in diameter in the wal Subsequent observat 10:35 AM and at 3:39 remained in disrepair b. Observation of Bat	om #112 on 11/14/17 at 3:28 was clogged up with poor at observations made on and at 3:36 PM revealed agged. ervations were related to air broken resident room with sharp splintered wood or #112 on 11/14/17 at 3:28 er edges of the room door or were broken with sharp sequent observations made AM and at 3:36 PM revealed an disrepair. om #202 on 11/14/17 at 3:49 er edges of the bathroom a sharp splintered wood. tions made on 11/15/17 at 3 PM revealed the door creations were related to air and repaint the walls with throom #113/114 on 11/14/17 a hole approximately 1 inch II behind the commode. tions made on 11/15/17 at 3 PM revealed the hole	F 25	 rounds 2 x weekly x 1 month a weekly x 2 months. Any ident concerns will be forwarded to Administrator for follow up. The results of the audits will b to the facility monthly Quality / Performance Improvement co months for further review and recommendations. The title of the person responsimplementing the acceptable p correction is the Administrator 	ified e forwarded Assurance mmittee x 3 sible for plan of		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345165	B. WING				/19/2017	
NAME OF P	ROVIDER OR SUPPLIER	L		:	STREET ADDRESS, CITY, STATE, ZIP CODE	_ .		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 253	in diameter in the wal Subsequent observat 10:37 AM and at 3:42 remained in disrepair c. Observation of Batt 11/14/17 at 3:49 PM r sink approximately 5 unevenly patched and the sink approximatel up with different color made on 11/15/17 at revealed the wall rem 4. The following obse facility's failure to repair with broken, cracked, caulking around the b along the bathtub: a. Observation of Batt at 3:31 PM revealed to of the commode was observations made on at 3:39 PM revealed to of the commode remain b. Observation of Batt at 3:35 PM revealed to of the commode was observations made on at 3:42 PM revealed to of the commode remain c. Observation of Batt 11/14/17 at 3:37 PM r the base of the commode remain Subsequent observation	I behind the commode. ions made on 11/15/17 at PM revealed the hole PM revealed the hole PM revealed the wall below the inches in diameter was d the wall at both sides of y 6 x 6 inches were touched Subsequent observations 10:47 and at 4:03 PM rained in disrepair. PM revealed to air or replace bathrooms discolored or stained base of the commode or throom #113/114 on 11/14/17 the caulking around the base stained. Subsequent n 11/15/17 at 10:35 AM and the caulking around the base stained. hroom #115/116 on 11/14/17 the caulking around the base ained stained. hroom #115/116 on 11/14/17 the caulking around the base ained stained. hroom #115/116 on 11/14/17 the caulking around the base ained stained. hroom #1121/122 on revealed the caulking around	F	253	3			

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345165	B. WING				0 /19/2017
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 253	around the base of th stained. d. Observation of Batt 11/14/17 at 3:49 PM r the base of the comm caulking along the ba Subsequent observat 10:47 AM and at 4:03 around the base of th bathtub remained unce e. Observation of Batt 11/14/17 at 4:04 PM r the base of the comm Subsequent observat 10:55 AM and at 4:10 around the base of th discolored. f. Observation of Batt at 4:09 PM revealed to of the commode was Subsequent observat 11:00 AM and at 4:14 around the base of th unchanged. g. Observation of Batt 11/14/17 at 4:12 PM r the base of the comm Subsequent observat	e commode remained hroom #202/203 on evealed the caulking around iode was stained and the thtub was broken. ions made on 11/15/17 at PM revealed the caulking e commode and along the changed. hroom #204/205 on revealed the caulking around iode was discolored. ions made on 11/15/17 at PM revealed the caulking e commode remained froom #304/305 on 11/14/17 he caulking around the base cracked and discolored. ions made on 11/15/17 at PM revealed the caulking e commode remained hroom #314/315 on revealed the caulking around	F	25			
	around the base of th stained. 5. The following obse facility's failure to labe						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345165	B. WING			11	C / 19/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 253	at 3:31 PM revealed a bucket with lid on the Subsequent observat 10:35 AM and at 3:11 remained unchanged b. Observation of Bat 11/14/17 at 3:39 PM r uncovered bed pan o commode. Subseque 11/15/17 at 10:42 AM the bed pan remained c. Observation of Bat 11/14/17 at 4:09 PM r uncovered wash basi an unlabeled and unc observed on the floor commode. Subseque 11/15/17 at 11:00 AM the wash basin and fr unchanged. 6. The following obse facility's failure to repai broken tiles: a. Observation of Bat 3:44 PM revealed the	hroom #113/114 on 11/14/17 an unlabeled and uncovered floor near the commode. ions made on 11/15/17 at PM revealed the bucket hroom #123/124 on revealed an unlabeled and n the floor near the nt observations made on and at 3:15 PM revealed d unchanged. hroom #304/305 on revealed an unlabeled and n under the sink. In addition, covered fracture pan at the back of the nt observations made on and at 3:26 PM revealed racture pan remained rvations were related to air bathroom floor with	F	253			
	were broken. Subseq 11/15/17 at 10:45 AM the tiles remained und b. Observation of Bat	-					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345165	B. WING				C / 19/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD	<u> </u>		
AUTUMN	CARE OF MARION				MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 253	 base of the commode observations made or at 4:10 PM revealed to unchanged. 7. The following obse facility's failure to clear stains: a. Observation of Bat 3:44 PM revealed the dirty with visible stain made on 11/15/17 at revealed the floor rem b. Observation of Bat 11/14/17 at 3:49 PM r with visible stains aro corners. Subsequent 11/15/17 at 10:47 AM the floor remained dir 8. The following obse facility's failure to rep bathroom sink that we wall: a. Observation of Roo PM revealed the heat approximately 1 inch Subsequent observat 10:52 AM and at 4:07 of the heater/AC unit b. Observation of Bat 11/14/17 at 3:58 PM r approximately 1 inch Subsequent observat 	e were cracked. Subsequent in 11/15/17 at 10:55 AM and the tiles remained rvations were related to an bathroom floor with dirty hroom #201 on 11/14/17 at floor at the corners was s. Subsequent observations 10:45 AM and at 3:17 PM nained dirty. hroom #202/203 on revealed the floor was dirty und the bathtub and at the observations made on and at 3:20 PM revealed ty. rvations were related to air the heater/AC unit and ere pulling away from the om #203 on 11/14/17 at 3:58 ter/AC unit was pulling away from the wall. ions made on 11/15/17 at ' PM revealed the condition remained unchanged. hroom #202/203 on	F	25:	3			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345165	B. WING				_ 19/2017	
NAME OF PF	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 253	facility's failure to cov floor near the commo a. Observation of Bat 11/14/17 at 4:04 PM r uncovered on the floo Subsequent observat 10:55 AM and at 3:21 remained uncovered. b. Observation of Bat 11/14/17 at 4:09 PM r uncovered on the floo Subsequent observat 11:00 AM and at 3:26 remained uncovered. c. Observation of Bat 11/14/17 at 4:15 PM r uncovered on the floo Subsequent observat 11:07 AM and at 3:30 remained uncovered. During an interview o Housekeeper #1 state rooms included trash dusting, floor sweepir bathroom cleaning. S housekeeping training job orientation. On av 16 resident rooms da deep cleaning for 2 roo	unchanged. rvations were related to er the plungers found on the de: hroom #204/205 on revealed the plunger was or near the commode. ions made on 11/15/17 at PM revealed the plunger hroom #304/305 on revealed the plunger was or near the commode. ions made on 11/15/17 at PM revealed the plunger hroom #316/317 on revealed the plunger was or near the commode. ions made on 11/15/17 at PM revealed the plunger hroom #316/317 on revealed the plunger was or near the commode. ions made on 11/15/17 at PM revealed the plunger hroom #316/317 on revealed the plunger was or near the commode. ions made on 11/15/17 at PM revealed the plunger hroom and the plunger was or near the commode. ions made on 11/15/17 at PM revealed the plunger hroom and the plun	F	253				
	She would report to the	ne maintenance department ny maintenance related						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/2017 APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345165	B. WING		_		_ 19/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			1	264 AIRPORT ROAD			
AUTUMN	CARE OF MARION		N	MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From page	9 60	F 253				
	-	ag and put it in the corner of nied her workload was					
	11/15/17 at 2:41 PM, (HM) stated she had leadership, in which 4 part-time employees. assigned 4 housekeep and 3 staff to do laund housekeeper and 1 la She audited each hou times monthly and fol performance enhance had not been able to months. As she had to task frequently, she d supervise her staff to of the facility. After the	among the 14 staff were For the first shift, she pers for cleaning resident or cleaning common areas, dry. She scheduled 1 aundry staff on second shift. Usekeeper's works at least 2 low up with feedbacks for ement. The HM stated she be fully staffed in the past 6 o perform housekeeper's id not have sufficient time to ensure optimum cleanliness to to the areas of the those issues needed to					
	11/15/17 at 4:13 PM t (MM) confirmed there bedrooms in the skille acknowledged that th were in disrepair and as possible. Accordin only maintenance sta to 8 months. The facil assistant about 1 mor heavy and overwhelm rounds at least 4 to 5 maintenance tasks th	times daily to look for at needed to be addressed boms, hallways, and other					

Facility ID: 922951

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	maintenance concern orders. However, the of the above areas of communicate mainter him. The work orders each nurse station an times daily. The MM a was prioritized with sa first, equipment issue cosmetic issues addre During an interview of #5 stated she would of on her rounds to ensu- odorless, and free of pan, urinal and fractur plastic bag and labeled During an interview of Assistant Director of N stated it was his exper- in a clean environmer Other than staffing iss attributed the incident communication amon department, and main During an interview of Administrator stated if staff to maintain the fa cleanliness as possib the identified houseker issues should be addre timely manner.	s via verbal reports or work MM stated he was unaware concern as the staff did not hance related issues with folders were located at d he checked at least 2 to 3 added maintenance work afety concerns addressed s addressed second and essed third. In 11/17/17 at 9:00 AM, NA check resident's bathroom ure the toilet was clean, clutter. Devices such as bed re pan were covered in the ed with resident's name. In 11/17/17 at 4:03 PM, the Nursing (DON)/Acting DON cotation for residents to live at and in proper repair. sues, the Acting DON c as a result of lack of g the staff, housekeeping	F	253			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345165	B. WING				C 19/2017
NAME OF PRO	VIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
AUTUMN C	ARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
	at 12:25 PM revealed bdor in this room befor around the toilet and in up the odor. The bedroom of Residurine when observed on 11/16/17 at 8:04 A Housekeeper #2 state 11/16/17 at 8:13 AM t form this room. She st freshener when she n facility started a deep rooms on 10/25/17. The which rooms had bee date and she noted R been deep cleaned si began. She further st be sprayed regularly a checked his closet. S checked his closet for The urine odor was me observed on 11/17/17 The Assistant Directo of Nursing stated on f expected staff to notif continuously smelled 11. Observations of sl 304/305 on 11/14/17 elevated toilet seat ha	bom smelled of urine. housekeeper #1 on 11/15/17 she has noticed a urine re. She stated she mopped used air freshener to clear dent #27 smelled of stale on 11/15/17 at 4:51 PM and M. ed during interview on hat she had noticed an odor stated that she sprays an air oted it. She stated the cleaning schedule for There was no record of in deep cleaned prior to this esident #27's room had not ince the documentation ated that this room had to as he often stored soiled he stated she routinely soiled briefs. bticeable from the hall when at 8:24 AM. r of Nursing/Acting Director 11/19/17 at 5:12 PM that he y him of rooms that	F	25:			

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-					FORM	M APPROVED 0. 0938-0391
DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
	345165	B. WING				C 19/2017
OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
bbservation on 11/15/ elevated toilet seat re- observed the previous An interview with Hou 8:14 AM revealed she for almost two years a assigned to the 300 h #2 stated residents' ro- cleaned daily and the disinfected including to of the seat. On 11/15/17 at 2:49 P observed leaving the An observation of the shared bathroom for r at 2:29 PM revealed t areas of dried brown r circumference of the to opening. On 11/15/17 at 2:53 P confirmed she was do Housekeeper #2 was cleaned and disinfected in the bathrooms. Ho moved the elevated to toilet and sprayed it w down all of the surfac- of the seat. Housekee she cleaned and disin seat in the shared bat that day.	17 at 8:14 AM revealed the mained unclean as a day. sekeeper #2 on 11/15/17 at a had worked at the facility and confirmed she was all that day. Housekeeper borns and bathrooms were toilets were cleaned and he seat and the underside PM Housekeeper #2 was 300 hall with her cart. elevated toilet seat in the rooms 304/305 on 11/15/17 he elevated toilet seat had matter covering the entire underside of the seat PM Housekeeper #2 was 300 hall with her cart. elevated toilet seat in the rooms 304/305 on 11/15/17 he elevated toilet seat had matter covering the entire underside of the seat PM Housekeeper #2 one for the day. asked when and how she ed the elevated toilet seats usekeeper #2 stated she oilet seat away from over the with a disinfectant and wiped es including the underside eper #2 could not recall if ifected the elevated toilet toilet toilet throom for rooms 304/305	F	25	53		
	FOR MEDICARE & I DEFICIENCIES CORRECTION DVIDER OR SUPPLIER ARE OF MARION SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From page observation on 11/15/ elevated toilet seat re observed the previous An interview with Hou 8:14 AM revealed she for almost two years a assigned to the 300 h #2 stated residents' ro cleaned daily and the disinfected including to of the seat. On 11/15/17 at 2:49 F observed leaving the An observation of the shared bathroom for r at 2:29 PM revealed to areas of dried brown for circumference of the to opening. On 11/15/17 at 2:53 F confirmed she was do Housekeeper #2 was cleaned and disinfect in the bathrooms. Ho moved the elevated to toilet and sprayed it w down all of the surfac of the seat. Houseke she cleaned and disin seat in the shared bat that day.	CORRECTION IDENTIFICATION NUMBER: 345165 2010ER OR SUPPLIER ARE OF MARION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 63 observation on 11/15/17 at 8:14 AM revealed the elevated toilet seat remained unclean as observed the previous day. An interview with Housekeeper #2 on 11/15/17 at 8:14 AM revealed she had worked at the facility for almost two years and confirmed she was assigned to the 300 hall that day. Housekeeper #2 stated residents' rooms and bathrooms were cleaned daily and the toilets were cleaned and disinfected including the seat and the underside of the seat. On 11/15/17 at 2:49 PM Housekeeper #2 was observed leaving the 300 hall with her cart. An observation of the elevated toilet seat in the shared bathroom for rooms 304/305 on 11/15/17 at 2:29 PM revealed the elevated toilet seat had areas of dried brown matter covering the entire circumference of the underside of the seat opening. On 11/15/17 at 2:53 PM Housekeeper #2 confirmed she was done for the day. Housekeeper #2 was asked when and how she cleaned and disinfected the elevated toilet seats in the bathrooms. Housekeeper #2 stated she moved the elevated toilet seat away from over the toilet and sprayed it with a disinfectant and wiped down all of the surfaces including the underside of the seat. Housekeeper #2 could not recall if she cleaned and disinfected the elevated toilet seat in the shared bathroom for rooms 304/305	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Asting colspan="2">(X2) MUL IDENTIFICATION NUMBER: Asting colspan="2">(X2) MUL IDENTIFICATION NUMBER: Asting colspan="2">ID ID REF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 63 F Continued From page 63 Deserved the previous day. An interview with Housekeeper #2 on 11/15/17 at 8:14 AM revealed she had worked at the facility for almost two years and confirmed she was assigned to the 300 hall that day. Housekeeper #2 stated residents' rooms and bathrooms were cleaned daily and the toilets were cleaned and disinfected including the seat and the underside of the seat. On 11/15/17 at 2:49 PM Housekeeper #2 was observed leaving the 300 hall with her cart. An observation of the elevated toilet seat in the shared bathroom for rooms 304/305 on 11/15/17 at 2:29 PM revealed the elevated toilet seat had areas of dried brown matter covering the entire circumference of the underside of the seat opening. On 11/15/17 at 2:53 PM Housekeeper #2 confirmed she was done for the day. Housekeeper #2 was asked when and how she cleaned and disinfected the elevated toilet seats in the bathrooms. Housekeeper #2 could not recall if	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Addition of the super-state of the state of the stat	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES (M) PROVIDERSUPPLERQUA A BULDING JA45165 SWING SWING SWING SWING SWING SUMMARY STATEMENT OF DEFICIENCIES (RECH DEFICIENCY WIST BE PRECEDED BY FULL RECOLLATORY OR LSC IDENTFYNAN INFORMATION) Continued From page 63 Description Description Continued From page 63 Description Description State of biology overs and confirmed she was assigned to the 300 hall that day. Housekeeper #2 and disinfected including the exeat had areas of the seat. On 11/15/17 at 2:49 PM Housekeeper #2 was observed leaving the 300 hall with her cart. An observation of the elevated toilet seat in the shared bathrooms were cleaned daily and the toilets were cleaned and disinfected including the estat and the underside of the seat. On 11/15/17 at 2:39 PM Housekeeper #2 was observed leaving the 300 hall with her cart. An observation of the elevated toilet seat in the shared bathroom for rooms 304/305 on 11/15/17 at 2:39 PM revealed the idevated toilet seat and areas of dried brown matter covering the entire circumference of the underside of the seat opening. On 11/15/17 at 2:39 PM Housekeeper #2 cauded she moved the elevated toilet seat away from over the collet and sprayed It with a disinfectant and wiped down all of the seat. Housekeeper #2 cauded she mo	ENT OF HEALTH AND HUMAN SERVICES FOR METCARE & MEDICAID SERVICES OMB NC CONSTRUCTION INFORMATION NUMBER: A BUILDING CONSTRUCTION A BUILDING A BUILDING CONSTRUCTION A BUILDING A B

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		345165	B. WING			/19/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 253 F 272 SS=E	Housekeepers were e and toilet with disinfect bathroom after they h room. The Housekeet the entire toilet includ base were to be scrut revealed the entire se be cleaned as well. On 11/15/17 at 3:14 F Supervisor was accor bathroom for rooms 3 condition of the elevar Housekeeping Super acceptable and would COMPREHENSIVE A CFR(s): 483.20(b)(1) (b) Comprehensive A (1) Resident Assess must make a comprel resident's needs, stre preferences, using the instrument (RAI) spec assessment must incl (i) Identification and (ii) Customary routin (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behav (viii) Psychological we (viii) Physical fun- problems. (ix) Continence.	expected to spray the sink ctant and return to clean the ave cleaned the residents' eping Supervisor explained ing the lid, seat, bowl and bbed. The interview further eat top and underside should PM the Housekeeping mpanied to the shared 804/305 and observed the te toilet seat. The visor stated it was not d be cleaned immediately. ASSESSMENTS ssessments ment Instrument. A facility hensive assessment of a engths, goals, life history and e resident assessment cified by CMS. The lude at least the following: d demographic information ne. is.	F 25			12/22/17

Facility ID: 922951

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/21/2017 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345165	B. WING		11/19/2017
NAME OF PI	ROVIDER OR SUPPLIER	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	CARE OF MARION			264 AIRPORT ROAD IARION, NC 28752	
	CLIMMA DV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 272	Continued From page	e 65	F 272		
	(xi) Dental and nutrit				
	(xii) Skin Conditions.				
	(xiii) Activity purs (xiv) Medications				
	(xiv) Medications (xv) Special treatmer				
	(xvi) Discharge p	-			
		tion of summary information			
	regarding the addition on the	nal assessment performed			
		triggered by the completion			
	of the Minimum Data	Set (MDS).			
		tion of participation in			
	assessment. The as include direct	sessment process must			
		n and communication with			
	the resident, as well a licensed and	as communication with			
	non-license	ed direct care staff members			
	on all shifts.				
	The assessment proc	cess must include direct			
		munication with the resident,			
		ation with licensed and are staff members on all			
	shifts.				
	This REQUIREMENT	is not met as evidenced			
	-	iews and staff interviews the		F272	
	facility failed to comp	lete Care Area Assessments		During the survey process it was iden	
	that addressed the un			Care Area Assessments were incomp	lete
		or Cognitive Loss/Dementia, vities of Daily Living, and		in addressing underlying causes and contributing factors related to Cognition	n
	Urinary Incontinence			Communication, Activities of Daily Liv	
	residents (Resident #	27, #28, #38, #46, #60, #64,		and Urinary Incontinence for Residen	t#
	#71, and #123).			28,#38 #46,#64 and #71 and resident	:
	The findings included	l:		#123.	
	Resident #28 was ad	mitted on 06/09/17 with		Resident #123 no longer resides in th facility. The Cognition Care Area	e

Event ID: 9KIX11

Facility ID: 922951

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			0.00			NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			ATE SURVEY
			A. BUILDIN	3	_	0
		345165	B. WING			С
		545165				11/19/2017
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		DDE	
	CARE OF MARION			1264 AIRPORT ROAD		
				MARION, NC 28752		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 272	Continued From page	e 66	F 2	72		
	diagnoses including			Assessment for Residents #	28 #38 #46	
				#64, and #71 has been com		
	Review of the admiss	sion Minimum Data Set		Social Service Manager to i	•	
		7 revealed Resident #28 had		the residents' cognition affe		
		gnition, could make herself		ability to make decisions, in		
	understood, and usu	ally understands. The		staff, and communicate nee	ds and how it	
	admission MDS note	d Resident #28 required		affects their ability to care for	or themselves.	
		with all her activities of daily		MDS nurses also updated the		
		ently incontinent of bowel and		Assessment for Resident #2		
	bladder.			urinary incontinence and ho		
				skin integrity. The Commun		
		Area Assessment (CAA)		Area Assessment for Reside		
		ve Loss/Dementia revealed		been updated by Social Ser		
		diagnosis of dementia and ications associated with the		audiology recommendation aids and pending follow up	-	
		ementia including: continued		January 2018 for hearing ai		
		nent, increased dependence		Care Area Assessment for F		
	on others to meet he			has been completed by MD		
	continued decrease i	•		include how her ADL decline		
		od and behavior issues. The		daily routine or ability to car		
		analysis of findings did not		MDS nurse and Social Serv		
	-	nt #28's cognitive impairment		proceed to care plan based	upon	
		ay function and care or		triggered Care Area Assess		
	include her strengths	and weaknesses.		Care Area Assessment upd	ates for	
				specific areas for identified		
		nducted with the Social		completed by MDS nurse, A		
		7/17 at 2:10 PM. The SW		Director and Social Services	s Manager by	
		doing MDS assessments		12/8/2017.		
		for several years. The SW				
		ng the assessment she		MDS staff will review MDS a		
		ent if they were able, talked		completed in the past 30 da		
		he notes for the look back		completion of triggered Care		
	-	me observations of the		Assessments and will comp		
		Ily included why the resident		plans for triggered Care Are		
	-	ue, what had been going on,		Assessments. MDS staff an		
		ognition problem when writing		Interdisciplinary Team will b		
	-	gs. The SW further stated as told she was putting too		by Regional Reimbursemen completion of Care Area As		
	much information in t	the CAA Summary and		and proceeding to care plan	based upon	

Facility ID: 922951

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TATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING	·	C
		345165	B. WING		11/19/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT
F 272	Continued From page	e 67	F 27	2	
	analysis of findings. completed Section C	The SW confirmed she had (Cognitive Patterns) and the ognitive Loss/Dementia for		triggered Care Area Ass 11/28/2017.	essments on
	Resident #28's admis could have added mo information.	ssion MDS and indicated she ore resident specific		The Administrator will au Area Assessments for co residents' assessments month and then once a	ompletion of two 2 x weekly x 1
	facility on 10/31/15 at 10/15/17. His diagno weakness, atrial fibril adult failure to thrive	lation, diastolic heart failure,		The results of the audits by MDS to the facility me Assurance Performance committee x 3 months for and recommendations.	onthly Quality Improvement
	cognition, having more loss without hearing a requiring extensive as transfers, toileting an	with severely impaired derately impaired hearing aids, having no behaviors, ssistance with bed mobility, d hygiene, and being t of bowel and bladder.		The title of the person re implementing the accept correction is the Adminis	table plan of
	completed 11/03/17 r description of his stre	rea Assessments (CAA) revealed there was no engths, weakness, or how pacted his day to day routine ows:			
	long term placement functioning varied. H dementia and consid- multiple comorbid dia for further cognitive d dependence on other The CAA summary d resident's cognition a	a stated Resident #27 was a and his baseline mental le had a diagnoses of ering his age, dementia and agnoses, he remained at risk leclines and increasing rs to meet his daily needs. id not indicate how the ffected his ability to make memory affected his ability			

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 12/21/2017 FORM APPROVED 1B NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		DNSTRUCTION		B) DATE SURVEY COMPLETED	
		345165	B. WING			C 11/19/2017		
NAME OF P	ROVIDER OR SUPPLIER	I		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
	CARE OF MARION		1264 AIRPORT ROAD		4 AIRPORT ROAD			
AUTUWIN	CARE OF MARION			MA	RION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	#27 had a diagnoses obstruction with a rec cholelithiasis (gall sto episodes of incontine with transfers, toiletin incontinent care. He alert nurse of any sig complications related summary did not indi- incontinence episode affected him, his skin care for his needs. c. The CAA for comm Resident #27 was ha utilize hearing aids. H ear and understood it right ear. The speake or tone or repeat com heard what was said. or desired at this time Assessment summar resident had been se hearing aids had bee decision had been mar resident fitted for hear Interview with the ME 11:24 AM revealed st communication and u She gathered her info from observing the re- resident, reviewing the talking to staff. She a picture of the reside problem and why the problem. During a fol Nurse #1 on 11/18/17 she was unaware of	of dementia and urinary sent hospitalization of ones). He has experienced nce and required assistance g, dressing, hygiene and verbalized understanding to ns or symptoms of to incontinence. The CAA cate how the frequent s (coded on the MDS) integrity, or his abilities to hunication stated that rd of hearing and did not He heard best out of his right f you spoke directly into his er may need to adjust voice munication to be sure he A consult was not indicated e. The Care Area y did not indicate the en by an audiologist, that n recommended, or if a ake about having the ring aids. DS Nurse #1 on 11/17/17 at he completed the urinary incontinence CAA. cormation for MDS and CAAs	F2	272				

If continuation sheet Page 69 of 170

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345165	B. WING				C 1 9/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 272	appointments and rec aids, she would have the CAA. Interview on 11/17/17 Worker who complete revealed that she typi CAA why the resident as due to age and dis complications of the c explain why she woul stated she did not add describing the individ summary. 3. Resident #123 was recently on 08/05/17. atherosclerotic heart disorder, Parkinson's The significant chang 03/31/17 coded her w cognition with no moo She was coded as re- with most activities of The Care Area Asses not include a descript the problem impacted follows: a. The cognition CAA Resident #123 had ad admission she had so cognitive skills using f status assessment to stating 'given the prog her dementia disease	commendations for hearing added that information in added that information in a at 2:10 PM with the Social ed the cognition CAA cally would include in the thad a cognition issue such bease, the risks and cognition problems and d care plan the issue. She d the specific details ual resident in the CAA a admitted to the facility most Her diagnoses included disease, major depressive Disease, and dementia. e Minimum Data Set dated with severely impaired od or behavior symptoms. quiring extensive assistance	F	272	2		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/21/20 FORM APPROV OMB NO. 0938-03		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345165	B. WING		C 11/19/2017		
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CO			
AUTUMN	CARE OF MARION			AIRPORT ROAD			
				RION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLETION HE APPROPRIATE DATE		
F 272	basic needs.' The C/ how the resident's co make decisions or ho ability to do things for b. The ADL CAA date to Resident #123's hi was at risk for a decli abilities resulting in re and a care plan would summary did not des assistance required, to inactivity, any strent impacted her abilities Interview with the ME 11:24 AM revealed sh communication and u She gathered her infor from observing the re- resident, reviewing the talking to staff. She a picture of the reside problem and why the problem. She stated	erm placement with ce on others to meet her AA summary did not indicate ognition affected her ability to ow her memory affected her r herself. ed 04/14/17 stated that due story and diagnoses, she ne in her functional ADL equiring more assistance d be developed. The CAA cribe the amount of possible complications due ngths or weakness that to care for any of her ADL. OS Nurse #1 on 11/17/17 at ne completed the urinary incontinence CAA. formation for MDS and CAAs esident, talking to the ne medical record, and stated she then tried to paint ent in the CAA describing the facility would care plan the	F 272				
	Worker who complete revealed that she typ CAA why the residen as due to age and dis complications of the of explain why she woul stated she did not ad	ically would include in the t had a cognition issue such sease, the risks and cognition problems and ld care plan the issue. She					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345165	B. WING				C 19/2017
NAME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				AIRPORT ROAD ION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 272	Continued From page	971	F 2	272			
	06/30/14. Her diagno following a cerebral in and hemiplegia and h Resident #71's annua dated 07/12/17 codec impaired cognition an assistance with most The Care Area Asses cognition dated 07/23 scored an 11 out of 11 Mental Status (BIMS) confusion, forgetfulne age related cognitive diagnoses of dementi scored varied. She w changes. There was cognition affected her day to day, why she e changes, or how her abilities to do things for Interview on 11/17/17 Worker who complete revealed that she typi CAA why the resident as due to age and dis complications of the c explain why she woul stated she did not ado describing the individu	afarction, muscle weakness lemiparesis. Al Minimum Data Set (MDS) d her with moderately d requiring extensive activities of daily living skills. sment (CAA) related to 6/17 stated Resident #71 5 on the Brief Interview for . The CAA noted she had ress and she showed signs of loss although she had no a. It was noted her BIMS vas at risk for cognitive no description as to how her abilities to make decisions experienced the cognitive memory affected her or herself. at 2:10 PM with the Social d the cognition CAA cally would include in the thad a cognition issue such rease, the risks and cognition problems and d care plan the issue. She d the specific details ual resident in the CAA					
	12/08/08. Her diagnos	admitted to the facility on ses included heart failure, ase, anxiety disorder and					

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	-	D HUMAN SERVICES					FORM): 12/21/2017 APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345165	B. WING			_		C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				12	264 AIRPORT ROAD			
AUTUMN	CARE OF MARION			М	IARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	major depressive disc		F	272				
	07/26/17 coded her w cognitive skills, and h	ith severely impaired aving no moods or ng extensive assistance with						
	cognition dated 08/08 progressive, declining dementia disease and risk for further cognitiv of behaviors issues, in other to meet basic da isolation. There was	no description as to how her abilities to make decisions memory affected her						
	Worker who complete revealed that she typi CAA why the resident as due to age and dis complications of the c explain why she would stated she did not add	cally would include in the had a cognition issue such ease, the risks and cognition problems and d care plan the issue. She						
	03/11/14 with current end stage renal disea dementia. Review of the annual 10/03/17 revealed Re	admitted to the facility on diagnoses of heart failure, se and non-Alzheimer's Minimum Data Set dated sident #46 was severely <i>v</i> ith no mood or behavior						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 272	cognition dated 10/16 was a long term resid admission his family r from a young age of r related to traumatic b vehicle accident in his history of traumatic b dementia put him at r including continued lo dependence on other physical declines, and summary did not indic cognition affected his interact with staff, cor his memory affected h himself. Interview on 11/17/17 Worker who complete revealed that she typi CAA why the resident as due to age and dis complications of the of explain why she woul stated she did not add describing the individu summary. 7. Resident #64 was a 09/07/17 with diagnos and non-Alzheimer's of Review of the admiss dated 09/19/17 revea severely cognitively in	rea Assessment (CAA) for /17 revealed Resident #46 ent of the facility and upon reported he had a history nemory/cognitive loss rain injury from a motor is early 20's. Resident #46's rain injury and vascular isk for complications ong term care, increasing is to meet his daily needs, d social isolation. The CAA cate how the resident's ability to make decisions, nmunicate needs, or how his ability to do things for at 2:10 PM with the Social ed the cognition CAA cally would include in the thad a cognition issue such tease, the risks and cognition problems and d care plan the issue. She d the specific details ual resident in the CAA admitted to the facility on ses of Alzheimer's disease dementia. ion Minimum Data Set	F	272			

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From page	2 74	F	272	2		
	cognition dated 09/18 would remain at risk f decline related to the and Alzheimer's diagr include continued Ion increasing dependent needs, and social isod did not indicate how t affected her ability to with staff, communicat memory affected her herself. Interview on 11/17/17 Worker who complete revealed that she typi CAA why the resident as due to age and dis complications of the of explain why she woul stated she did not add describing the individ summary. 8. Resident #60 was a 05/30/16 with diagnos and chronic obstruction Review of the annual 06/07/17 revealed Ref intact and required or assistance with activity	ce on others to meet daily lation. The CAA summary he resident's cognition make decisions, interact the needs, or how her ability to do things for a t 2:10 PM with the Social ed the cognition CAA cally would include in the thad a cognition issue such sease, the risks and cognition problems and d care plan the issue. She d the specific details ual resident in the CAA admitted to the facility on ses of anemia, weakness ve pulmonary disease. Minimum Data Set dated esident #60 was cognitively nly supervision to limited ties of daily living (ADL).					
	dated 06/21/17 revea for decline in her fund	rea Assessment (CAA) led Resident #60 was at risk tional ADL abilities due to y and medication use. The					

Facility ID: 922951

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345165	B. WING _				C 19/2017
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 272 F 278 SS=D	CAA summary did no function affected her do things for herself. An interview conducted MDS Nurse #1 reveal CAA for Resident #60 her information from o and Nurse Aide docut interviews. She stated of the resident in the of the problem and why She stated she did no the resident in the suf ASSESSMENT ACCURACY/COORD CFR(s): 483.20(g)-(j) (g) Accuracy of Assess must accurately reflect (h) Coordination A registered nurse mu each assessment with participation of health (i) Certification (1) A registered nurse the assessment is con (2) Each individual wh assessment must sig that portion of the asse (j) Penalty for Falsification	t indicate how her ADL daily routine or her ability to ed on 11/17/17 at 11:24 with led she completed the ADL 0. She stated she gathered observations, record review mentation and staff d she tried to paint a picture CAA summary by describing it would be care planned. of add specific details about mmary. MNATION/CERTIFIED assments. The assessment of the resident's status. UNATION/CERTIFIED assments. The assessment of the appropriate professionals. e must sign and certify that mpleted. no completes a portion of the n and certify the accuracy of assment. ation nd Medicaid, an individual		272			12/22/17

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		ND HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 12/21/201 RM APPROVE NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DA	TE SURVEY MPLETED
		345165	B. WING		1	C 1/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1264 AIRPORT ROAD		
AUTUMN	CARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	Continued From page 76 (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		F 27	8		
	and false statement i	ndividual to certify a material n a resident assessment is ey penalty or not more than ssment.				
	material and false sta	nent does not constitute a atement. 「 is not met as evidenced				
	facility failed to accur on the Minimum Data	iew and staff interview, the ately code the history of falls a Set (MDS) for 1 of 8 or falls (Resident #69).		F 278 It was identified that MDS for F #69 inaccurately coded history prior to admission. A correction Admission assessment for Re	/ of falls on to the	
	The findings included			was completed, transmitted ar on 11/21/2017 by MDS. This	•	
	10/03/17 with diagno			longer resides in the facility.		
	weakness, atrial fibril cardiomyopathy.	lation and ischemic		The MDS staff will review codi of falls prior to Admission for A assessments completed in the	dmission	
	Set) dated 10/10/17 o cognition, requiring e mobility, transfers, to	ssion MDS (Minimum Data coded him with intact xtensive assistance with bed ileting and having had no and no history of falls prior		days to identify MDS for accur Correction to prior assessmen completed for any inaccurate of identified related to history of f Admission assessment. The R Reimbursement Specialist has the MDS staff on accuracy of o	acy. A t(s) will be coding falls on Regional s educated	
	The Care Area Assessment (CAA) dated 10/16/17 stated that per his pre-admission social history completed by the resident and his wife, Resident #69 had a fall 30 days prior to admission and a fall 2 to 6 months prior to			To monitor ongoing compliance staff will audit MDS assessme accurate coding of history of fa	e, the MDS nts for	

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE	
			A. BUILDII	NG			C
		345165	B. WING			11/	19/2017
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
					DEFICIENCY)		
F 278	Continued From page	577	F	278			
1 2/0	admission.	, , , ,		270	Admission assessments x 3 months.		
	Intonvious with the MD	S Nurse #1 on 11/18/17 at			The results of the audits will be forward	lad	
		preadmission history was			to the facility monthly Quality Assurance		
	obtained prior to adm	ission in order to have any			Performance Improvement committee		
		t needed in house prior to			months for further review and recommendations.		
		alled speaking to the resident not sure about the specifics.			The title of the person responsible for t	he	
	She looked in the con	nputer system for the			implementing of the acceptable plan of		
	-	history but it was not in the			correction is the Administrator.		
	computer system for appeared the coding the						
F 279	•••	HENSIVE CARE PLANS	F 2	279			12/22/17
SS=D	CFR(s): 483.20(d);48	3.21(b)(1)					
	483.20						
		st maintain all resident					
		ted within the previous 15 it's active record and use the					
		nents to develop, review					
		nt's comprehensive care					
	plan.						
	483.21	ara Diana					
	(b) Comprehensive C	ait fidiis					
		levelop and implement a					
		on-centered care plan for tent with the resident rights					
		(2) and §483.10(c)(3), that					
	includes measurable	objectives and timeframes					
		nedical, nursing, and mental eds that are identified in the					
		ssment. The comprehensive					
	care plan must descri	-					
	(i) The services that a	are to be furnished to attain					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345165	B. WING				_ 19/2017
NAME OF PF	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 279	 physical, mental, and required under §483.24 (ii) Any services that y under §483.24, §483.24 provided due to the required ment under §483.10, including the services provide as a result of recommendations. If a findings of the PASAF rationale in the resident's representation of the resident's representation of the resident's representation. (A) The resident's goard desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's representational contact agencies entities, for this purportion of the part of the part of the resident's prefuture discharge. Fact whether the resident's representation of the part of the par	ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 3.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive (s)- als for admission and efference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. In the comprehensive care in accordance with the n in paragraph (c) of this is not met as evidenced iew and staff interviews the	F	279	F279	70	
	facility failed to develo	by a dental care plan for 1 of for dental needs (Resident			Residents #123, #38, #27 and #46 wer identified as having incomplete care	e	

Facility ID: 922951

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ID PLAN OF		(X1) PROVIDER/SUPPLIER/CLIA		LE CO	NSTRUCTION	(X3) DATE	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i		COM	PLETED
							С
		345165	B. WING			11	/19/2017
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MARION				AIRPORT ROAD RION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 279	Continued From page	70	F 27	0			
1 215		o failed to develop activity			lans – Bosidont #123 no longor rosid	oc in	
		urable goals and needed			plans. Resident #123 no longer resid he facility. The activity care plans we		
	-	3 residents sampled for			pdated by the Activity Director for		
	activities (Residents #	•			Residents #38 and #27 with intervent	ons	
				b	based upon likes provided by family.	The	
	The findings included	:			Dental care plan for Resident #46 was		
					pdated by the MDS nurse. These w	ere	
		s readmitted to the facility on		c	completed by 12/8/2017.		
	disease, dementia, ar	oses included Parkinson's		Т	The MDS staff reviewed the care plan	s for	
	disorder.				lental and activity needs based on	5 101	
					riggered Care Area Assessments in t	he	
	The significant chang	e Minimum Data Set (MDS)			MDS assessments completed within t		
		d her with severely impaired		p	bast 30 days.		
	-	g interests of somewhat					
		spapers, music, animals,			The Regional Reimbursement Specia		
	weather. Attending fa	and going outside in nice			n-serviced the Interdisciplinary Team completion of Comprehensive Care p		
	religious activities we				and measurable goals on 11/28/2017		
	preferences for the as	ssessment was provided by		т	o monitor ongoing compliance, the		
	family.				Administrator/Designee will audit trigg		
					Care Area Assessments and review c		
	-	o Care Area Assessment for Resident #123, the current			plan for completion of interventions ba on triggered Care Area Assessments		
	care plan was develo				neasurable goals x 3 months.	anu	
		y needs including that she					
	preferred and enjoyed	U		т	The results of the audits will be forward	rded	
	watching television, b	eing around people and			o the facility monthly Quality Assuran		
		was also noted that she			Performance Improvement committee	x 3	
		ties with reminders and staff			nonths for further review and		
		red one on one visits at goal was for Resident #123			ecommendations. The title of the person responsible for		
		of interest daily/weekly thru			mplementing the acceptable plan of		
	-	get date was 04/28/17.			correction is the Administrator.		
	There was only one ir	that she would receive a					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 12/21/2017 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345165	B. WING		_	(11/ [,]	C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF MARION		1	264 AIRPORT ROAD			
AUTOWIN			N	MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page	80	F 279				
	10/25/17 included that with the assistance ar staff, staff provided or monitored her needs.						
	2:40 PM revealed that care plan for activities resident did at home at interests in the facility developed a goal she to attend as much as Activity Director states in Resident #123's att Activity Director works The Activity Director st were provided to the rest the Activity Director st were provided to the rest activities and one on not included in the care 2. Resident #38 was at 12/08/08. Her diagnor major depressive discons The significant chang dated 07/26/17 codecons impaired cognition. Fe the questions related coded as having som- newspapers, music, g	ed at the facility full time. stated the goal itself was not staff reading it. In addition, sated more interventions resident including tend activities, taking her to one activities which were					
	triggered for Resident	a Assessment for activities #38 the current care plan /28/16 and addressed the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	activity needs includir enjoyed singing, social encouragement and a interests included nai visits. The care plan to "attend the activity next review." The tar There was only one in initiated on 04/28/16 f monthly calendar. Interview with the Act 2:40 PM revealed that care plan for activities resident did at home a interests in the facility developed a goal she to attend as much as Activity Director state was met by her perso resident's attendance that the goal was not In addition, the Activiti interventions were pro- which she should hav 3. Resident #27 was 10/13/15 and recently His diagnoses include atrial fibrillation, and o The significant chang 10/22/17 coded him v cognition and modera family provided answy preferences and note activities and religious	ng that she preferred and als and church events with assistance from staff. Other I club, bingo and family goal was for Resident #38 of interest daily/weekly thru get date was 01/10/18. Intervention listed with a date that she would receive a ivity Director on 11/17/17 at t when she developed a is she included what the and then tried to find their the she stated that when she is wanted to get the resident she would go to. The d she determined if a goal anal observations of the at activities. She stated measurable to other staff. y Director stated more by ided to Resident #38 re included in the care plan. admitted to the facility on the readmitted on 10/15/17. ed adult failure to thrive, dementia. e Minimum Data Set dated with severely impaired ately impaired hearing. The ers to resident #27's activity d that doing his favorite is activities were very other interests of somewhat	F	279			

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED		
		345165	B. WING				C / 19/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE				
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 279	animals, news and gr Although there was m activities triggered for care plan was develop target date of 01/02/1 that he preferred and and socializing with h interests were people events and socials. If hard of hearing and n during a group event. "attend activities of im review." There were 05/02/16 as follows: e activities and resident calendar. Interview with the Act 2:40 PM revealed that care plan for activities resident did at home a interests in the facility developed a goal she to attend as many act The Activity Director s goal was met by her p resident's attendance that the goal was not 4. Resident #46 was a 03/11/17 with current artery disease, respira non-Alzheimer's demo	oup activities. o Care Area Assessment for Resident #37 the current ped on 05/02/16 and had a 8. The activity needs were enjoyed watching television is roommate. Other watching, singings church t was noted that he was eeded to sit near the front The goal was for him to terest daily/weekly thru next 2 interventions both initiated engage resident in group t will receive a monthly ivity Director on 11/17/17 at t when she developed a a she included what the and then tried to find their . She stated that when she wanted to get the resident ivities as he would go to. stated she determined if a bersonal observations of the at activities. She stated measurable to other staff. admitted to the facility on diagnoses of coronary atory failure and entia. Minimum Data Set (MDS) led Resident #46 was npaired but could e his needs understood. The	F	279					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMF			
		345165	B. WING				19/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279 F 280 SS=D	natural teeth or tooth Review of the Care A dated 10/13/17 revea edentulous and did no dentures. He denied of not appear to have ar diet. His intake was g pain or problems and remained healthy, pin could perform oral car and cues but generall needed. Dental consu Review of the care plan no dental care plan for An interview conducted with MDS Nurse #1 re stated a triggered are care plan should be of dental care plan shoul Resident #46 and did missed. RIGHT TO PARTICIP CARE-REVISE CP CFR(s): 483.10(c)(2)(483.10 (c)(2) The right to part and implementation of plan of care, including (i) The right to particip including the right to i be included in the plan request meetings and	fragments (edentulous). rea Assessment (CAA) led Resident #46 was ot utilize upper or lower chewing problems and did ny difficulty with his current ood. He also denied oral none were noted. Gums k and free of lesions. He re with set up, supervision y staff assistance was an dated 10/13/17 revealed or Resident #46. ed on 11/17/17 at 11:25 AM evealed if the CAA summary a would be care planned a ompleted. She stated a Id have been completed for not know how it was ATE PLANNING i-ii,iv,v)(3),483.21(b)(2) ticipate in the development f his or her person-centered g but not limited to: pate in the planning process, dentify individuals or roles to nning process, the right to		279			12/22/17

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345165	B. WING				C 19/2017
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	2 84	F	280			
	expected goals and o amount, frequency, a	pate in establishing the utcomes of care, the type, nd duration of care, and any o the effectiveness of the					
	(iv) The right to receiv included in the plan o	ve the services and/or items f care.					
		e care plan, including the ificant changes to the plan					
		-					
	(i) Facilitate the inclus resident representativ	sion of the resident and/or /e.					
	(ii) Include an assess strengths and needs.	ment of the resident's					
	(iii) Incorporate the re cultural preferences ir	sident's personal and n developing goals of care.					
	483.21 (b) Comprehensive C	are Plans					
	(2) A comprehensive	care plan must be-					
	(i) Developed within 7 the comprehensive as	days after completion of ssessment.					
	(ii) Prepared by an int includes but is not lim	erdisciplinary team, that ited to					

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	1 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345165	B. WING			(11/	_ 19/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	85	F2	280			
	(A) The attending phy	vsician.					
	(B) A registered nurse resident.	e with responsibility for the					
	(C) A nurse aide with resident.	responsibility for the					
	(D) A member of food	and nutrition services staff.					
	the resident and the r An explanation must medical record if the	ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the					
		staff or professionals in ined by the resident's needs e resident.					
	team after each asse comprehensive and o assessments.	vised by the interdisciplinary ssment, including both the uarterly review is not met as evidenced					
	Based on observatio interviews, the facility for 2 of 8 sampled res #63) reviewed for acc	ns, record review and staff failed to update care plans sidents (Residents #38 and sidents and 1 of 11 sampled 123) for activities of daily			F280 The following residents were identified not having up to date care plans related accidents and toileting. The Toileting a Fall care plan for resident #63 has been updated by the MDS nurse. The Activit Care Plan has been updated by Activiti	d to ind n ties	
	The findings included	admitted to the facility on			Director for resident #38. Resident #12 no longer resides in the facility. Update were completed by 12/8/2017.	3	

Event ID: 9KIX11

Facility ID: 922951

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/2017 1 APPROVEE). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		SURVEY LETED
		345165	B. WING				_ 19/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
	CARE OF MARION			12	64 AIRPORT ROAD		
AUTOWIN	CARE OF MARION			M	ARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 280	Continued From page	2.86	F 2	200			
1 200			F 2	.00			
	12/08/08. Her diagno depressive disorder,				The Interdisciplinary Team has review	ed	
	cerebrovascular dise	-			care plans of other residents in the fac		
					to validate care plan is up to date with	-	
		ently updated 11/14/17 with			resident's current status including falls		
	interventions included a call bell in reach (added 07/11/16); anti-roll back device on the wheelchair				activities, and Activities of Daily Living		
					including eating ability, bathing and	-	
		quent safety reminders nskid mat beside bed(added			toileting. The Regional Reimburseme Specialist in-serviced the Interdisciplin		
		id socks in bed (added			Team on completion of updates to car	-	
	03/17/17).				plan when resident's status changes of		
	,				11/28/2017. The licensed nurses were		
		t report revealed Resident			in-serviced on 12/8/2017 regarding		
		ll on 05/29/17 at 8:30 AM.			updating the care plan when the resid	ent	
		on her buttocks between			has a status change including a fall.		
		he bed. The resident stated back into bed. Per the			The Interdisciplinary Team will review	caro	
		l 06/05/17, a dycem (nonskid			plans prior to care plan meetings to	care	
		o the wheelchair seat.			validate that the care plan is up to date	e	
					with current resident status. The	-	
		e Minimum Data Set (MDS)			Interdisciplinary Team will review		
		I she had severely impaired			Physician orders and changes in resid		
		ktensive assistance with			status as part of morning risk meeting	and	
		y living skills and had no falls sessment (06/30/17).			weekly resident review meeting and		
	since the previous as	555511H11 (00/30/17).			update care plan as resident status or orders change. The MDS staff and		
	The Care Area Asses	sment dated 08/08/17 for			Director of Nursing will complete an au	Judit	
		t risk for falls secondary to			1 x a week of 4 random residents for	-	
		ognitive deficits and multiple			three months with identified falls, new		
	-	It was noted that she			physician orders or changes of status	to	
	exhibited good safety call system for assist	 awareness and utilized the ance. 			verify care plan is updated.		
					The results of the audits will be forwar	ded	
		ports revealed that on			to the facility monthly Quality Assurance		
		Resident #38 was found in			Performance Improvement committee	х 3	
		bottom between the toilet			months for further review and		
		liate action taken per the			recommendations.		
		on-skid mat in the bathroom. es dated 10/26/17 the			The title of the person responsible for implementing the acceptable plan of		

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						FORM	D: 12/21/2017
STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 280	Continued From page	87		280			
1 200	resident was to be off			200	correction is the Administrator		
		d and an antiskid mat was					
	Review of the current	care plan revealed the care					
	1 *	h toileting on care rounds, eeded on 10/26/17. The					
		ude the antiskid mat in the					
		m in the wheelchair. In					
	addition, the Kardex used by nurse aides for individual care did not include the antiskid mat in						
	the bathroom or dyce	m in the wheelchair.					
		n 11/13/17 at 2:56 PM, on					
		on 11/16/17 at 8:05 AM, and revealed there was no					
		athroom adjacent to her					
	Observations made o	n 11/13/17 at 11:05 AM,					
		, 11/15/17 at 12:13 PM,					
		and 11/18/17 at 11:33 AM no being in the wheelchair.					
	Interview with MDS N	lurse #1 on 11/17/17 at					
		alls were discussed during					
	• •	weekdays and the care					
		and revised then. She could m or the antiskid mat in the					
		ed being placed on the care					
	plan.						
	Interview with the Ass						
		or of Nursing on 11/18/17 at falls were discussed every					
		plan updated at that time.					
	Updating the care pla	n ensured the interventions					
		Ily added on the Kardex for n. He stated the dycem					

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CENTER		D HUMAN SERVICES				FORM	0: 12/21/2017 1 APPROVED 0: 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COMP	
		345165	B. WING		_		_ 19/2017
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF MARION			264 AIRPORT ROAD IARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	been updated on the 2. Resident #123 was most recently on 08/0 included Parkinson's dysphagia. The quarterly Minimut 08/14/17 coded her w cognition and requirin The next quarterly ME her again with severe requiring extensive as Review of the current daily living skills last of 11/03/17 included the participate with ADL a function through the r Interventions included independent with eati Supervise/Assist RN of On 11/15/17 at 8:38 A was observed to set u her breakfast tray. Al and gave her a bite of	he bathroom should have care plan. s admitted to the facility 5/16. Her diagnoses Disease, dementia and m Data Set (MDS) dated ith severely impaired g set up for eating. DS dated 10/25/17 coded ly impaired cognition and ssistance with eating. care plan for activities of completed on last updated goal for the resident to to able at the current level of eview dated of 04/28/17. d "Resident is generally ng following set up. (as needed)." M, Nurse Aide (NA) #12 up and serve Resident #123 though he encouraged her f food to get her started	F 280				
	herself any food items her the breakfast mea On 11/15/17 at 12:36 observed to feed hers At 12:44 PM DNA #12 drink independently.	did not attempt to feed and a nurse had to feed al. PM, Resident #123 was self some of her lunch tray. 2 sat and encouraged her to At 12:53 PM a nurse sat sident #123 her meal.					

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SINTERNOT OF DEFIDENCIES AND PLAY OF CORRECTION (X1) PROVIDER SUPPLIES J45165 (X2) MULTIFIC CONSTRUCTION A BUILDING (X2) MULTIFIC CONSTRUCTION A BUILDING (X2) DUT E SUPPLY COMPLETED C (X2) DUT E SUPPLY C (X2) DUT E SUPPLY C </th <th></th> <th></th> <th>ID HUMAN SERVICES MEDICAID SERVICES</th> <th></th> <th></th> <th></th> <th>FORM</th> <th>APPROVED 0. 0938-0391</th>			ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
345165 B. WING 11119/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, QP CODE 1264 AIRPORT ROAD MARION, NC 28752 COMPLEX 1264 AIRPORT ROAD MARION, NC 28752 COMPLEX	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY		
AUTUMIN CARE OF MARION 1284 ARPORT ROAD MARION, NC 23723 Image: Note of the control of deficiency must be precised by Full reach deficiency must be precon the precise of the control deficiency reach deficie			345165	B. WING				-		
AUTUMN CARE OF MARION MARION, NC 28752 PHIERX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PREFX (EACH ORFRECTION Y MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG PREFX (COSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH ORFRECTION PACTORY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DEFICIENCY F 280 Continued From page 89 F 280 F 280 F 280 MDS Nurse 42 was interviewed on 11/07/17 at 11/24 AM. She stated she was new to the facility and doing MD'S and care plans. She could not reflect her change in ability to feed herself and the need for more assistance. F 280 3. Resident #63 was admitted to the facility on 11/18/15 with diagnoses of non-Alzheimer's dementia, restlessness/agitation and muscle weakness. F Review of the facility incident report dated 10/07/17 revealed Resident #63 that an unwitnessed fail attempting to go to the toilet unassisted. The interventions to be put into place were to educate Resident #63 that an unwitnessed fail attempting to go as per call light for assistance and to initiate the toileting program for her. Review of the care plan dated 10/25/17 revealed Resident #63 was a fail risk due to actual fails and further fails related to advanced age, unsteady gail/balance, poor safety awareness, dementia, multiple co-morbid medical diagnoses, and use of psychoactive medications. The goal was for Resident #63 to have no complications related to recent fail through next review and no fail related injuries requiring hotogsptalization	NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
MARION, NC 2972 WHID TRO SUMMARY STATEMENT OF DEFICIENCIES (EXCH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC DENTIFYING INFORMATION) D PREFIX ING PROVIDER'S PLAY OF CORRECTION (EXCH OPRICENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Computing DATE F 280 Continued From page 89 MD'S Nurse #2 was interviewed on 11/17/17 at 11:24 AM. She stated she was new to the facility and doing MD'S and care plans. She could not recall reviewing this care plan for Resident #123 but stated it was reviewed on 11/03/17. She stated the care plan should have been updated to reflect her change in ability to feed herself and the need for more assistance. F 280 Review of the facility incident report dated 10/07/17 revealed Resident #63 had an unwitnessed fail attempting to go to the toilet unassisted. The interventions to be put into place were to educate Resident #63 to use her call light for assistance and to initiate the toileting program for her. Review of the care plan dated 10/25/17 revealed Resident #63 was a fall risk due to actual falls and further fails related to advanced age, unsteady gaitbalance, poor safety awareness, dementia, multiple co-morbid medical diagnoses, and us of psychoactive medications. The goal was for Resident #63 to have no complications related to recent fail through next review and no fall related injuries requiring hospitalization					1	264 AIRPORT ROAD				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECIBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLETION DEFICIENCY F 280 Continued From page 89 MD'S Nurse #2 was interviewed on 11/17/17 at 11:24 AM. She stated she was new to the facility and doing MD'S and care plans. She could not recall reviewing this care plan for Resident #123 but stated the care plan should have been updated to reflect her change in ability to feed herself and the need for more assistance. F 280 3. Resident #63 was admitted to the facility on 11/18/15 with diagnoses of non-Alzheimer's dementia, restlessness/agilation and muscle weakness. Review of the facility incident report dated 10/07/17 revealed Resident #63 to use her call light for assistance and to initiate the toileting program for her. Review of the care plan dated 10/25/17 revealed Resident #63 was a fall risk due to actual falls and further fall stenation to obavened age, unsteady gait/balance, poor safety awareness, dementia, multiple co-morbid medical diagnoses, and use of psychoactive medications. The goal was for Resident #63 to have no complications related to recent fall through next review and no fall related injuries requiring hospitalization	AUTUMN	CARE OF MARION			N	MARION, NC 28752	ORRECTION (X5)			
MD'S Nurse #2 was interviewed on 11/17/17 at 11:24 AM. She stated she was new to the facility and doing MD'S and care plans. She could not recall reviewing this care plan for Resident #123 but stated it was reviewed on 11/03/17. She stated the care plan should have been updated to reflect her change in ability to feed herself and the need for more assistance. 3. Resident #63 was admitted to the facility on 11/18/15 with diagnoses of non-Alzheimer's dementia, restlessness/agitation and muscle weakness. Review of the facility incident report dated 10/07/17 revealed Resident #63 had an unwitnessed fall attempting to go to the toilet unassisted. The interventions to be put into place were to educate Resident #63 to use her call light for assistance and to initiate the toileting program for her. Review of the care plan dated 10/25/17 revealed Resident #63 was a fall risk due to actual falls and further falls related to advanced age, unsteady gait/balance, por safety awareness, dementia, multiple co-morbid medical diagnoses, and use of psychoactive medications. The goal was for Resident #63 to have no complications related to recent fall through next review and no fall related injuries requiring hospitalization	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION		
anti-rollback to wheelchair, fall mat at bedside, maintain call light within easy reach and bed in adjusted position, non-skid mat at bedside, non-skid shoes during the day, non-skid socks at bedtime, and offer toileting with care rounds as needed. The care plan was not updated with the toileting program intervention from the fall on	F 280	MD'S Nurse #2 was in 11:24 AM. She stated and doing MD'S and o recall reviewing this o but stated it was revie stated the care plan s reflect her change in a the need for more ass 3. Resident #63 was a 11/18/15 with diagnost dementia, restlessnes weakness. Review of the facility 10/07/17 revealed Re unwitnessed fall atten unassisted. The interview were to educate Resi for assistance and to for her. Review of the care pla Resident #63 was a fa and further falls related unsteady gait/balance dementia, multiple co and use of psychoact was for Resident #63 related to recent fall the fall related injuries red through next review. anti-rollback to wheel maintain call light with adjusted position, nor non-skid shoes during bedtime, and offer toil needed. The care pla	hterviewed on 11/17/17 at d she was new to the facility care plans. She could not are plan for Resident #123 awed on 11/03/17. She should have been updated to ability to feed herself and sistance. admitted to the facility on ses of non-Alzheimer's ss/agitation and muscle incident report dated isident #63 had an npting to go to the toilet ventions to be put into place dent #63 to use her call light initiate the toileting program an dated 10/25/17 revealed all risk due to actual falls ed to advanced age, e, poor safety awareness, -morbid medical diagnoses, ive medications. The goal to have no complications hrough next review and no quiring hospitalization The interventions included: chair, fall mat at bedside, nin easy reach and bed in n-skid mat at bedside, g the day, non-skid socks at leting with care rounds as n was not updated with the	F	280					

Facility ID: 922951

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		D HUMAN SERVICES MEDICAID SERVICES			FORM	MAPPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		SURVEY PLETED
		345165	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	dated 10/27/17 revea cognitively intact and review. Review of the facility for the Nurse Aides for Resident #63 was not Resident #63 was not program due to the in to the kardex and the An interview conducte with the Assistant Dire Nursing (ADON/DON has a fall it was review next day with new inter place to prevent future DON's responsibility to to the care plan and k toileting program was toileting with care rou	ly Minimum Data Set (MDS) led Resident #63 was had 1 fall since the last kardex, an information guide or resident care, revealed t on a toileting program. ver placed on the toileting tervention not being added care plan. ed on 11/18/17 at 5:26 PM ector of Nursing/Director of) revealed after a resident wed in the fall huddle the erventions to be put into e falls. He stated it was the o add the new interventions	F 28			
F 281 SS=J	on 10/07/17.	ED MEET PROFESSIONAL	F 28	31		12/22/17
	(b)(3) Comprehensive	e Care Plans				
	-	d or arranged by the facility, nprehensive care plan,				
	(i) Meet professional s This REQUIREMENT	standards of quality. is not met as evidenced				

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 12/21/20 MAPPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		345165	B. WING		11	C // 19/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CARE OF MARION			1264 AIRPORT ROAD		
AUTUMIN	CARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 281	Continued From page	e 91	F 28	1		
	by: Based on record rew interviews the facility physician standing or monitor the clotting ti which led to the labor times that resulted in for 1 of 3 residents re- thinner) therapy (Res admitted to the hospir reduce his elevated b also failed to confirm a physician ordered r a 2 day delay in admi ordered for bursitis for for pharmaceutical set Immediate Jeopardy staff failed to monitor Resident #139, who w milligrams (mg) once physician's standing of transcribing Resident orders staff did not m clotting time on 10/21 10/27/17. Immediate 11/19/17 when the fac implemented a credit The facility remains of scope and severity le harm with the potenti- harm that is not Imme monitoring of systems completion of employ	iew and Physician and staff failed to transcribe a ders for a laboratory test to me of a resident's blood ratory test being missed four an elevated bleeding time eviewed on Warfarin (blood ident #139). Resident #139 tal and received treatment to bleeding time. The facility a therapeutic exchange for medication which resulted in inistration of a medication or 1 of 1 resident reviewed ervices (Resident #66). began on 10/21/17 when the blood clotting time for was receiving Warfarin 10 a day per, per the resident's orders. Due to staff not :#139's physician's standing onitor the resident's blood //17, 10/23/17, 10/25/17 and Jeopardy was removed on cility provided and ble allegation of compliance. but of compliance at a lower vel of D (Isolated no actual al for more than minimal ediate Jeopardy) to ensure s put in place and ree training. at F281 for example #2 at a vel of D.		F 281 It was identified during the surve process that resident #139 did n standing orders transcribed relat monitoring of coumadin.Resider no longer in the facility.It was als identified that resident #66 did n celebrex as ordered due to nurs confirming pharmacy therapeutie interchange. The orders of residents admitted through 11/19/17, as well as res with warfarin orders were audite correct transcription of orders fo related to warfarin. There were negative findings based on this a A standing order for completion labs for residents admitted with for warfarin was obtained from th Medical Director on 11/17/17 by Director of Nursing. A cart to Medication Administrati Record Audit was completed by Director of Nursing of Autumn C Mocksville on 12/7/17 to identify medications not available for administration. All medications a present based on this audit. Director of Nursing or designee complete audits of residents rec warfarin 3 x a week for 3 months validate accurate transcription o orders into Point Click Care and Coumadin flow sheet. They will continue with review of new order week day clinical meeting. Director of Nursing or designee	Not have ted to lab at #139 is so ot receive e not c d 10/18/17 idents d for r INR labs no audit. of INR an order he the the are of any were staff will eiving s to f INR onto the also ers in the will verify	
	The findings included	:		the presence of any newly order		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/21/2017 M APPROVED D. 0938-0391
STATEMENT (TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345165	B. WING _				C / 19/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	264 AIRPORT ROAD		
AUTUMIN	CARE OF MARION			Μ	IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From page 1. Resident #139 was 10/18/17 with diagnos failure, Myasthenia G duodenal ulcer, and p Review of the admiss dated 10/25/17 revea moderately cognitivel anticoagulants during Review of Resident # from the hospital date Resident #139 had a He was discharged 0 admitted with duoden blood thinner). He was units of blood during subsequently readmit possible pulmonary e burden as well as left seen by hematology converting from Xare Lovenox (blood thinn 10/07/17 and reporte 10/10/17 for weakness didn't say what date t Warfarin but he was o mg as below.	e 92 s admitted to the facility on ses of acute respiratory gravis, hypertension, oneumonia. sion Minimum Data Set led Resident #139 was y impaired and received the assessment period. assessment period. as thistory and Physical ed 10/10/17 revealed series of hospitalizations. 9/10/2017 after being hal bleed while on Xarelto (a st transfused a total of 4 that stay. Resident #139 was tted on 10/02/17 with a embolism with low clot clower lobe infiltrate. He was who recommended to (blood thinner) to er). He was discharged on d back to hospital on as. The hospital records the Lovenox was changed to discharged on Warfarin 10	F 2	281	DEFICIENCY) medication in the medication cart after review of orders in the week day clini meeting. This will be audited 3x a we for 3 months Results of the audits will be forwarder the facility monthly Quality Assurance Performance Improvement committeer months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	cal ek d to e e x 3	
	10/18/17 revealed the Resident #139 was a check International N	al discharge summary dated e impression/plan for s follows: continue Warfarin, ormalized Ratio (INR) daily eck clotting time of blood),					
	Review of the hospita 10/18/17 revealed Re	al discharge summary dated esident #139's					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	
		345165	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 281	anticoagulation therap the Facility Physician. 10/21/17. The INR on target INR of 2 to 3. Review of the facility Anticoagulants was: INR will be performed receiving Warfarin. If admission or is starte be performed every o every other week x 4, otherwise ordered by Review of the care pla Resident #139 receive goal for no complicati use. The interventions medications as ordered changes. Monitor for internal/external bleed ordered. Protect from Review of the facility Resident #139 from 1 revealed the following -Warfarin 10 milli for anticoagulation the -No orders for IN Review of the facility revealed the INR was result of 2.1 with no c 10 mg once a day. Resident #139 missed	by would be monitored by . The next INR was due 10/18/17 was 1.9 with a Standing Orders for I monthly on all residents a resident is receiving upon d on medication, an INR will ther day for 1 week, then then monthly, unless MD. an dated 10/18/17 revealed ed anticoagulant use with a ons related to anticoagulant s included: administer ed. Monitor for behavior signs and symptoms of ding. Monitor labs as injury. physician orders for 0/18/17 through 10/27/17 g: grams (mg) every afternoon erapy.	F	281			

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CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		FORN OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _				LETED
		345165	B. WING			_		C 19/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		10/2011
AUTUMN	CARE OF MARION				264 AIRPORT ROAD MARION, NC 28752			
()(4) ID		ATEMENT OF DEFICIENCIES				PLAN OF CORRECTION		(¥5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From page orders.	94	F	281				
	PM revealed Resident breath and a dark pur on his inner right calf. and an order was rec sent to the emergence evaluation and treatm Review of a hospital of 10/28/17 revealed Re the ED on 10/27/17 for edema with extensive family member report extensive bruising de ago and given his me requested an evaluati extensive bruising of large hematoma on th and bruising on his le hospital laboratory tes 7.8 on 10/27/17. The Warfarin, give Vitamir reverse Warfarin), an Plasma (a blood prod portion of whole blood swelling of the hemate transferred to a larger respiratory distress of Review of a hospital a Physical dated 10/28/ was seen in the Emer shortness of breath a clots. The report state 7.8 and a large centra	tent. discharge summary dated sident #139 presented at or bilateral lower extremity bruising and confusion. A ed they had noticed veloping in both feet 2 days dical history they had on. The Physician noted the right lower extremity, a ne top of of his right foot, ft foot. Review of the st results revealed an INR of plan was to hold the n K (a medication used to d consider Fresh Frozen uct made from the liquid d) if there was further oma. Resident #139 was local hospital due to						
	Plasma (a blood prod portion of whole blood swelling of the hemati transferred to a larger respiratory distress of Review of a hospital a Physical dated 10/28/ was seen in the Emer shortness of breath a clots. The report state 7.8 and a large central	uct made from the liquid d) if there was further oma. Resident #139 was local hospital due to n 10/28/17. admission History and 17 revealed Resident #139 rgency Room for swelling, nd a concern of possible ed his INR was elevated at al line was placed to correct of partially to Vitamin K and						

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE			
		345165	B. WING				C 19/2017		
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-			
			1264 AIRPORT ROAD						
AUTUMIN	CARE OF MARION			Ν	MARION, NC 28752				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 281		ed on 11/17/2017 at 4:20 PM	F	281					
	Resident #139's INR during his stay at the therapeutic range. He	tian revealed he reviewed one time (on 10/19/17) facility and it was in the e stated the INR should have out nor standing orders and							
	been checked after that per standing orders and any result above 3 or below 2 should have been called to him. He further stated it was his expectation for the nurses to enter the standing orders for the INR checks to be completed and								
		im. He stated he was 39's INR's weren't being ding orders and should have							
	with Nurse #2 revealed to 7:00 AM shift on the admitted to the facility 11:00 PM nurse enter admission orders into stated when a new re Warfarin the standing into the computer for for a week then 1 time then once a month. S enters the admission standing order for INF Warfarin. She stated have been entered for	ed on 11/17/2017 at 6:44 PM ed she worked the 11:00 PM e night Resident #139 was 7. She stated the 3:00 PM to red all of Resident #139's the computer. Nurse #2 sident was admitted on orders should be entered INR checks every other day e a week for 4 weeks and he stated the nurse that orders should enter the R checks if they are on INR standing order should r Resident #139 for every s because he was admitted							
	with Nurse #3 reveale #139 on 10/18/17 and computer. She stated	-							

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345165	B. WING _			C 11/19/2017		
NAME OF P	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
AUTUMN	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 281	checks in the compute have put the order for Warfarin order but over 9:17 AM with the facil INR value of 7.8 was the INR checks been avoided. An interview conducted with the Assistant Dire (DON)/Acting DON re admitting the resident standing orders for IN resident was on Warfa Round Team that con Nurses checked all ne morning and he did ne missed to check Resi the INR should have I day for 1 week then of then once a month. An interview conducted 11/19/17 at 7:30 AM re expectation for the ad standing order for INF admitted on Warfarin, know how the order w Round Checks. The Administrator, DO Director of Clinical Se Immediate Jeopardy of On 11/19/17 at 4:56 F	r for every other day INR er. She stated she should INR checks with the erlooked it. conducted on 11/18/17 at ity Physician revealed an a critical lab value and had done it could have been ed on 11/18/17 at 11:32 AM ector of Nursing evealed it was the nurse tresponsibility to enter the IR checks to be done if the arin. He stated the Risk sisted of Administrative ew admission orders every ot know how the order was dent #139's INR. He stated been checked every other once a week for 4 weeks ed with the Administrator on evealed it was her Imitting nurse to put in the R checks for residents She stated she did not was missed during Risk	F2	281				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/21/2017 APPROVED	
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _				
		345165	B. WING	B. WING			C 19/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
IAG	REGULATORTORE		IAG		DEFICIENCY)			
F 281	Continued From page	97	F	281				
	F281 Meeting Profess	sional Standards						
	The Plan of Correcting	g the specific deficiency						
	Resident # 139 was a 10/18/17. Resident w	idmitted to this facility on						
		Nurse #3 failed to follow the						
		standing orders related to						
	-	s, and the risk rounds failed transcription of the standing						
		It, facility failed to monitor						
		on four occasions including; 0/25/17 and 10/27/17.						
	Resident #139 was he	ospitalized on 10/27/17 and						
	found to have an elev	ated INR level of 7.8.						
		plementing the Acceptable the specific deficiency cited.						
	All resident that receive potential to be affecte							
	On 11/17/17 manager	ment staff began on the policy and procedure						
	as it relates to transcr	iption of orders including						
	-	R monitoring. Re-education						
	scheduled shift to wor	•						
		cated on the policy during o transcribing orders in to						
	PCC.							
	Education with Nurse 11/17/17.	# 3 was completed on						
		ecurring the admitting nurse o Point Click Care (PCC)						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345165	B. WING			C 11/19/2017		
NAME OF PI	ROVIDER OR SUPPLIER		•	3	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 281	the flowsheet will ther nurse on the same sh To complete validation administrative nurses of Warfarin orders in H on a flowsheet and Pu- record as part of wee The monitoring proce Correction is corrected cited remains corrected regulatory requirement Nursing management residents with orders validate transcription to the flowsheet. Any be corrected immedia physician will be notif The title of the persor implementing the acc the Director of Nursin Date of Alleged Comp Immediate Jeopardy 5:38 PM when intervie they had received in-st transcribe standing on residents on Warfarin	he PT/INR/Coumadin he order and placement on h be validated by a second hift. In of accuracy, the will review the transcription PCC and placement of INRs CC treatment administration kday morning risk meeting. dure to assure the Plan of ed and the specific deficiency ed and in compliance with hts. It will complete an audit of for Warfarin 3 x weekly to of INR orders into PCC and identified discrepancies will ately and the prescribing ied. In responsible for eptable plan of correction is g. bliance is: 11/19/17 was removed on 11/19/17 at ews with Nurses confirmed service training on how to rders for INR checks for	F	281				
	residents on Warfarin	admitted to the facility on						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345165	B. WING			C 11/19/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>·</u>	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 281	Minimum Data Set (M revealed Resident #6 adequate vision and o Review of care plan o Resident #66 was at a superior pubic fractur goal was for Resident the highest degree pointerventions included medication as ordered and reported unreliev Review of Resident # 10/13/17 revealed the Celebrex 200 milligra one time a day for bu was sent electronical evening of 10/13/17. Review of Resident # Administration Record 200 mg was not giver 10/14/17. An order fo mouth one time a day started on 10/16/17. I after Resident #66 co on 10/20/17. During an interview o Resident #66 stated s receive Celebrex for I she had no idea why medication as soon a #66 added she did re morning of 10/16/17 a	d osteoporosis, her fracture. Review of the IDS) dated 10/18/17 6 was cognitively intact with clear speech. lated 02/09/17 revealed risk for pain related to left e and osteoporosis. The t #66 to maintain comfort to possible through next review.	F	28			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV	938-0391	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	RVEY	
C 345165 B. WING 11/19/20	C 11/19/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN CARE OF MARION 1264 AIRPORT ROAD MARION, NC 28752		
	(X5) OMPLETION DATE	
F 281 Continued From page 100 F 281 when she was supposed to receive the Celebrex. During an interview on 11/16/17 at 5:37 PM, Nurse #7 explained whenever there was a prescription order, the nurse who received the order electronically to the pharmacy. Nurse #7 stated she sent Resident # 66's Celebrex order to the pharmacy on 10/13/17 evening. She could not explain why the facility waited until 10/16/17 to start Resident # 66's Meloxicam therapy. During a phone interview on 11/17/17 at 8:57 AM, the Pharmacist stated the pharmacy received the Celebrex order electronically on 10/13/17 at 5:56 PM. Since the order came in after the 5:00 PM cut off time, it would be delivered on the next day. The Pharmacist stated the phare the 5:00 PM cut off time, it would be delivered on the next day. The Pharmacist explained the facility had a formulary agreement regarding therapeutic interchange. Any order for Celebrex 200 mg would be automatically switched to Meloxicam 7.5 mg and the pharmacy would send an "Order Pending Confirmation" electronically. The nurse who provided care for the specific resident was required to confirm the order with the physician before it could be started. According to the Pharmacist, the Meloxicam order was filed on 10/13/17, at evening, and the medications were delivered to the facility on 10/14/17 at 2:35 AM. Per the Academy of Managed Care Pharmacy, therapeutic interchange was defined as "the practice of replacing, with the prescribing physician's approval, a prescription medication originally prescribed for a patient with a chemically different medication." During an interview on 11/17/17 at 9:44 AM, the Assistant Director of Nursing (ADON)/Acting		

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345165	B. WING			C 11/19/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD		
					MARION, NC 28752		
(X4) ID PREFIX TAG			ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 281 F 282 SS=D	DON explained when interchange, the nursi "Order Pending Confi order would appear o resident would start to this case, the nurses Resident #66 on 10/1 10/15/17 evening had electronically in a time was finally confirmed Resident #66 started During an interview o Nurse #4 acknowledg failed to confirm Resid on the morning of 10/ had been working for 2017. She was unawa confirm the order as s on handling "Order Per electronically. During an interview of Assistant Director of N stated he expected th outstanding order per beginning of the shift pass. The DON attribut training. It was his exp medication orders to 1 as ordered in a timely SERVICES BY QUAL CARE PLAN CFR(s): 483.21(b)(3)(ever there was a therapeutic e had to acknowledge the rmation" tab so that the n the eMAR and the o receive the medication. In who provided care for 4/17 morning through failed to confirm the order ely manner. When the order on 10/16/17 morning, to receive her Meloxicam. In 11/17/17 at 10:01 AM, led she was the nurse who dent #66's Meloxicam order 14/17. Nurse #4 stated she the facility since September are of the requirement to she had never been trained ending Confirmation" In 11/17/17 at 4:10 PM, the Nursing (DON)/Acting DON e nurse to check for holing confirmations at the and before medication uted the incident as lack of pectation for all the be filled and administered manner. IFIED PERSONS/PER		281			12/22/17

Facility ID: 922951

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/21/201 FORM APPROVED OMB NO. 0938-039		
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED			
		345165	B. WING		C 11/19/2017		
NAME OF PI	ROVIDER OR SUPPLIER	·	s	TREET ADDRESS, CITY, STATE, ZIP CODE			
	CARE OF MARION		1	264 AIRPORT ROAD			
AUTOMIN			N	MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 282	Continued From page must-	e 102	F 282				
	care. This REQUIREMENT by: Based on observatio resident and staff inter implement care plann residents reviewed for (Resident #28, #66) a reviewed for accident The findings included 1. Resident #28 was diagnoses including of Review of a care plan Resident #28 was ad incontinence of bowe for complications relations Interventions included	n resident's written plan of T is not met as evidenced ans, record reviews and erviews, the facility failed to hed interventions for 2 of 11 or activities of daily living and 1 of 8 residents ts (Resident #63). I: admitted on 06/09/17 with dementia. In dated 06/13/17 revealed mitted with a history and bladder and was a risk ated to incontinent episodes. d to check and change per rd; and check for wetness on		F282 During the survey process it was ide for residents #28,#66 and #63 that of plan interventions were not impleme for ADL's, accidents and resident cho due to lack of a specific assignments NA's and the device list with fall interventions not being updated to re- new or changes in assistive devices each resident.New assignment shee have been implemented with specific room assignments for each Nursing assistant and the fall interventions a being monitored and updated in mor- risk meeting and monitored for the presence of during Management roo rounds.	are inted bices s for eflect for ets c re re rning		
	Urinary Incontinence Resident #28 had epi both bowel and blado with activities of daily her risk factors she h to incontinence. Review of a quarterly dated 09/15/17 revea severely impaired cos	rea Assessment (CAA) for dated 06/22/17 revealed isodes of incontinence of der and required assistance living. It was noted despite ad no complications related r Minimum Data Set (MDS) aled Resident #28 had gnition and required with transfer, dressing,		Resident requiring assistance with A care have been identified by the interdisciplinary team. Care plans a kardex were verified as accurately identifying needs with ADL care. Nursing staff have been reeducated 12/8/2017 by the Administrator and/ Director of Nursing/designee concer the expectation that all residents are receive ADL care according to their ras documented on their care plans a kardex. The reeducation included the process for the unit assignment sheet	nd by or ning to needs and e new		

Facility ID: 922951

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ATION NUMBER: 345165 DEFICIENCIES ECEDED BY FULL NG INFORMATION) The quarterly s always and noted no	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) 2 identify dependent resident needs and	DATE
The quarterly s always and noted no	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) 2	11/19/2017 E (X5) COMPLETIC
The quarterly always and noted no	ID PREFIX TAG	1264 AIRPORT ROAD MARION, NC 28752 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	E (X5) COMPLETIC
The quarterly always and noted no	ID PREFIX TAG	MARION, NC 28752 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) 2	E COMPLETIO
The quarterly always and noted no	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETIO
always and noted no	F 282		
always and noted no		identify dependent resident needs and	
served a pair of pink nts were visibly oted as well. At rved in her room remained visibly it #28's room at d she had a were visibly wet as well. At 5:25 #28 to the e her pain. room at 5:31 PM Resident #28. nd the urine odor ext to her 5 served and set 5:33 PM and 4/17 at 5:33 PM As assigned to e did not get ed the NAs e a specific A #17 stated the		bathing schedule To monitor and maintain ongoing compliance the Department heads and Director of Nursing or designee will monitor the care rounds and meal serv 2x a week x4 weeks then monthly x2 months to validate tray set up, bathing and incontinent care are provided to dependent residents and that fall interventions are in place. Any negative findings will be immediately corrected. Results of the audits will be forwarded the facility Quality Assurance Performa Improvement committee monthly x3 fo further review and recommendations. The title of the person responsible for implanting the acceptable plan of correction is the Administrator. The Department Heads or designee wi monitor for fall interventions being press during management room round 2x a week for 1 month and then weekly for 3 months to validate fall interventions are place.	to ance r
	 11/14/17 served a pair of pink nts were visibly oted as well. At rved in her room remained visibly t #28's room at d she had a were visibly wet as well. At 5:25 : #28 to the e her pain. room at 5:31 PM Resident #28. nd the urine odor ext to her 5 served and set 5:33 PM and 4/17 at 5:33 PM As assigned to e did not get ed the NAs e a specific A #17 stated the unds before she d and changed as not observed time during a O PM until 5:25 the dining room 	served a pair of pink ints were visibly oted as well. At rved in her room remained visibly t #28's room at d she had a were visibly wet as well. At 5:25 #28 to the e her pain. room at 5:31 PM Resident #28. ind the urine odor ext to her 5 served and set 5:33 PM and 4/17 at 5:33 PM As assigned to e did not get ed the NAs e a specific A #17 stated the unds before she d and changed as not observed time during a 0 PM until 5:25	served a pair of pink ints were visibly oted as well. At remained visibly t #28's room at d she had a were visibly wet as well. At 5:25 #28 to the e her pain. room at 5:31 PM Resident #28. ind the urine odor ext to her 6 served and set 5:33 PM and 2 H17 at 5:33 PM As assigned to e did not get ed the NAs e a specific A #17 stated the unds before she d and changed as not observed time during a 0 PM until 5:25 interventions are in place. Any negativ findings will be immediately corrected. Results of the audits will be forwarded the facility Quality Assurance Performa Improvement committee monthly x3 fo further review and recommendations. The title of the person responsible for implanting the acceptable plan of correction is the Administrator. The Department Heads or designee w monitor for fall interventions being pres- during management room round 2x a week for 1 month and then weekly for months to validate fall interventions are place.

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/21/2017 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345165	B. WING			_		C 19/2017
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752			
					-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page by Nurse #11.	9 104	F	282				
	An interview with NA a revealed she did not a rounds that afternoon showers. NA #18 wa Resident #28 at any t observation from 4:20 she was wheeled into #11. During an interview of #16 was asked which and changed before s had checked and cha were in bed and the re call lights. NA #16 wa Resident #28 at any t observation from 4:20 she was wheeled into #11. An interview with Nur PM revealed she did in pants were wet with u incontinence before ta An interview was cond Administrator on 11/12 Administrator further s NAs to check every re beginning of the shift. 2. Resident #66 was a diagnoses including h	aking her to the dining room. ducted with the 4/17 at 5:54 PM. The t was not acceptable for a the dining room or served wet with urine. The stated she expected the esident on rounds at the						

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						FORM	D: 12/21/2017	
STATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	OMB NO. 0938-0391 (X3) DATE SURVEY			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED		
		345165	B. WING				C 19/2017	
NAME OF PF	ROVIDER OR SUPPLIER	I		ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 282	282 Continued From page 105		F:	282	2			
	Review of a care plan Resident #66 had a s advanced age, decrea diagnoses. Interventi assistance as needed ensure her needs wei schedule and as need needed. Review of a quarterly dated 10/18/17 revea was intact and she way known. The quarterly required one person p and no rejection of car Review of the 100 ha Resident #66 was sch on Tuesday and Frida During an interview o Resident #66 stated s showers a week but of and this was a proble further explained she but only one the week An interview with Nur 11/15/17 at 9:00 AM r the "long" section of t other NA on the 100 h her second day worki stated showers were they don't have time of A follow up interview of Resident #66 on 11/1	 a dated 02/09/17 revealed to ased mobility and other ions included to provide daily d to complete all care and re met; and showers per ded with assistance as Minimum Data Set (MDS) led Resident #66's cognition as able to make her needs (MDS noted Resident #66 obysical assist with bathing are was noted. Il shower schedule revealed heduled to receive showers ay during the second shift. n 11/13/17 at 10:18 AM she was supposed to get two did not get them consistently im for her. Resident #66 had two showers last week k before. se Aide (NA) #12 on revealed he was assigned to he 100 hall that day and the hall was agency and it was ing at the facility. NA #12 not getting done because due to the staffing. 						

		ID HUMAN SERVICES				FORM): 12/21/2017 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345165	B. WING		_	C 11/19/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		10/2011
				1264 AIRPORT ROAD			
AUTUMN	CARE OF MARION			MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	a week consistently d Resident #66 indicate month and there were hall.	e 106 ue to staffing problems. ed a lot of staff quit last e not enough NAs for the ducted with the Assistant	F 282				
	Director of Nursing (A 11/17/17 at 5:03 PM. expectation was for the preferred number of se indicated Resident #6 and if she said she was a week then she was stated he felt showers consistently due to sta 3. Resident #63 was a 11/18/15 with diagnos	DON)/Acting DON on The ADON stated his he residents' to receive their showers a week. The ADON 66 was alert and oriented as not getting showers twice not. The ADON further is were not being given					
	weakness. Review of the care pla Resident #63 was a fa and further falls relate unsteady gait/balance dementia, multiple co and use of psychoact was for Resident #63 related to recent fall th fall related injuries red through next review. anti-rollback to wheel maintain call light with adjusted position, nor non-skid shoes during bedtime, and offer toil needed.	an dated 10/25/17 revealed all risk due to actual falls ed to advanced age, e, poor safety awareness, -morbid medical diagnoses, ive medications. The goal to have no complications hrough next review and no quiring hospitalization The interventions included: chair, fall mat at bedside, nin easy reach and bed in					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345165	B. WING _			C 11/19/2017	
	ROVIDER OR SUPPLIER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 264 AIRPORT ROAD IARION, NC 28752	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	review. Review of the facility for the Nurse Aides for Resident #63 should mat at her bedside. Observations made of 11/16/17 at 8:08 AM, 11/18/17 at 12:39 PM Resident #63 lying in mat or anti-skid mat at An interview conducte with Nurse #10 revea a fall mat or a non-ski An interview conducte with Nurse Aide #14 m for Resident #63 on the shift frequently and sho or non-skid mat at he An interview conducte with the Assistant Dire (DON)/Acting DON re expectation for an inter and the kardex to be the fall mat and non-ski ADL CARE PROVIDE	led Resident #63 was had 1 fall since the last kardex, an information guide or resident care, revealed have a fall mat and non-skid n 11/15/17 at 8:35 AM, 11/16/17 at 9:01 AM, and , and 11/18/17 at 2:58 PM of her low bed revealed no fall at her bedside. ed on 11/16/17 at 8:25 AM led Resident #63 did not use id mat at her bedside. ed on 11/18/17 at 3:00 PM revealed she provided care he 3:00 PM to 11:00 PM he had never had a fall mat r bedside. ed on 11/18/17 at 5:26 PM ector of Nursing evealed it was his ervention on the care plan in place for the resident and skid mat should have been		282			12/22/17
SS=E	CFR(s): 483.24(a)(2) (a)(2) A resident who	is unable to carry out g receives the necessary					

Facility ID: 922951

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AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PIFC	CONSTRUCTION		
NAME OF PF			A. BUILDING				E SURVEY PLETED
NAME OF PF		345165	B. WING			11	C / 19/2017
	OVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ALITURAL /				126	64 AIRPORT ROAD		
AUTUMIN	CARE OF MARION			MA	ARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 312	Continued From page	e 108	F 3 ²	12			
		good nutrition, grooming, and	10	12			
	personal and oral hyg						
		is not met as evidenced					
	by:						
	•	ns, record reviews, and			F-312		
		failed to provide incontinent			During the survey process it was ident	tified	
	care (Resident #27, #	•			the facility staff did not provide necess		
	-	set up (Resident #123) for 4			ADL assistance for Residents #27, #2	-	
	of 11 sampled resider	nts reviewed for activities of			123, and #79 due to lack of specific		
	daily living.				assignments for NA's and insufficient		
					staffing. New assignments sheets with	1	
	The findings included	1:			specific assignments has been		
					implemented and staffing initiative		
		admitted on 06/09/17 with			continues with improvements noted.		
	diagnoses including c	dementia.			Resident requiring assistance with AD	L	
	Boviow of a core plan	dated 06/12/17 revealed			care have been identified by the interdisciplinary team. Care plans and	4	
	Resident #28 was ad	n dated 06/13/17 revealed			kardex were verified as accurately	1	
		l and bladder and was a risk			identifying needs with ADL care.		
		ited to incontinent episodes.			Nursing staff have been reeducated b	v	
	-	d to check and change per			12/8/2017 by the Administrator and/or		
		d; and check for wetness on			Director of Nursing/designee concerni		
	rounds during the nig	-			the expectation that all residents are to	-	
	0 0				receive ADL care according to their ne		
	Review of the Care A	rea Assessment (CAA) for			as documented on their care plans an		
		dated 06/22/17 revealed			kardex. The reeducation included the		
		isodes of incontinence of			process for the unit assignment sheets		
		ler and required assistance			identify dependent resident needs and	I	
		living. It was noted despite			bathing schedule		
		ad no complications related			To monitor and maintain ongoing		
	to incontinence.				compliance the Department heads and	d	
	D · · · · ·				Director of Nursing or designee will		
		Minimum Data Set (MDS)			monitor the care rounds and meal ser	vice	
		led Resident #28 had			2x a week x4 weeks then monthly x2		
	severely impaired cog				months to validate tray set up, bathing	I	
		with transfer, dressing,			and incontinent care are provided to		
		d toilet use. The quarterly			interviewable and non-interviewable		
	MDS indicated Reside	ent #28 was always and bladder and noted no			residents. Any negative findings will b immediately corrected.	ie i	

Facility ID: 922951

		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/21/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		NSTRUCTION	(X3) DATE COME	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
A 1 171 18451	CARE OF MARION			1264 A	AIRPORT ROAD		
AUTUMIN	CARE OF MARION			MARI	ION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	Continued From page	: 109	F 31	12			
F 312	urinary toileting progra Rejection of care was Observations of Resid revealed at 4:20 PM s propelling in the hall w The crotch area of the a faint urine odor was Resident #28 was obsected crotch area of her par Nurse #11 entered Resident PM and Resident #28 headache. Resident and a faint urine odor PM Nurse #11 wheeled dining room and aske Nurse #11 returned to and administered med Her pants remained v was noticeable when wheelchair. Nurse Aid up Resident #28's sup exited the dining room An interview with NA a revealed she was one the 200 hall that even there until 4:00 PM. If worked together and of resident or room assig other NAs had alread arrived but they typicate everyone on the hall. checking on Resident continuous observatio PM when she was while by Nurse #11.	am had been attempted. not observed. dent #28 on 11/14/17 she was observed self vearing a pair of pink pants. e pants were visibly wet and noted as well. At 5:05 PM served in her room and the nts remained visibly wet. esident #28's room at 5:24 e stated she had a #28's pants were visibly wet was noted as well. At 5:25 ed Resident #28 to the d her to rate her pain. the dining room at 5:31 PM dication to Resident #28. isibly wet and the urine odor standing next to her de (NA) #16 served and set oper tray at 5:33 PM and n. #17 on 11/14/17 at 5:33 PM e of three NAs assigned to ing and she did not get NA #17 stated the NAs did not have a specific gnment. NA #17 stated the y started rounds before she ally checked and changed NA #17 was not observed #28 at any time during a on from 4:20 PM until 5:25 eeeled into the dining room	F 31	Ri th In fu Ti in	esults of the audits will be forwarde ne facility Quality Assurance Perfor nprovement committee monthly x3 in the review and recommendations he title of the person responsible for nplanting the acceptable plan of porrection is the Administrator.	nance for	
		#18 on 11/14/17 at 5:39 PM					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345165	B. WING			1	/19/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	revealed she did not a rounds that afternoon showers. NA #18 wa Resident #28 at any to observation from 4:20 she was wheeled into #11. During an interview o #16 was asked which and changed during r the shift. NA #16 stat changed the resident residents that turned was not observed che any time during a cor 4:20 PM until 5:25 PM into the dining room to An interview with Nur PM revealed she did pants were wet with u incontinence before ta An interview was con Administrator on 11/1 Administrator stated i resident to be taken t a meal wearing pants Administrator further NAs to check every re beginning of the shift. revealed the Administ given the NAs a room 2. Resident #27 was facility on 10/31/15 ar 10/15/17. His diagno	assist with incontinence a because she was giving s not observed checking on time during a continuous D PM until 5:25 PM when the dining room by Nurse n 11/14/17 at 5:44 PM NA residents were checked rounds at the beginning of ted they had checked and s that were in bed and the on their call lights. NA #16 ecking on Resident #28 at thinuous observation from A when she was wheeled by Nurse #11. se #11 on 11/14/17 at 5:50 not notice Resident #28's urine or check her for aking her to the dining room. ducted with the 4/17 at 5:54 PM. The t was not acceptable for a o the dining room or served s wet with urine. The stated she expected the esident on rounds at the . The interview further trator thought the nurse had n assignment. originally admitted to the nd recently readmitted on	F	31:	2		

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
					PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	adult failure to thrive a The significant chang dated 10/22/17 codec cognition, having no to extensive assistance toileting and hygiene, incontinent of bowel a noted no toileting pro- MDS noted the activit a. The Care Area Assidated 11/03/17 stated episodes of incontine The current care plan a goal for Resident #2 elimination needs as Interventions included any incontinent episo toileting, pericare and indicated and per resident that incontinent care of needed and staff show rounds. Resident #27 was observed	and dementia. e Minimum Data Set (MDS) d him with severely impaired behaviors, requiring with bed mobility, transfers, and being frequently and bladder. The MDS gram. Under bathing, the y did not occur. essment for incontinence I he was at risk for increased nce as well as complication. initiated 05/05/16 included 27 to be assisted with needed through 01/02/18. d to monitor and assist with des; provide assistance with I clothing management as	F	31:			
	light blue thin pants w a wet area around his rings at the edges of was observed as he p hall. At 8:12 AM NA a	which were observed to have crotch and darker dried the wet area. A urine odor bassed the surveyor in the #6 pushed him to the dining ned in the dining room					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD	<u>,</u>	10/2011
AUTUMN	TUMN CARE OF MARION				MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 312	through breakfast. Th #27 was observed in with yellow dark stain dried stain could be s extending from his km Resident #27 was obs 9:42 AM and his croto crotch to his knee on was evident. Staff en hall at 9:46 AM. The the hallway at this tim see his wet pants fror wound physician and to provide wound care roommate. Both the Resident #27's room on rounds. Resident the hall. Resident #2 wet blue pants, wetre thigh when observed odor was noted from Incontinence care wa 10:39 AM after NA #9 to his roommate. NA had not planned on ca this time. They pushe bathroom and remove pants and socks were and his pants had drie NA #9 stated at this ti On 11/14/17 at 10:46 conducted during a g NA #8, NA #10, and a were on the hall wher They all stated that the assignment regarding	hen at 9:35 AM, Resident his room in his wheelchair ed light blue pants and the een on his outer right thigh ee toward his bottom. served again on 1/14/17 at ch was very wet from his the inner thigh. A urine odor itered the room across the odor of urine was strong in he and the surveyor could in the hall. At 9:48 AM the Nurse #8 entered the room e to Resident #27's physician and Nurse #8 left at 9:56 Am and continued #27 was still visibly wet from 7 remained with the same less observed under the right at 10:04 AM. The urine the hallway at 10:07 AM. s observed on 11/14/17 at 0 and #11 had provided care #9 and NA #11 stated they aring for Resident #27 into the ed his clothes. His blue e soaked through with urine ed urine stains on the legs. me "This is bad." AM, interviews were roup interview with NA #7, an orientee NA #12, who re Resident #27 resided.	F	312	2		

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345165	B. WING			11	U/19/2017
	ROVIDER OR SUPPLIER		- 1		STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	produced the assignment staff and the showers pass ice but room nur NA #7 stated the assign number of nurse aide start providing care for hall and others start at and if enough, some She further stated the at the far end of the h resided. NA #7, NA # stated they had not pic care this morning. NA #6 stated at 11/14 not notice Resident # pushed him down the On 11/14/17 at 10:53 not given him care this assignment sheet on revealed NA #9 was r #27, as room assignment to staff names. Furth stated she was not as and just came in to he rooms as of 5 minutes She stated they usua rooms. She stated the enough coverage for the shift on time. Interview with NA #11 revealed she was from her 3rd day in this fac no specific assignment from room to room to #11 stated she had reference.	hent sheet which listed the to be given and who was to mbers were not assigned. gnments depend on the s present. Sometimes they or residents at one end of the the other end of the hall start care in the middle. Fre were 2 other nurse aides all where Resident #27 t8, NA #10 and NA #12 all rovided Resident #27 any	F	312	2		

Facility ID: 922951

If continuation sheet Page 114 of 170

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF PF	ROVIDER OR SUPPLIER	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	morning and it would an actual resident assist staff. During an interview of Assistant Director of I Nursing stated regard resident care was alw nursing staff. Other the timely manner, it was provide incontinent can they were doing round 11/19/17 at 5:12 PM reaction aides to have and know provide the necessary including checking and residents as needed. b. The Care Area Assist daily living (ADL) date #27 had a recent illned inability to improve his The current care plan a target goal of 01/02 Resident #27 exhibitin had a goal for him to Under bathing it was assistance of 1 with b The Kardex Report, at (NA) of individual resid that his showers were Fridays. Review of the bathing	e had not given him care this make it easier if there was signment provided to the n 11/17/17 at 4:14 PM, the Nursing/ Acting Director of fless of staffing levels, vays the first priority for han answering call lights in a his expectation for NAs to are immediately even when ds. Follow up interview on revealed he expected nurse by their assignments to y care and services and changing incontinent essment for activities of ed 11/03/17 stated Resident tess and he was at risk for the s ADL abilities. h, initiated 05/05/16 and with /18 for the problem of ng self care performance participate with ADL as able. noted he required bathing and showers.	F	31:	2		
	provided by the facilit	assignments per room/bed y, revealed Resident 27's the list to be captured for					

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/21/201 1 APPROVEI). 0938-039
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION G		LETED
		345165	B. WING		(11/ [,]) 19/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	•	
	CARE OF MARION			1264 AIRPORT ROAD		
Acronity				MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 312	showers. Review of t the medical record co revealed he had not t 09/22/17 through 09/3 through 11/15/17. Resident #27 was ob on 11/13/17 at 11:24 AM. Interview with the Ass Nursing/Acting Direct 11/17/17 at 4:23 PM, admission the activity preferences. The nur information and place The ADON stated the completed all shower and the showers ther second shift by the D He stated generally s doors were scheduled by the windows were However, this change the computer system staff to document sho schedule. ADON the developed by the pre showers based on the these forms starting of Resident #27's room/ sheet from 10/23/17 to	the ADL documentation in ompleted by nurse aides, been showered from 30/17; from 10/06/17 served to have urine odors AM and 11/14/17 at 8:10 sistant Director of tor of Nursing (ADON) on the ADON stated that upon <i>x</i> staff asked about bathing rse then took this ed it on the shower schedule. e shower team who rs on first shift was dissolved in spread over first and ON (no longer employed). showers for the beds by the d for first shift and the beds scheduled for second shift. e had not been updated in and therefore did not allow owers given per the new en provided a new system vious DON to document e new schedule. Review of	F 3			
	5:14 PM. She stated and went by the writte	interviewed on 11/17/17 at she cared for Resident #27 en assignment sheet for rs. She stated she had ower on second shift.				

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	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COMF	PLETED
		345165	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	545165	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	19/2017
					1264 AIRPORT ROAD		
AUTUMN	CARE OF MARION			1	MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	9 116	F	312	2		
		s readmitted to the facility on oses included atherosclerotic agia, dementia and					
		stated she received a diet with nectar thick liquids					
	coded her with severe requiring extensive as	m Data Set dated 10/25/17 ely impaired cognition, ssistance with all activities of ding eating and she was ic diet.					
	10/13/17 through 11/0 summary dated 11/01 tolerated mechanical liquids with mild overt penetration/aspiration from having had mod	tion/aspiration during initial					
		nt #123 was noted chocking chanical soft diet and order					
	observed delivering a She received her food container of bread cru bread crumbs were n	AM Nurse Aide (NA) #12 was nd setting up her meal tray. d pureed with a small umbs off to the side. The ever opened or added to the 15 sat and assisted feeding					

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345165	B. WING		_	(11/) 19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page her at 9:18 AM.	e 117	F 312				
	up, uncovered the co Resident #123 began	M NA #13 set her meal tray ntainer of bread crumbs and to feed herself. NA #13 did mbs into the pureed food.					
	She stated that the br thicken food but had r receive bread crumbs NA #12 about them a	ed on 11/16/17 at 9:14 AM. ead crumbs were used to never seen a pureed diet s. She stated she had asked and he stated the crumbs d thicker and she could add anted.					
	that for pureed diets, substitute for the bread diets. She stated the breadcrumbs into a for She further stated that responsible for education	ood item with tray set up.					
	06/18/13 with diagnos anxiety, depression, a above knee. Review (MDS) dated 09/13/17 was cognitively intact of daily care. She req with 2 + persons phys toileting, bed mobility, and bathing. Residen impairment on right u The MDS further indic	oper & lower extremities. cated Resident #79 was with bladder and was					

Facility ID: 922951

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 12/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345165	B. WING			_		C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	Review of care area a Resident #79 required her activities of daily I above knee amputatio for decline in her funct Review of care plan d Resident #79 was deg assistance. Interventio toileting assistance or as needed and encour for assistance at the f During an interview of Resident #79 stated s 11/14/17 at around 5: wet in bed. It took NA answer her call light. she was soaking wet NA #3 replied he had residents and promise few minutes. NA #3 tu leaving the room. Resione hour without havi addressing her incont activated the call light NA #3 came back and needed? NA #3 then and apologized indica Resident #79 stated s embarrassed, disrega had to wait in soaking hour. During an observation Resident #79 was ale	Assessments revealed d assistance with most of iving (ADL) due to right on (AKA). She was at risk tional ADL abilities. ated 05/18/17 revealed bendent on staff for toileting ons included providing incontinence care routinely raging Resident #79 to call irst urge. In 11/15/17 at 10:51 AM, the activated the call light on 00 AM as she was soaking #3 about 5 minutes to When she told NA #3 that and needed to be changed, to finish rounding on his ed her to come back in a irmed off the call light before sident #79 waited for almost ing any nursing staff inent needs. When she again at around 6:00 AM, d asked her what she provided incontinent care ting they were short of staff.	F	312				

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		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345165	B. WING		1	1/19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1264 AIRPORT ROAD		
AUTUMN	CARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 312	Continued From pag	0.110	Г 21	2		
1 512			F 31	2		
	Nurse #4 stated all N	on 11/15/17 at 12:05 PM, As were required to				
		ned rounds in a timely				
		s a nurse, she expected NAs				
		t care as needed during the				
	rounds as resident ca	are had a higher priority.				
	During a phone inter	view on 11/15/17 at 12:42				
		view on 11/15/17 at 12:43 I he worked third shift on the				
		on the morning of 11/14/17				
		are of Resident #79. He was				
	not familiar with the r	esidents as it was his				
		g in the facility and his first				
		Hall. He started the last				
	•	ound 5:00 AM and he was Il lights as there were only 2				
		00 Hall to provide care for				
	around 50 residents.	•				
	answering any call lig	ght for incontinent care at				
		romising any resident to				
		was doing his rounds. NA #3				
		sident #79 was in soaking would have addressed her				
	incontinent needs im					
	During on interviews					
		on 11/16/17 at 8:28 AM, NA ked with NA #3 on third shift				
		ended on the morning of				
		not remember seeing NA #3				
	responding to Reside	ent #79's call light at around				
		e was busy with resident				
		esident was asking for				
		ng his rounds, he would take irst, then continue with the				
		's first night working at 100				
		working on 100 Hall for third				
		as overwhelming for NA #3.				
	He agreed resident of	are should be prioritized				
	over the rounds at al					1 I I I I I I I I I I I I I I I I I I I

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345165	B. WING		-	9/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD	<u> </u>	
				MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	9 120	F 312	2		
F 313 SS=D	Assistant Director of I stated regardless of s was always the first p Other than answering it was his expectation care immediately eve rounds. He also expe resident call lights on provide the assistanc TREATMENT/DEVIC HEARING/VISION CFR(s): 483.25(a)(1)((a) Vision and hearing To ensure that resider and assistive devices	ES TO MAINTAIN (2) Ints receive proper treatment to maintain vision and facility must, if necessary,	F 313	3	1	2/22/17
	office of a practitioner treatment of vision or office of a professiona provision of vision or This REQUIREMENT by: Based on record revi facility failed to follow recommendation for b	hearing impairment or the al specializing in the hearing assistive devices. is not met as evidenced ew and staff interviews, the through with an audiology pilateral hearing aids for 1 of eviewed for hearing loss		F313 During the survey process it was identitient that Resident #27 did not have an appointment to follow up on recommendation for hearing aids due to that facility not having a tracking proce in place for follow-up appointments. Resident #27 has an appointment	to	

Event ID: 9KIX11

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/21/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345165	B. WING		C 11/19/2017
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 313	Resident #27 was ori on 10/31/15 and rece His diagnoses include fibrillation, diastolic he Review of the medica #27 had been to the a hearing test. Resident #27 also wa 09/11/17 in order to o hearing aids. At this removed from his ear recommended bilater A nursing note dated by Nurse #7 noted Ref from the appointment bilateral hearing aids contain any further in Resident #27 having appointments or follo aids. Resident #27 was ob aids on 11/13/17 at 1 11/14/17 at 8:08 AM 8:46 AM and 2:48 PM AM. The significant chang dated 10/22/17 coded hearing with no heari Assessment dated 11 stated that Resident a did not utilize hearing his right ear and under into his right ear. The	ginally admitted to the facility ently readmitted on 10/15/17. ed muscle weakness, atrial eart failure, and dementia. al record revealed Resident audiologist on 08/07/17 for a as seen by a physician on obtain medical clearance for appointment, he had wax rs and the physician ral hearing aids. 09/11/17 at 2:51 PM written esident #27 had returned t with recommendations for . The medical record did not	F 313	 scheduled on 1/22/2018 with Asheve ENT at 1 PM for evaluation of need hearing aids. Social Service will me that resident has an appointment at transported to appointment to obtai hearing aids if ordered. Family has notified of appointment. Social service and transportation staudit MD orders daily ongoing for a identified orders for outside service related to hearing to validate appoint scheduled and completed. Social S and Transportation staff educated to Administrator on use of tracking log validation of hearing appointments 12/13/17. Social Service and Transportation staff educated to completion of appointment. The results of the audit will be forwate to the facility monthly QAPI commit months for further review and recommendations. The title of the person responsible for the administrator of the facility monthly QAPI commit months for further review and recommendations. The title of the person responsible for the administrator of the administrato	I for onitor nd is in s been taff will iny s ntment Service by g for on staff earing arded tee x 3

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/21/2017 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345165	B. WING			_		C 19/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				12	264 AIRPORT ROAD			
AUTUMIN	CARE OF MARION			Μ	IARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 313	be sure he heard what not indicated or desired Interview with Nurse A 4:16 PM revealed she #27 having hearing ait hard of hearing. Interview with NA #4 of revealed that Resider hearing and staff had hear what they wante On 11/16/17 at 2:11 P conducted with NA #6 and transported many appointments regulard were appointment she for nurses to complete with an order for a con- ordered a consult. She these appointment she with making requested arranging transportation consult report and if a was noted as being me subsequently schedul She further stated she to the appointment on checked and found no sheet being filled out obtain hearing aids. A was present during th she did not know any appointment being ne On 11/16/17 at 2:36 F	at was said. A consult was ed at this time. Aide (NA) #2 on 11/14/17 at a was unaware of Resident ds and stated he was very on 11/15/17 at 5:45 AM at #27 was extremely hard of to yell at him to get him to d him to do. PM an interview was b who made appointments y residents to their ly. She explained there eets at each nursing station e if a resident was admitted nsult or their physician he stated that she reviewed eets daily and followed up d appointments and on. If NA #6 took the tment, she returned with a in additional appointment eeded she would le the new appointment. e did not take Resident #27 n 09/11/17. She also o record of an appointment by nursing for a follow up to A second transporter, NA #7 is interview and also stated thing about a follow up eeded. PM, NA #6 stated that	F	313				
	was present during th she did not know any appointment being ne On 11/16/17 at 2:36 F	is interview and also stated thing about a follow up reded.						

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/21/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345165	B. WING		C 11/19/2017
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 313	Continued From page overlooked, she had j appointment in Janua		F 31	3	
	stated that she noted recommendations for nursing notes. She re to reach via phone the been very hard to get then passed the infor She stated it was prov	bilateral hearing aids in the ecalled trying unsuccessfully e responsible party who had a hold of via phone and mation onto the next shift.			
F 323 SS=D	at 3:54 PM verified th	be filled out so that follow could be made by the SION/DEVICES	F 32	3	12/22/17
	from accident hazard (2) Each resident reco	ronment remains as free			
	appropriate alternativ bed rail. If a bed or s must ensure correct in	ails, including but not limited			

Facility ID: 922951

If continuation sheet Page 124 of 170

STATE INFORMATION OF CONSIDERING AND THE STATE AND RESIDENCE AND PLAN OF CONSIDERT OF SUPPLY DOI: 100 (100 (100 (100 (100 (100 (100 (100		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
Jump Composition Supervises Jump Composition Supervises <t< td=""><td>STATEMENT (</td><td>OF DEFICIENCIES</td><td>(X1) PROVIDER/SUPPLIER/CLIA</td><td></td><td></td><td>CONSTRUCTION</td><td colspan="2">COMPLETED</td></t<>	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	COMPLETED	
AUTURN CRE OF MARION 1284 ARPORT ROAD MARION PC 201528 1284 ARPORT ROAD MARION PC 201528 0(9) [0] PREFIX TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE CREATED IN SILL) [0] PREFIX TAC [1] PREFIX TAC [1] PREFIX TAC [1] PREFIX TAC [2] PREFIX TAC [2] PREFIX TAC [2] PREFIX TAC [2] PREFIX TAC [2] PREFIX PREFIX [2] PREFIX TAC [2] PREFIX PREFIX [2] PREFIX TAC [2] PREFIX PREFIX [2] PREFIX PREFIX [2] PREFIX PREFIX [2] PREFIX PREFIX [2] PREFIX			345165	B. WING _				
MARION, NC 28752 OWNED TAG Summary stratement of deficiencies (pace deficiency wust of expected per visu. Resultation values of expected per visu. Resident #38 was admitted to the facility on typertension. Review of the fail care plan initiated on 05/02/16 reviewed for fail and remained at risk for fails due to advanced age, independent ambulation and multiple co-motify metci. Review of the fail care plan initiated on 05/02/16 reviewed for fails verse and will be follow-up in clinical rounds and fail interventions to review of the reviewed for hall and remained at risk for fails were in exprise and multiple co-motify metci. Review of the fail care plan initiated 05/02/16 reviewed for reparation for fails were reviewing care plans and xardex to idex were in exprise plans directed planed review of the sist then fealling of the resident sist for fails by the Interdisciplinary Team on 12/8/17. The Interesed on the planed review of the sist of the resid	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
Description BARDAN, NC 28752 PREFIX TAG SUMMARY STATEMENT OF DEFICENCES (EACH CORRECTION FULL BEFREEDES FULL REGULATORY OR LSCIDENTIFYING INFORMATION) D D DEFICIENCY TAG CORRECTION (EACH CORRECTION FULL PREPOPERATE DEFICIENCY) CORRECTION FULL PREPOPERATE DEFICIENCY CORRECTION FULL PREPOPERATE DEFICIENCY CORRECTION FULL PREPOPERATE DEFICIENCY CORRECTION FULL PREPOPERATE DEFICIENCY CORRECTION					1:	264 AIRPORT ROAD		
Price IEACH DEFICIENCY MOLIDE COMPLETION PREFIX TAC IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OF THE APPROPRIATE COMPLETION F 323 Continued From page 124 F 323 F 32	AUTUMN	CARE OF MARION			N	IARION, NC 28752		
(1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident regresentative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This RECUIRENENT is not met as evidenced by: Based on observations, record review, and staff interventions of a nonskid mat in the bathroom, toileting after meals and a nonskid mat in the wheelchair to prevent fails for 1 of 8 residents reviewed for falls (Resident #38). The findings included: Resident #38 was admitted to the facility on 12/08/06. Her diagnoses included numbulation and multiple co-morbid medical diagnoses and antidepressant use. The goal was for Resident #38 to have no fall related nignoses and antidepressant use. The goal was for Resident #38 to have no fall related ingroups and multiple co-morbid medical diagnoses and antidepressant use. The goal was for Resident #38 to have no fall related ingroups and multiple co-morbid medical diagnoses and antidepressant use. The goal was for Resident #38 to have no fall related injuries requiring hospitalization through next review. This goal was indited of 05/02/16. Interventions included: F323 Review of the fail care plan initiated on 05/02/16 revealed she had an actual fail and remained at risk for falls due to lack of galls by the Interdisciplinary Team on 12/8/17. The licensed nurse aides were in-serviced by Director of Nursing (DON) Administrator/Designee on reviewing care plan and Kardex to iderview. This goal was initiated 05/02/16. Interventions included: Treview of the fail care plan initiated on 05/02/16 revealed by had an actual fail and remained at ris	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to initiate planned interventions of a nonskid mat in the bathroom, toileting after meals and a nonskid mat in the wheelchair to prevent fails for 1 of 8 residents reviewed for fails (Resident #38). F323 The findings included: F323 Resident #38 was admitted to the facility on 12/08/08. Her diagnoses ind and the fail inter, major depressive disorder, anxiety, and hypertension. F323 Review of the fail care plan initiated on 05/02/16 insk for fails due to advanced age, independent ambutation and multiple co-morbid medical diagnoses and antidepressant use. The goal was for Resident #38 to have no fail related injuries requiring hospitalization through next review. This goal was nititated 05/02/16. Interventions included: F323 Review of the fail care plan initiated on 05/02/16 injuries requiring hospitalization through next review. This goal was initiated 05/02/16. Interventions included: F323 Review of the fail care plan and tardified meaning and risk for fails use to advanced age, independent ambutation and multighe co-morbid medical injuries requiring hospitalization through next review. This goal was initiated 05/02/16. Interventions included: Care plans for resident's r	F 323	Continued From page	e 124	F	323			
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*frequent safety reminders and verbal cues to allow staff to assist when feeling weak or to assist12/8/2017.The Interdisciplinary Team will review new		review. This goal was	s initiated 05/02/16.					
allow staff to assist when feeling weak or to assist The Interdisciplinary Team will review new								
with dressing (initiated 12/19/16):			-				new	
*maintain call light in easy reach (initiated initiated							dav	

Facility ID: 922951

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/21/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				12	264 AIRPORT ROAD		
AUTUMN	CARE OF MARION			М	IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	05/02/16); *bed in lowest positio *monitor ambulation a assistance with activi resident is generally i 05/02/16); *nonskid mat at beds *nonskid socks at bed The quarterly Minimu 04/03/17 coded her w cognition, and needin bed mobility and trans with no injury since the Review of the inciden 05/29/17 at 8:30 AM Resident #38 calling to in the floor on her but wheelchair and the be trying to get back in b revealed she had rem transfer back to bed. was to place a dycern wheelchair seat. A quarterly MDS date #38 with decreased of severely impaired cog extensive assistance transfers. She was n injuries since previou A significant change I her with severely imp extensive assistance	en (initiated 05/02/16); ability and need for ties of daily living skills as independent (initiated ide (initiated 07/02/16); and dtime (initiated 12/14/16). Im Data Set (MDS) dated with moderately impaired ng limited assistance with sfers and having had a fall ne last assessment. It report for a fall dated revealed the nurse heard for help and found her sitting ttocks between the ed. Resident stated she was bed. The investigation noved her shoes and tried to At this time the intervention in (nonskid surface) in the ed 06/30/17 coded Resident cognition, now having gnition and needing with bed mobility and loted with 1 fall and no s assessment. MDS dated 07/26/17 coded vaired cognition, and needing with bed mobility and had no falls since the	F	323	morning clinical meeting, as well as, weekly resident risk review meeting to ensure care plan and Kardex are upd to reflect current resident status include interventions this will be an ongoing process. The Department heads will monitor that interventions for fall redu are in place as identified on the fall ca- plan as part of the management round Any newly hired Department Heads a 12-08-2017 will be educated on the al process. Department Heads/Designee will mor for fall interventions being present dur management room rounds 2 x a week 1 month and then once a week for 2 months to validate fall interventions an place. The results of the audits will be forward to the facility monthly Quality Assuran Performance Improvement committee months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	ated ling ction re ds. fter bove itor ing i for re in ded ce	

If continuation sheet Page 126 of 170

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF P	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	dated 08/08/17 stated age, cognitive deficits diagnoses and used a these risks she had n good safety awarenes be developed. Review of the care pla interventions since 20 bathroom light on for safety (initiated on 03 added to the care pla On 10/12/17 a quarte assessed with impaire memory and severely ability (the previous b status was not succes experienced no falls a assistance with bed n Interview with the MD 11:44 AM revealed th always carry over the via looking at her care meals and as needed interventions on 10/20 Per the incident repor 10/25/17 at 2:47 AM. hollering and she was in the bathroom betwo The immediate action toileting on care round in the bathroom. This to the care plan.	sment (CAA) relating to falls d that she had advancing and multiple co-morbid antidepressants. Despite o recent falls and exhibited as daily. A care plan would an revealed the only added 016 was to leave the a nightlight to increase /13/17). The dycem was not n. rly MDS noted she was ed short and long term r impaired decision making rief interview for mental safully used). She had and required extensive mobility and transfers. PS nurse #1 on 11/17/17 at at the computer did not interventions. She noted e plan that toileting after was added to the	F	323	3		

If continuation sheet Page 127 of 170

	-	ID HUMAN SERVICES				FORI	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3		PLETED
		345165	B. WING				C / 19/2017
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD		
					MARION, NC 28752		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	 11/14/17 at 8:18 AM, 11/17/17 at 10:39 AM skid mat in the bathroo Resident 38's roomm quarterly MDS dated intact cognition) state that she has never see bathroom. Interview with the hout 8:12 AM revealed she housekeeper for Resi could not recall any n bathroom. b. Observations made 11/14/17 at 10:40 AM 11/16/17 at 8:05 AM a dycem was observed taking room. At 1:05 PM, Re using the toilet alone with NA #13 on 11/15 she took Resident #33 she normally did not st the trays were picked resident was able to t she was not familiar wher second day. At 1 observed to independ down. Review of the Kardex reference on individual state of the tardex reference on target of the tardex reference on target of the tardex reference on the tardex reference on target of the target of the tardex reference on target of the target	on 11/16/17 at 8:05 AM, and revealed there was no anti- iom adjacent to her room. ate (Resident #122 with her 10/27/17 coding her with d on 11/16/17 at 8:05 AM een a nonskid mat in the usekeeper #2 on 11/16/17 at e was the normal dent #38's room and she on-skid mat in the e on 11/13/17 at 11:05 AM, , 11/15/17 at 12:13 PM, and 11/18/17 at 11:33 AM no being in the wheelchair. 2 PM Nurse Aide (NA) #13 Resident #38 down to her esident #38 was observed in the bathroom. Interview /17 at 1:06 PM revealed that 8 down to her room but that start toileting until after all up. When asked if the oilet herself she stated that with the resident #38 was lently walk to her bed and sit	F	32:			
	reference on individua toileting was to be ofference	-					

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ENTER	S FOR MEDICARE 8					<u>IO. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION		TE SURVEY MPLETED
		345165	B. WING		1	C 1/19/2017
IAME OF PF	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP C		
	CARE OF MARION		120	64 AIRPORT ROAD		
			MA	ARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 323	Continued From page	ne 128	F 323			
	· · ·	eelchair or the mat in the	1 020			
	11:44 PM revealed to every weekday mor completed to ensure place. She was una mat, toileting after n the bathroom was n also stated that whe is complete, she up aides were provided	DS Nurse #1 on 11/17/17 at that fall reports are reviewed ning and risk rounds are e planned interventions are in able to say why the dycem heals and the nonskid mat in ot put into the care plan. She en she ensures the care plan dated the Kardex so nurse I the necessary information. unaware of these planned				
F 329 SS=J	11/18/17 at 5:26 PM nurse put in immedi facility holds a fall h investigate the spec up with interventions circumstances of the responsibility to ens put into place. ADC initiated the interver care plan which will the nurse aides' Kar the interventions to place for Resident # DRUG REGIMEN IS	ctor of Nursing (ADON) on I revealed that after a fall, the ate interventions. Then the uddle in which staff ifics of the incident and come is pertinent to the e fall. It has been the DON's ure needed interventions are on stated the nurse who ation should place it on the then automatically put it on rdex. He stated he expected be in the care plan and in 38. S FREE FROM RUGS	F 329			12/22/17
	483.45(d) Unnecess Each resident's drug unnecessary drugs.	g regimen must be free from				

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/21/2017 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
			A. BUILDI				c
		345165	B. WING			11/	19/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ΔΗΤΗΜΝ	CARE OF MARION			12	264 AIRPORT ROAD		
AUTOMIN				Μ	IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	e 129	F	329			
	drug when used						
	(1) In excessive dose therapy); or	(including duplicate drug					
	(2) For excessive dur	ation; or					
	(3) Without adequate	monitoring; or					
	(4) Without adequate	indications for its use; or					
		adverse consequences se should be reduced or					
		of the reasons stated in bugh (5) of this section.					
	483.45(e) Psychotrop Based on a comprehe resident, the facility m	ensive assessment of a					
	drugs are not given the medication is necessary	-					
	gradual dose reduction interventions, unless an effort to discontinu This REQUIREMENT by: Based on record revi	clinically contraindicated, in			F 329 It was identified during the survey proc	ess	
	time of a resident's bl	-			that the admitting nurse did not transcr		

Facility ID: 922951

If continuation sheet Page 130 of 170

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		ATE SURVEY
			A. BUILDING			С
		345165	B. WING			11/19/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		11/13/2017
				1264 AIRPORT ROAD		
AUTUMN	CARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 329	Continued From pag	e 130	F 32	0		
1 020			F 32		onitor eletting	
		missed four times that ed bleeding time for 1 of 3		a standing order for lab to m time for Resident #139. Res	-	
		n Warfarin (blood thinner)		longer resides in the facility.		
		39). Resident #139 admitted		order for labs was obtained		
		eceived treatment to reduce		director and the orders for co	•	
	his elevated bleeding			transcription on new admiss	ion and new	
				orders will be monitored in c	linical	
		began on 10/21/17 when		morning meeting.		
		the blood clotting time of		Residents with warfarin orde		
	Resident #139, who			audited for correct transcript		
		the resident's standing		for INR related to warfarin.		
	11/19/17 when the fa	eopardy was removed on		negative findings based on t standing order for completio		
		ble allegation of compliance.		residents admitted with orde		
		but of compliance at a lower		was obtained from the Medic		
		evel of D (Isolated no actual		11/17/17 by the Director of N	lursing.	
		ial for more than minimal		Nurses were in serviced 11/		
		ediate Jeopardy) to ensure		12/8/17 on standing order fo	r INR. Orders	
	monitoring of system	• •		of new admission and orders		
	completion of employ	/ee training.		previous 24 hours will be rev		
				weekday morning clinical me		
	The findings included	1:		hired nurses after 12-08-201		
	Resident #130 was a	admitted to the facility on		educated on the above proc Nursing Management staff w		
		ses of acute respiratory		audits of residents receiving		
	failure, Myasthenia			weekly x 3 months to validat		
	duodenal ulcer, and			transcription of INR orders in		
				Care and Coumadin flow she		
		#139's History and Physical		also continue with review of		
	from the hospital date			weekday morning clinical me	-	
		series of hospitalizations.		Results of the audits will be		
		9/10/2017 after being		the facility monthly Quality A		
		nal bleed while on Xarelto (a		Performance Improvement of		
		as transfused a total of 4 that stay. Resident #139 was		months for further review an recommendations.	u	
		itted on 10/02/17 with a		The title of the person respo	nsible for	
		embolism with low clot		implementing the acceptable		
		t lower lobe infiltrate. He was		correction is the Administrate	•	
	seen by hematology					

Facility ID: 922951

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
		345165	B. WING				C / 19/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 329	10/07/17 and reported 10/10/17 for weakness didn't say what date t Warfarin but he was of mg as below. Review of the hospita 10/18/17 revealed the Resident #139 was as check International N (laboratory test to che goal INR 2-3. Review of the hospita 10/18/17 revealed Re anticoagulation therap the Facility Physician 10/21/17. The INR on target INR of 2-3. Review of the care pla Resident #139 receiv goal for no complicati use. The interventions medications as order changes. Monitor for internal/external bleed ordered. Protect from Review of the admisss dated 10/25/17 revea moderately cognitivel	to (blood thinner) to er). He was discharged on d back to hospital on ss. The hospital records he Lovenox was changed to discharged on Warfarin 10 al discharge summary dated e impression/plan for s follows: continue Warfarin, ormalized Ratio (INR) daily eck clotting time of blood), al discharge summary dated esident #139's py would be monitored by . The next INR was due a 10/18/17 was 1.9 with a an dated 10/18/17 revealed ed anticoagulant use with a ons related to anticoagulant s included: administer ed. Monitor for behavior signs and symptoms of ding. Monitor labs as injury. tion Minimum Data Set led Resident #139 was y impaired and received the assessment period.	F	329			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	
		345165	B. WING				
	ROVIDER OR SUPPLIER		ł		STREET ADDRESS, CITY, STATE, ZIP CODE 1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 329	INR will be performed receiving Warfarin. If admission or is starte be performed every of every other week x 4, otherwise ordered by Review of the facility Resident #139 from 1 revealed the following Warfarin 10 millig for anticoagulation the No orders for INF Review of the facility revealed the INR was result of 2.1 with no c 10 mg once a day. Resident #139 misser 10/23/17, 10/25/17 ar orders. Review of a nurse's m PM revealed Residen breath and a dark pur on his inner right calf. and an order was rec sent to the emergenc treatment. Review of a hospital of 10/28/17 revealed Residen the ED on 10/27/17 for edema with extensive family member report	I monthly on all residents a resident is receiving upon d on medication, an INR will ther day for 1 week, then then monthly, unless MD. physician orders for 0/18/17 through 10/27/17 g: grams (mg) every afternoon erapy. R testing. PT/INR/Warfarin Flowsheet c checked on 10/19/17 with a hange in orders for Warfarin d INR checks on 10/21/17, nd 10/27/17 per the standing ote dated 10/27/17 at 4:38 it #139 reported shortness of rple raised area was noted The physician was notified eived for Resident #139 to y room for evaluation and discharge summary dated asident #139 presented at or bilateral lower extremity e bruising and confusion. A	F	329	9		

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345165	B. WING		_		C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF MARION			264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	extensive bruising of large hematoma on the and bruising on his le hospital laboratory tes 7.8 on 10/27/17. The Warfarin, give Vitamir reverse Warfarin), and Plasma (a blood prod portion of whole blood swelling of the hemath transferred to a larger respiratory distress on Review of a hospital a Physical dated 10/28/ was seen in the Emer shortness of breath a clots. The report state 7.8 and a large centra his INR. He responder was given 2 units of F An interview conducted with the facility physic Resident #139's INR during his stay at the therapeutic range. He been checked after th any result above 3 or called to him. He furth expectation for the nu orders for the INR che the results called to h unaware Resident #1	dical history they had on. The Physician noted the right lower extremity, a ne top of of his right foot, ft foot. Review of the st results revealed an INR of plan was to hold the n K (a medication used to d consider Fresh Frozen uct made from the liquid d) if there was further oma. Resident #139 was tocal hospital due to n 10/28/17. Admission History and 17 revealed Resident #139 regency Room for swelling, nd a concern of possible ed his INR was elevated at al line was placed to correct d partially to Vitamin K and Fresh Frozen Plasma. ed on 11/17/2017 at 4:20 PM cian revealed he reviewed one time (on 10/19/17) facility and it was in the e stated the INR should have hat per standing orders and below 2 should have been ner stated it was his inses to enter the standing ecks to be completed and	F 329				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND FLAN OF	CORRECTION	IDENTIFICATION NOWIBER.	A. BUILD	ING .			C
		345165	B. WING				0 /19/2017
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD		
					MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 329	with Nurse #2 revealed to 7:00 AM shift on the admitted to the facility 11:00 PM nurse enter admission orders into stated when a new re Warfarin the standing into the computer for for a week then 1 time then once a month. Se enters the admission standing order for INF Warfarin. She stated have been entered for other day INR checks on Warfarin. She furth administered Resider never checked his INF An interview conducted with Nurse #3 revealed #139 on 10/18/17 and computer. She stated Warfarin 10 mg in the put the standing order checks in the computer have put the order for Warfarin order but over stated she had admin Warfarin but had never A follow up interview of 9:17 AM with the facil INR value of 7.8 was the INR checks been avoided.	ed on 11/17/2017 at 6:44 PM ed she worked the 11:00 PM e night Resident #139 was y. She stated the 3:00 PM to red all of Resident #139's the computer. Nurse #2 esident was admitted on orders should be entered INR checks every other day e a week for 4 weeks and the stated the nurse that orders should enter the R checks if they are on INR standing order should r Resident #139 for every s because he was admitted her stated she had ht #139's Warfarin but had R. ed on 11/17/17 at 7:00 PM ed she admitted Resident d put his orders in the she put his order for e computer but she did not r for every other day INR er. She stated she should r INR checks with the erlooked it. She further histered Resident #139's	F	329	9		

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/2017 APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345165	B. WING				C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 329	with the Director of Newas the nurse admitti to enter the standing of done if the resident with the Risk Round Team Administrative Nurses orders every morning the order was missed INR. He stated the IN checked every other of week for 4 weeks the An interview conducter 11/19/17 at 7:30 AM r expectation for the ad standing order for INF admitted on Warfarin. know how the order with Round Checks. She finave been checked ef then once a week for month. The Administrator, DC Director of Clinical Se Immediate Jeopardy of On 11/19/17 at 4:56 F following Credible Alle F329 Unnecessary M The Plan of Correctin Resident # 139 was a 10/18/17. Resident with admission. Licensed I policy for transcribing	ursing (DON) revealed it ng the resident responsibility orders for INR checks to be as on Warfarin. He stated that consisted of a checked all new admission and he did not know how to check Resident #139's R should have been day for 1 week then once a n once a month. ed with the Administrator on evealed it was her mitting nurse to put in the R checks for residents She stated she did not vas missed during Risk urther stated the INR should very other day for a week 4 weeks then once a DN, and the Regional rivices were informed of on 11/19/17 at 1:11 PM. PM, the facility provided the egation of Compliance: edication Use g the specific deficiency dmitted to this facility on	F	329	9		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		LETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	to identify the missed INR orders. As a resu Resident #139's INR 10/21/17, 10/23/17, 11 Resident #139 was he found to have an elev The Procedure for Im Plan of correction for All resident that receiv potential to be affecte "An audit was comple of Nursing of current in Warfarin to validate IN Click Care (PCC) and (Warfarin) flowsheet. to monitoring. "An audit was comple nurse of residents. Ac 11/19/17 to validate IN Click Care (PCC) and (Warfarin) flowsheet. to monitoring. "On 11/17/17 manage re-educating nurses of as it relates to transcr ordering of lab for INF is complete as of 11/1 "Education with Nurse 11/17/17. "To prevent this from 1 nurse will enter the or	transcription of the standing lt, facility failed to monitor on four occasions including; 0/25/17 and 10/27/17. ospitalized on 10/27/17 and rated INR level of 7.8. plementing the Acceptable the specific deficiency cited. ve Warfarin have the d. ted on 11/17/17 by Director residents currently receiving NR orders entered in Point I on the PT/INR/Coumadin No negative findings related ted on 11/19/17 by licensed dmitted from 10/18/17 - NR orders entered in Point I on the PT/INR/Coumadin No negative findings related ement staff began on the policy and procedure iption of orders including R monitoring. Re-education	F	329			

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		LETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MARION				I264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	"The transcription of t the flowsheet will ther nurse on the same sh "To complete validation administrative nurses of Warfarin orders in I on a flowsheet and or administration record morning risk meeting. The monitoring proce Correction is correcte cited remains correcte cited remains correcte regulatory requirement "Nursing management residents with orders validate transcription PCC TAR and to the fl discrepancies will be the prescribing physic "In addition nursing ma weekly results of INR Physician of abnormator The title of the person implementing the acc the Director of Nursin Date of Alleged Comp Immediate Jeopardy of 5:38 PM when intervious	he order and placement on a be validated by a second iff. on of accuracy, the will review the transcription PCC and placement of INRs a the PCC treatment (TAR) as part of weekday dure to assure the Plan of d and the specific deficiency ed and in compliance with ats. at will complete an audit of for Warfarin 3 x weekly to of INR standing orders into flowsheet. Any identified corrected immediately and cian will be notified. management will audit 3x s to validate notification of al INRs results. a responsible for eptable plan of correction is g and Administrator. pliance is: 11/19/17 was removed on 11/19/17 at ews with Nurses confirmed service training on how to a for INR checks for	F	329			

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TATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3)	B NO. 0938-039 DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER.	A. BUILD	NG			C	
		345165	B. WING			11/19/2017		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MARION		1264 AIRPORT ROAD		64 AIRPORT ROAD ARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 353	Continued From page	e 138	F	353				
F 353 SS=J	SUFFICIENT 24-HR NURSING STAFF PER			353			12/22/17	
	483.35 Nursing Servi	ces						
	the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil accordance with the at §483.70(e). [As linked to Facility / be implemented beging (Phase 2)]	must have sufficient nursing staff with riate competencies and skills sets to rsing and related services to assure fety and attain or maintain the highest physical, mental, and psychosocial of each resident, as determined by sessments and individual plans of care ering the number, acuity and of the facility's resident population in e with the facility assessment required (e). o Facility Assessment, §483.70(e), will ented beginning November 28, 2017						
	sufficient numbers of of personnel on a 24- nursing care to all res resident care plans:	sidents in accordance with						
	(i) Except when waive this section, licensed	ed under paragraph (e) of nurses; and						
	(ii) Other nursing personal (iii) Other nursing personal limited to nurse aides	sonnel, including but not						
	this section, the facili	aived under paragraph (e) of ty must designate a licensed harge nurse on each tour of						

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		345165	B. WING			C / 19/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1264 AIRPORT ROAD		
AUTUMIN	CARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 353	Continued From page	9 139	F 3	53		
	(a)(3) The facility must nurses have the spect sets necessary to carridentified through resident described in the plan (a)(4) Providing care if assessing, evaluating resident care plans ar needs. This REQUIREMENT by: Based on observation interviews, family inte the facility failed to pro- care for 8 of 14 samp #27, #28, #46, #66, # The facility failed to as number to prevent ab incontinence care, toi training to agency sta their responsibilities for up, and make assign aware of the individua for residents relating to nurse aide threw a me to staffing frustrations meal tray hit Resident her wheelchair nearby permitted to continue	et ensure that licensed ific competencies and skill e for residents' needs, as dent assessments, and of care. includes but is not limited to , planning and implementing nd responding to resident's ' is not met as evidenced ns, record reviews, resident rviews, and staff interviews, ovide sufficient staffing to led residents (Residents 71, #79, #123, and #174). ssign nurse aides in the use, provide residents with leting, and showers, provide ff so they were aware of or personal care and tray set nents so nurse aides were al residents and care needed to toileting and showers.		F353 During the annual survey process identified the facility did not provi sufficient nursing staff to prevent abuse,provide incontinence care, toileting,showers and did not prov training to agency staff so they w aware of their responsibilities for care and tray set-up. The facility has a new staffing init recruit additional staffing. the Department Managers mornin meeting staffing will be reviewed ensure sufficient nursing staff is scheduled. The designated 300 f charge nurse and/or Manager on contact the RN on call if there is a with sufficient staffing on the wee Adjustment of resources will be n	de vide ere personel itative to During ng to nall Duty will an issue kends. nade as	
	F223 and F226 was r the facility provided an Allegation of Immedia	ediate Jeopardy for tags emoved on 11/19/17 when nd implemented a Credible ite Jeopardy Removal. of compliance at a lower		needed and department heads/ni management/ancillary staff will be assigned duties that they are able perform if needed. The facility will call in staff and/or agency staffing if needed in order	e e to r utilize	

Facility ID: 922951

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/21/2017 MAPPROVED D. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345165	B. WING			C 11/19/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752			
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE	
TAG	REGULATORT OR L	SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)			
F 353	Continued From page	140	F	353				
	with the potential for r	E (Pattern no actual harm nore than minimal harm that			maintain consistent sufficient staffing.			
		bardy) due to example #3, and #6 are at the scope			To monitor and maintain ongoing compliance the department managers	will		
	•	solated no actual harm with than minimal harm that is			complete interviews with 3 residents 32 week, 3 residents weekly x4 weeks, ar			
	not Immediate Jeopar	dy).			then 3 residents monthly x1 month to ensure there are no issues related to c	are		
	The findings included	:			and staffing. Any negative findings wil addressed immediately to the	be		
	1.Cross Refer to F223 Based on record revie	3: ww, resident interview, and			administrator. The results of the audits will be forward	led		
	staff interviews, the fa	cility failed to provide an ntained 1 of 3 residents'			to the facility Quality Assurance Performance Improvement meeting for	3		
	right to be free from a				months for further review and recommendations.			
	2.Cross Refer to F226				The title of the person responsible for			
	facility failed to impler	ew, and staff interviews, the nent their abuse policy and			implementing the acceptable plan of correction is the Administrator.			
	-	the prevention, protection of 3 residents (Resident						
	#71 who were reviewe	ed for abuse investigations.						
	The Administrator and were informed of Imm 11/16/17 at 6:18 PM.	l Regional Clinical Nurse ediate Jeopardy on						
		in acceptable credible te jeopardy removal on as follows:						
	The plan of correcting	the specific deficiency.						
	The plan should addre to the deficiency cited	ess the processes that lead						
	Nurse aide (NA)#2 wa	identified on 10/23/17 as not removed from her nen she became upset and						

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	resident's meal tray. 1 #71 being hit with objito continue working b Nursing. When identifioutburst by the NA, sl being frustrated related Administrator implement 10/24/17 related to su sufficient staff with the Human Resource Ma nursing and nurse aid and licensed nurses at 10/24/17 a. Since 10/24/17 we applications and hired b.	Ig a computer mouse and a This resulted in Resident ect and NA#2 was allowed efore calling the Director of fying the root cause of the he stated it occurred due to ed to inadequate staffing. ented a staffing initiative on ufficient nursing services and e following elements: nager Evaluate Current le Vacancies nurse aides and Update log weekly have received 16 NA d 15 of those applicants. have received 7 nurse d 5 of those applicants. ector of Nursing evaluated overstaffing on day shift, night shift and understaffing fing was adjusted by er schedule to even out the evenings 10/24/2017.	F	353			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
A					1264 AIRPORT ROAD		
AUTUMN	CARE OF MARION				MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	bonus \$650.00/\$500. Administrator implem	00-10/26/2017. ented shift bonus for nurses	F	353	3		
	shifts on 08/28/17.	s for those picking up extra					
	local community colle assistant student who or who to desires to a	This is a contract with the ge to sponsor a nursing b is attending their program ttend the program. Facility ooks, and certification test in					
	daily staffing call to di recruitment effort Adn	ional support staff attend scuss needs and ongoing ninistrator implemented and increase 11/10/2017.					
	Administrator placed advertising for NAs or	signs throughout community n 11/10/2017.					
		plementing the acceptable the specific deficiency cited.					
	department managers (MOD) policy and Dep MOD will be impleme process is new to the management/adminis weekends both sched on the needs of the co	duled and at random based enter, to include					
	allegations of abuse with immediately by the M Administrator and the	OD who will notify the Director of Nursing. The 0 hall is the designated					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF P	ROVIDER OR SUPPLIER	L		\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	Residents were intervidepartment managers staffing. No new neg identified. To prevent this from r and Director of Nursin Regional Vice Preside Sufficient Staffing and The facility will contin indicated above and v staffing meeting to as staffing is available do meet the resident's ne resources will be mad department heads/nu staff will be assigned perform if needed.	ately of any staffing e potential to be affected. viewed on 11/17/17 by facility is regarding care related to ative findings were ecurring the Administrator ng were educated by the ent of Operations regarding d ongoing staffing plan. ue with the staffing initiative will continue to have a daily sure sufficient nursing uring morning meeting to eeds. Adjustment of de as needed and rsing management/ancillary duties that they are able to available staff if needed and	F	353	,		
	related to care and st forms will be reviewed related to care and st resolved by the Admin Nursing.	istrator to identify any issues affing. Resident concern d daily to ensure any issues affing are investigated and nistrator and the Director of					
	of correction is effecti	dure to ensure that the plan ve and that specific ins corrected and/or in					

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	APPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
	345165	B. WING _				C 19/2017
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			12	264 AIRPORT ROAD		
AUTUMN CARE OF MARION			Μ	IARION, NC 28752		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
 department managers 3 residents 3 x week x monthly x 1 to ensure to to care and staffing. A addressed immediately The results of the audit facility Quality Assurant Improvement meeting recommendations. The Administrator will of Assurance Performance on 11/17/17 with the fathe Regional Team and review. The title of the person implementing the acce the Administrator. Date of Alleged Compling Immediate Jeopardy w when observations and confirmed the facility has the master schedule to shifts was evenly distri- actual assignments for Confirmation was obta engages contracts for a aide vacancies and that implemented. The faci- confirmed the hiring of 	gulatory requirements. in ongoing compliance the will complete interviews on 4 weeks, weekly x 4 then there are no issues related iny negative findings will be y to the administrator. ts will be forwarded to the ice Performance for further review and conduct an Ad HOC Quality be Improvement meeting icility Interdisciplinary team, d the Medical Director to responsible for ptable plan of correction is iance is 11/19/17 d interviews with staff ad made adjustments in o assure that staffing on all buted and staff were given covering resident care.	F	353			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	
		345165	B. WING				
NAME OF PF	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 353	 appropriate nursing soversight. 3. Cross refer to F312 Based on observation interviews the facility care (Resident #2' assistance with tray so of 11 sampled residend daily living. 4. Cross Refer to F22 Based on observation interviews, the facility incontinence care wh sampled residents (R 5. Cross Refer to F24 Based on observation interviews, the facility incontinence care to 3 resulting in 2 resident eating while wet with (Resident #79) reque forgotten by staff. 6. Cross Refer to F24 Based on record revie interviews, the facility with their preferred nu 3 of 5 resident review #46, #66, and #174). 	 Manager On Duty expectation of obtaining taff coverage during their 2: hs, record reviews, and failed to provide incontinent 7, #28, and #79) and het up (Resident #123) for 4 hts reviewed for activities of 24: hs, record reviews and staff failed to provide en needed to 3 of 12 esidents #27, #28, and 79). 41: hs, record reviews and staff failed to provide a of 12 sampled residents is (Resident #27 and #28) urine and 1 resident's st for incontinence care 42: hs, record reviews and staff failed to provide a of 12 sampled residents is (Resident #27 and #28) urine and 1 resident's st for incontinence care 42: https://www.and.com/incontec/and/or failed to provide residents' unber of showers a week for red for choices (Resident 	F	35:	3		
	Assistant Director of I DON by the Administr						

ND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		E SURVEY PLETED
		345165	B. WING		11	C / 19/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
	CARE OF MARION			1264 AIRPORT ROAD		
	SARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 353	Continued From page	e 146	F 35	53		
F 356 SS=B	summer when staff w and a proposal was r salary adjustment wh month. The Acting D previous DON came 2017 she started a tr dot" system for cover absences which the r like either. As a resu interview further reve NAs on the 7:00 AM the 3:00 PM to 11:00 7 NAs on the 11:00 F which had become di September 2017 esp night shifts. The Acti covered the schedule early or stay over, tra for extra shifts, and h assignment. The Act stayed more times th there was not adequa Currently, the facility filled and had a contr NAs. He indicated th orientation the follow	AFFING INFORMATION -(4)	F 35	6		12/22/17
	(1) Data requirement the following information	nts. The facility must post tion on a daily basis:				
	(i) Facility name.					

Facility ID: 922951

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345165	B. WING				C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	13/2011
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD		
					MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 356	Continued From page	9 147	F	356	5		
	by the following categ	aff directly responsible for					
	(A) Registered nurses	3.					
	(B) Licensed practical vocational nurses (as	I nurses or licensed defined under State law)					
	(C) Certified nurse aid	des.					
	(iv) Resident census.						
	(2) Posting requireme	ents.					
		ost the nurse staffing data h (g)(1) of this section on a inning of each shift.					
	(ii) Data must be post	ed as follows:					
	(A) Clear and readabl	le format.					
	(B) In a prominent pla residents and visitors	ace readily accessible to					
	The facility must, upo make nurse staffing d	posted nurse staffing data. In oral or written request, lata available to the public ot to exceed the community					
	facility must maintain staffing data for a min	tion requirements. The the posted daily nurse nimum of 18 months, or as , whichever is greater.					

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/21/201 M APPROVE <u>). 0938-039</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		345165	B. WING		11	C / 19/2017
NAME OF PF	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP COD		
	CARE OF MARION			1264 AIRPORT ROAD		
	JARE OF MARION			MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 356	Continued From page		F 35	56		
	This REQUIREMENT	is not met as evidenced				
	Based on review of c	daily nurse staffing data and		F356		
		acility failed to maintain 18		During the annual survey end		
	months of daily nurse	e staming data.		it was discovered that the fac have 18 months of daily poste	•	
	The findings included	:		data.	sa stannig	
	On 11/18/17 at 3:00 F	PM the Assistant Director of				
		ng DON provided the survey		The Director of Nursing has b		
	•	ne daily nurse staffing data Il he was able to locate.		reeducated by the Administra the appropriate storage and r		
	and stated this was a			the daily posted staffing data.		
		ed copies of the daily nurse		will now be stored in a binder	and will be	
	staffing data revealed 01/09/17 through 11/	I the documents were dated 17/17.		maintained for at least 18 mo		
	On 11/19/17 at 8:21 A	AM the Acting DON stated		The Director of Nursing will a binder 2x a week for 4 weeks		
	they had looked in the	e previous DON's office and		for 2 months to ensure the pla	•	
	were not able to locat staffing data prior to 0	te any of the daily nurse		place.		
	stanning data phor to t	51705/17.		The results of the audit will be	e forwarded	
				to the facility Quality Assuran		
				Performance Improvement co 3 months for further review and		
				recommendations.		
				The title of the person respon	sible for	
				implementing the acceptable		
			_	correction is the Administrato	r.	
	THERAPEUTIC DIET PHYSICIAN	PRESCRIBED BY	F 36	57		12/22/17
33-D	CFR(s): 483.60(e)(1)	(2)				
	(e) Therapeutic Diets					
	(a)(1) Thoropoutia dia	ets must be prescribed by				
		els musi de drescrided dv				

Facility ID: 922951

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		ND HUMAN SERVICES			PRINTED: 12/21/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C
		345165	B. WING		11/19/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
	CARE OF MARION			264 AIRPORT ROAD	
			N	IARION, NC 28752	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETIO
F 367	Continued From pag	e 149	F 367		
	(a)(2) The attending	physician may delegate to a			
	registered or licensed				
	prescribing a residen				
	therapeutic diet, to th	e extent allowed by State			
	law.	Γ is not met as evidenced			
	by:	i is not met as evidenced			
		ons, record review and staff		F367	
	interviews, the facility			It was identified during the survey pl	rocess
		ets for 2 of 3 sampled		that Residents #123 and #27 were s	served
		utic diets. Resident #123's		diets not consistent with physician	
	·	followed and Resident #27's		orders.Dietary staff and Housekeep supervisor did not follow the residen	
	thickened liquid diet	was not followed.		orders for pureed diet or thickened I	
	The findings included	1:		All diet orders have been verified for	-
				accuracy and tray cards match the I	M.D.
		s readmitted to the facility on		order. There is also a updated list pe	
		oses included dysphagia,		in the main dining room every morni	
	Parkinson's Disease	and dementia.		staff to verify diets. The dietary man is also monitoring for correct diets b	•
	The guarterly Minimu	um Data Set (MDS) dated		served. Resident #123 was assessed	-
		with severely impaired		Speech Therapist on 11/16/17 and o	-
	cognition, having no			was changed to mechanical soft, ne	
		with all activities of daily		thick. Resident #123 no longer resid	
	nechanically altered	eating and receiving a		facility. Resident #27 diet was confi as thickened liquid. A list of all resid	
		ulet.		diets and consistency is available in	
	Quarterly dietary not	es dated 10/25/17 noted she		room for reference for staff prior to	
		I soft diet and nectar liquids.		providing drink or food to residents.	
		11/01/17 of 40.50 DM -t-t		100% review of diet orders was	
	-	11/01/17 at 12:56 PM stated /as noted choking multiple		completed by the Regional Dietician 11/16/17 to verify current diet orders	
	times on the mechan	•		Point Click Care match dietary tray	
		anged the diet to pureed		Any identified discrepancies were	
	consistency.			corrected immediately.	
				The Dietary Manager and dietary sta	
		ated 11/1/17 noted she was		were in-serviced by Regional Dietici	
	on a pureed texture of	diet.		11/16/17 regarding accuracy of tray	card

Facility ID: 922951

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/21/2017 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345165	B. WING			1'	C 1/19/2017
NAME OF PI	ROVIDER OR SUPPLIER	·		SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MARION			12	264 AIRPORT ROAD		
AUTOMIN				м	IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 367	Continued From page	ə 150	F	367	to motob distant orders in Deist Click		
	on 11/15/17 at 8:38 A meal of scramble egg with thickened milk. accompanied the me pureed consistency a Nurse Aide (NA) #13 noted coughing on pu- were never offered. Resident #123 again breakfast meal on 11 contained a bowl of c Resident #123 began foods. The Speech Therapis 11/16/17 at 9:08 AM. with Resident #123 be being a hospice resid with her Resident #12 diet. She further state permitted for resident On 11/16/17 at 9:12 A interviewed and state have thickened milk of then stated that chee pureed diet if approve Interview with NA #13 was agency staff and she arrived. She state that cheerios should in noted it was on the tra-	al included the need for ind cheerios. At 9:06 AM as tried to feed her she was ureed foods. The cheerios was served a pureed /16/17 at 9:00 AM which heerios with thickened milk. to feed herself the pureed at was interviewed on She stated that she worked efore she transferred to lent. At the time she worked 23 was on a mechanical soft ed that cheerios were not is on a pureed diet. AM the Dietary Manger was ad that cold cereal should on it for pureed diets. She rios would be ok on a ed by the speech therapist. B on 9:36 AM revealed she received no training when ted that she was unaware not be on a pureed diet and ay card. ered Dietician (RD) was			to match dietary orders in Point Click Care. The facility staff who assist in delivery of meals were in-serviced by Dietary Manager and Director of Nurs or designee on 11/15/17 through 12/8/2017 regarding the use of tray ca and diet list to verify diet and consiste prior to serving residents food or drink.Newly hired staff after 12-08-207 will be educated on the above process Dietary Manager will complete audit 6 residents weekly x 3 months comparin diet orders,tray card accuracy, correct being served and availability of diet lis dining room for accuracy. The results of audits will be forwarded the facility monthly Quality Assurance Performance Improvement committee months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	ard ncy 17 s. ng diet t in to	
	Interview with NA #13 was agency staff and she arrived. She staft that cheerios should noted it was on the tr The corporate Regist	B on 9:36 AM revealed she received no training when ted that she was unaware not be on a pureed diet and ay card.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
A 1 171 18451					1264 AIRPORT ROAD		
AUTUMIN	CARE OF MARION				MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 367	diet tray as the physic #123. 2. Resident #27 was 10/31/15 and most re diagnoses included d thrive and dementia. The significant chang 10/22/17 coded him v cognition, eating with mechanically altered Physician orders date receive nectar consis The nutrition Care Are 11/03/17 stated he re regular ground diet w On 11/15/17 at 8:00 A himself into the dining staff member present Housekeeping superv a regular cup of coffe stated that she somet room by opening it up up in the hall waiting residents drinks. She was usually in the din asked how she knew stated she would ask she had questions ab stated she did not kno liquids and would hav further stated that she	vere not to be on a pureed cian ordered for Resident admitted to the facility on cently on 10/15/17. His ysphagia, adult failure to e Minimum Data Set dated vith severely impaired set up only, and receiving a diet. ed 10/31/17 noted he was to tency fluids. ea Assessment dated ceived a no added salt ith nectar thick liquids. M, Resident #27 wheeled g room for breakfast. The in the dining room was the visor. At 8:04 AM, the isor provided Resident #27 e which he drank from. She times helped in the dining o if the residents were lined to enter and offer the e stated that a nurse aide ing room with her. When the residents' diets she dietary or a nurse aide if yout a resident's diet. She ow who was on thickened ve to ask dietary staff. She e was unaware Resident #27	F	367	7		
	regular ground diet w On 11/15/17 at 8:00 A himself into the dining staff member present Housekeeping superv housekeeping superv a regular cup of coffe stated that she somet room by opening it up up in the hall waiting residents drinks. She was usually in the din asked how she knew stated she would ask she had questions ab stated she did not kno liquids and would hav	AM, Resident #27 wheeled g room for breakfast. The in the dining room was the visor. At 8:04 AM, the risor provided Resident #27 e which he drank from. She times helped in the dining o if the residents were lined to enter and offer the e stated that a nurse aide ing room with her. When the residents' diets she dietary or a nurse aide if yout a resident's diet. She pow who was on thickened ve to ask dietary staff. She e was unaware Resident #27					

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM AF	PROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SUR COMPLET	RVEY
		345165	B. WING _			11/19/2	2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIAT		(X5) DMPLETION DATE
F 367	Continued From page	9 152	F	367			
F 371 SS=E	11/16/17 at 9:09 AM t served nectar thick co FOOD PROCURE, S	TORE/PREPARE/SERVE -	FS	371		12/	/22/17
		rom sources approved or ry by federal, state or local					
		ood items obtained directly subject to applicable State lations.					
	facilities from using pr	s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices.					
		es not preclude residents s not procured by the facility.					
		, distribute and serve food in essional standards for food					
	foods brought to resid visitors to ensure safe handling, and consum This REQUIREMENT by: Based on observation facility failed to discar whole milk and 32 car	is not met as evidenced ns and staff interviews the d 34 cartons of out of date		F371 It was identified that the fac date cartons of milk and nu which were disposed on 11	tritional shak		

Event ID: 9KIX11

Facility ID: 922951

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TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		345165	B. WING		C 11/19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETIC
F 371	Continued From page	e 153	F 37 ⁻	1	
	The findings included	ł:		The Dietary Manger and the Region Dietician reviewed all food items in kitchen to identify any expired items	in the
kito foll *25		during the initial tour of the at 8:36 AM revealed the		11/14/17. No other items were in Dietary staff were in-serviced by Dietary Manger and Regional Di 11/16/17 and 11/17/17 regarding	the etician on
		serve whole milk in the walk iration date of 11/12/17.		expiration dates of food items.Ne staff after 11-17-2017 will be edu the above process.	ewly hired
		erve whole milk on the ady to be placed on resident an expiration date of		An audit of expiration dates for fe will be completed by the Dietary 3 x per week for one month and weekly for 2 months. The results of the audits will be f	Manager then
		ment shakes with a 1/10/17 and 9 shakes with ndwritten dates in the walk in		to the facility monthly Quality Ass Performance Improvement commonths for further review and recommendations. The title of the person responsib	surance nittee x 3
	with the Dietary Mana man had delivered m was his job to take ba She stated the staff of have caught the out of	ed on 11/13/17 at 8:40 AM ager (DM) revealed the milk ilk earlier that morning and it ack all of the outdated milk. on the serving line should of date milk and taken it off DM further stated the		implementing the acceptable pla correction is the Administrator.	
	days after being take placed into the walk i the shakes should or being taken out of the	nt shakes are dated for 14 n out of the freezer and n cooler to thaw. She stated nly be kept 14 days after e freezer per manufacturer I the shakes dated 11/10/17			
	that was the 14th day further stated the 9 n with smeared dates s	scarded on 11/10/17 because / after being thawed. She utritional supplement shakes should have been discarded o way of knowing what the			

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345165	B. WING		C 11/19/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752	
0(A) ID					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 371	Continued From page	e 154	F 37	1	
	An interview conduct	ed on 11/19/17 at 8:00 AM			
	with the Administrato				
		tchen staff to make sure all			
		ate and served within that			
F 372	date.	E & REFUSE PROPERLY	F 37	2	12/22/17
SS=E	CFR(s): 483.60(i)(4)		1 07.		
		bage and refuse properly. Γ is not met as evidenced			
	by:	ons and staff interviews the		F372	
		1 of 2 dumpsters from		It is the practice of this facility to dis	spose
	overflowing and cove	-		of garbage and refuse properly. The	
	The findings included	1:		Maintenance Director and Dietary Manager have cleaned the area ar the dumpster and the dumpster lid	
		nade of the dumpster on revealed bags of trash		closed as of 12/7/17. Dietary and Maintenance staff were	e
		e of the dumpster and the		educated by Regional Dietician on	
	dumpster was uncove	ered.		11/16/17 and 11/17/17 on proper w disposal including use of dumpster	
	An interview conduct	ed on 11/13/17 at 9:06 AM		keeping lid closed.	
	with the Dietary Mana	-		An audit proper disposal of waste a	
		r left the lid open on the		dumpster closure will be completed	-
		y to Monday due to overflow rom putting the bags on the		Dietary Manager, Maintenance Dir Manager on weekend duty 2 x a w	
	-	ne trash service picked up		one month and then weekly for 2 n	
	•	through Friday but did not		The results of the audits will be for	
	come on Saturday or	Sunday.		to the facility monthly Quality Assu	
	An interview conduct	ed on 11/15/17 at 11:51 AM		Performance Improvement commit months for further review and	tee x 3
		ed on minor at most Aw		recommendations.	
	didn't leave the dump	oster uncovered over the		The title of the person responsible	
		throw the trash bags on the		implementing the acceptable plan	of
	ground and he would Monday mornings. H	have a mess to clean up on		correction is the Administrator	

Facility ID: 922951

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DA	NO. 0938-039 TE SURVEY MPLETED
	CONTRACTION		A. BUILDING			C
		345165	B. WING		1	1/19/2017
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CO	DDE	
AUTUMN	CARE OF MARION			AIRPORT ROAD		
			I	RION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 372	Continued From page	e 155	F 372			
		n on Saturday and Sunday n for another dumpster.				
	11/19/17 at 7:40 AM to leave the dumpste	ed with the Administrator on revealed it was unacceptable r uncovered over the buld have to add another				
F 431 SS=D	dumpster. DRUG RECORDS, L BIOLOGICALS CFR(s): 483.45(b)(2)	ABEL/STORE DRUGS & (3)(g)(h)	F 431			12/22/17
	drugs and biologicals them under an agree §483.70(g) of this par	t. The facility may permit to administer drugs if State under the general				
	that assure the accur dispensing, and admi	cility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and ne needs of each resident.				
		ion. The facility must services of a licensed				
	disposition of all cont	tem of records of receipt and rolled drugs in sufficient ccurate reconciliation; and				
	(3) Determines that d that an account of all maintained and perio					

Facility ID: 922951

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TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
				_		с	
		345165	B. WING			1	1/19/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				264 AIRPORT ROAD IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIOI DATE
F 431	labeled in accordance professional principle appropriate accessor instructions, and the applicable. (h) Storage of Drugs (1) In accordance wit the facility must store locked compartments controls, and permit of have access to the ke (2) The facility must p permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t package drug distribu quantity stored is min be readily detected. This REQUIREMENT by: Based on observatio interviews, and manu facility failed to remov Tamsulosin from 1 of Findings included: Manufacturer specific the package insert intervieway from	and Biologicals. a used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when and Biologicals. h State and Federal laws, all drugs and biologicals in a under proper temperature only authorized personnel to eys. provide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the imal and a missing dose can T is not met as evidenced ons, record review, staff facturer specifications, the ye 20 capsules of expired	F	431	F431 It was identified during the survey protected that the facility did not remove a card containing 20 capsules of expired tamsulosin from a medication cart du a process for checking medication card was not in place. The expired medication cards was removed immediately and carts checked for any additional expired medications which none were found. There is a new system	l le to arts	

Event ID: 9KIX11

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	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING		с		
		345165	B. WING		11/19/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET		
F 431	Continued From page	e 157	F 43 ⁻	1			
	one medication card Tamsulosin 0.4 millig date of 05/29/17 was at 200 Hall. During an interview of Nurse #7 stated if a r it would be pulled and by the nurse who rec were to check their ref for expired medication expiration prior to me attributed the inciden During an interview of Assistant Director of also the Unit Manage were expected to che cart and medication s expired medication. H document the nightly	ram (mg) with an expiration found in medication cart #1 in 11/15/17 at 3:40 PM, nedication was discontinued, d returned to the pharmacy eived the order. The nurses espective medication carts n each shift and to check for dication administration. She t to human error. In 11/15/17 at 3:55 PM, the Nursing (ADON) who was er stated the third shift nurses eck their entire medication storage rooms each night for lowever, the facility did not medication audit. He ication carts and storage		Medication carts and medication rowere audited for expired medication the Regional Nurse on 12-05-2017 other medications were found to be date. Licensed nurses were in-serviced regarding storage and labeling of medications by Administrator/Direc Nursing completed on 12-08-2017 hired nurses 12-08-2017 forward we educated on the above process. Medications carts will be audited for expired medications weekly x 2 we then monthly x 3 months by Direct Nursing/ designee. The audits will be reveiwed by the Assurance Performance Improver Committee monthly for 3 months for further review and recommendatio The person responsible for impler the acceptable plan of correction is Administrator.	ns by and no e out of ctor of Newly vill be or eeks or of Quality nent or ns. menting		
	Assistant Director of DON stated the facilit check for expired me requiring the nurses t administration, the fa shift nurses to check carts and storage roo the consultant pharm for expired medicatio quarterly or as neede conducted random m weekly. At any time w	o check for expiration before cility had scheduled the third their respective medication on every night. In addition, acist had visited the facility					

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						<u>NO. 0938-039</u> TE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	LE CONSTRUCTION	COMPLETE	
		345165	B. WING			C 11/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/15/2017
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	who received the ord from the cart and retu	e 158 er to pull the medication urn it to the pharmacy in a ure the facility was free of	F 43	1		
F 490 SS=J	· ·	STRATION/RESIDENT	F 49	0		12/22/17
	enables it to use its re efficiently to attain or practicable physical, well-being of each react This REQUIREMENT by: Based on observation and resident interview to operationalize a set abuse for 1 of 3 samp #71) and ensure residents #66, #71, #79, #123, Immediate jeopardy to Resident #71 was str meal tray thrown by a permitted the nurse a on that unit due to sh Jeopardy was remove facility provided and i	mental, and psychosocial sident. F is not met as evidenced ans, record reviews and staff ws, the administration failed afe environment free from bled residents (Resident dent needs were met for 8 of a (Residents #27, #28, #46, and #174). began on 10/23/17 when tuck by a flying object from a a nurse aide. Nurse #1 hide to continue to pass trays ort staffing. Immediate ed on 11/19/17 when the mplemented a Credible		F490 During the annual survey process identified the facility did not prov sufficient nursing staff to preven abuse,provide incontinence care toileting,showers and did not pro- training to agency staff so they w aware of their responsibilities for care and tray set-up.During ann ending 11/19/2017, it was identit the facility did not follow the faci policy and procedure resulting ir unsafe environment for resident	ide t s, ovide r personel ual survey fied that lity abuse n an #71.	
	Allegation of Immedia facility remains out of severity level of E (Pa the potential for more not Immediate Jeopa education and ensure	ate Jeopardy Removal. The f compliance at a scope and attern no actual harm with than minimal harm that is rdy) to complete employee e monitoring systems put into ad sufficient to meet the care		Reeducation was completed for staff on 11/17/17 concerning fac policy and procedures and the n Manager on Duty process. Ree was performed by the Administra Regional Vice President of Oper the Director of Nursing, and the	ility abuse ew ducation ator, the rations,	

Facility ID: 922951

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/21/201 [°] RM APPROVEI IO. 0938-039 [°]
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345165	B. WING			1	1/19/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CARE OF MARION			12	264 AIRPORT ROAD		
				M	IARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	Continued From page	e 159	F	490			
	needs of the residents			100	Director of Clinical Services.		
	The findings included				The Administrative Department Mana will complete abuse policy and proce	dure	
	1. Cross Refer to F22 Based on record revie	23: ew, resident interview, and			questionnaires with 3 staff members week x 4 weeks, then monthly for 2	3x a	
	staff interviews, the facility failed to provide an				months. Any negative findings will be	9	
		ntained 1 of 3 residents'			addressed immediately by the		
	right to be free from a	abuse (Resident #71).			administrator or Director of Nursing. The Administrator or designee will		
	2. Cross Refer to F22	26:			complete resident questionnaires with	n 3	
	Based on record revie			residents 3x a weekx 4 wees, then			
		ment their abuse policy and			monthly x2 months related to care an		
		the prevention, protection 1 of 3 residents who were			services. Any negative findings will b addressed immediately by the	e	
	-	vestigations (Resident #71).			Administrator or Director of Nursing The facility will have a Manager on D	uty	
	3. Cross Refer to F35				every Saturday and Sunday from 11a		
		ns, record reviews, resident erviews, and staff interviews,			3pm. The 300 hall charge nurse is th designated nurse in charge in the	ie	
		ovide sufficient staffing to			absence of the Administrator, Direct	or of	
		led residents (Residents			Nursing, Or the Manager on Duty. The Manager on Duty.		
	#27, #28, #46, #66, #	71, #79, #123, and #174).			Manager on Duty or the designated r in charge will report any negative find		
		d Regional Clinical Nurse			to the Administrator immediately. Ger		
	were informed of Imm 11/16/17 at 6:18 PM.	nediate Jeopardy on			information gathered will be shared w the Administrator in the next manage morning meeting.		
	The facility provided a	an acceptable credible					
	allegation of immedia	te jeopardy removal on			Results of the questionnaires will be		
	11/19/17 at 11:57 AM	as follows:			forwarded to the facility Quality Assur Performance Improvement committee		
	The plan of correcting	g the specific deficiency.			3 months for further review and		
		ess the process that lead to			recommendations.		
	The areas of concern	identified on 10/23/17			The title of the person responsible for implementing the acceptable plan of	-	
	Nurse aide (NA) #2 w	/as not removed from her hen she became upset and			correction is the Administrator.		

Facility ID: 922951

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345165	B. WING				C / 19/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	resident's meal tray. 1 #71 being hit with objito continue working b Nursing. An investigation was a Administrator and Dir Reportable Incident s Day on 10/27/17. The (Name of City La notified of the inciden charges filed on 10/23 assessed for injury by negative outcome On 11/16/17 the faciliti investigation related t resident #71 occurrent findings, during state conducted by the Adm Nursing Facility). It wa not immediately suspitive while Director of Nurs the Nurse on duty. On 11/16/17 the Nurs 10/23/17 occurrence investigation. NA #2 and Nurse 1 w from payroll system o 11/16/17 statements of original investigation	In the second se	F	490			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/2017 / APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´				LETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD		
					MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	9 161	F	490	D		
	affected. Interviewable on 11/17/17 by Depar care issues and staffin findings were noted. F non-interviewable had completed by licensed new care concerns idd the root cause of the of #1 (NA). The NA#1 st being frustrated related To prevent this from re and Regional Clinical immediate in-house e related to F223 Abuse and implementation of (screening/training/pre investigation/protection 11/16/17 the Administ department heads on procedures. Departme education for staff on continue through 11/1 performed to ensure a abuse and aware that tolerated at the facility Education will continue will not be permitted to received. New hires will be educ and procedure upon h The Regional Vice Pre	Residents who are d complete body checks d nurses on 11/17/17. No entified. When identifying outburst by the Nurse Aide tated it occurred due to ed to staffing. ecurring the Administrator Services Director started education on 11/16/17 e and F226 development of policy and procedures evention/ identification/ on and reporting response. trator re-educated abuse and policy and nent heads completed duty and the education will 7/17. This education was staff was properly trained on t abuse would not be /. the via telephone and staff o work until education is cated on the abuse policy nire.					
	The Regional Vice Pro re-educated the Licen						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				1	1264 AIRPORT ROAD		
AUTUMN	CARE OF MARION			ſ	MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 490	Administrator on abus and conducting a pro- on 11/17/17. Administrator implem 10/24/17 to ensure su sufficient staff in orde and effectively. Administrator implem 10/24/17 related to su sufficient staff with the Human Resource current nursing and n Update log weekly 10 Since 10/24/17 w applications and hired Since 10/24/17 w applications and hired Administrator and Dir staffing and identified adequate staffing on 1 on evening shift. Staf implementing a maste staffing on days and e Administrator improve various web site on 1 increased the number hires. Evaluated weel Manager. - Administrator secure assist with staffing 10 - Administrator impler and increase 11/10/2 aides - Administrator initiate	se, policy and procedures per/thorough investigation ented a staffing initiative on ufficient nursing services and r to use resources efficiently ented a staffing initiative on ufficient nursing services and e following elements: e Manager to evaluate urse aide vacancies and 0/24/17 we have received 16 NA d 15 of those applicants. we have received 7 nurse d 5 of those applicants. ector of Nursing evaluated overstaffing on day shift, night shift and understaffing fing was adjusted by er schedule to even out the evenings 10/24/2017. ed recruiting online on 0/26/2017 which has r of applicants and new kly by Human Resources ed 2 Agency contracts to	F	490			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMF	SURVEY PLETED
		345165	B. WING				C 19/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 490	up extra shifts on 8/24 - Administrator initiate program-10/26/2017- local community colle assistant student who or who to desires to a is paying for tuition, b return for 6 months er - Administrator and re staffing call to discuss recruitment efforts 10 - Administrator placed community advertising On 11/13/17 the Admi department managers (MOD) policy and Dep process is new to the management/adminis weekends both sched on the needs of the com management rounds allegations of abuse w immediately the MOD Administrator and the Nurse assigned to 30 nurse in charge in the Administrator immedia abuse or concerns. To prevent this from re was educated by the operations regarding relates to the regulation	2017 nented shift bonus for ssistants for those picking 3/17. ed a new Aide College This is a contract with the ge to sponsor a nursing o is attending their program ttend the program. Facility ooks, and certification test in mployment. gional support staff on daily a needs and ongoing /24/17 d signs throughout g for NAs on 11/10/2017. inistrator educated the s on the Manager On Duty partment head duties. This facility and provides for trative coverage on fuled and at random based enter, to include and addressing concerns or which will be handled o who will notify the Director of Nursing. The 0 hall is the designated	F	490			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/2017 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /		E CONSTRUCTION	(X3) DATE	
		345165	B. WING				C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	2 164	F4	490			
	The Administrator will initiative indicated abores staffing meeting to as effectively and efficient highest practicable pro- psychosocial well-bein Adjustment of resource and department head management/ancillany duties that they are all The monitoring proce of correction is effecting deficiency cited remains compliance with the re- The facility will call in utilize agency staffing maintain ongoing com The facility Administration will start abuse questing 11/17/17 related to ab procedures (7 element completed on 3 staff, findings will be address The facility will condured ASSURANCE PERFOR meeting on 11/17/17 of the Regional Team and review. To monitor and maintant	continue with the staffing ove and will have a daily ssure resources are used htly to attain or maintain the hysical, mental, and ng of each resident. ces will be made as needed s/nursing y staff will be assigned ble to perform if needed. dure to ensure that the plan ve and that specific ins corrected and/or in egulatory requirements. available staff if needed and if needed to monitor and npliance: ative/Department Managers ionnaires with all staff on puse and policy and its). The audits will be 3 x weekly. Any negative					
		y to ensure there are no and staffing.Any negative					

	S FOR MEDICARE &				OMB NO. 0938-
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	oonneonon		A. BUILDING		
		345165	B. WING		С
		545165			11/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
AUTUMN	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DAT
F 490	Continued From page	e 165	F 490		
	findings will be addre				
	The title of the person	n responsible for ceptable plan of correction is			
	the Administrator.				
	Date of Alleged Com	pliance is: 11/19/17			
		was removed on 11/19/17			
		direct and supervisory staff been inserviced and knew the			
		and procedures including			
		had to be removed from			
	-	iately, witnesses had to be			
	interviewed, and doc	umentation had to be			
		ng notes including event			
	information, assessm				
		on. The staff knew signs of			
		do if they were feeling ed other coworkers with			
		addition, observations and			
	•	confirmed the facility had			
		the master schedule to			
	assure that staffing o	n all shifts was evenly			
	distributed and staff v	-			
	assignments for cove				
		tained that the facility			
		r agency coverage for nurse hat the bonus incentive was			
		acility supervisory staff also			
		of several new employees			
		or orientation. Supervisory			
	staff interviews confir				
	inserviced on the new	-			
		expectation of obtaining			
		staff coverage during their			
	oversight.				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/21/2017 // APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /			(X3) DATE COMP	SURVEY LETED
		345165	B. WING				C 19/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARION				264 AIRPORT ROAD //ARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 514 SS=D	LE CFR(s): 483.70(i)(1)(f (i) Medical records. (1) In accordance with standards and practic maintain medical recor are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org (5) The medical recor (i) Sufficient informatic (ii) A record of the res (iii) The comprehensiv provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re This REQUIREMENT by:	TE/ACCURATE/ACCESSIB 5) n accepted professional es, the facility must ords on each resident that ented; e; and ganized d must contain- on to identify the resident; ident's assessments; ve plan of care and services preadmission screening valuations and cted by the State; 's, and other licensed	F	514	It was identified during the survey		

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/21/201 1 APPROVE). 0938-039		
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED		
		345165	B. WING			C 19/2017		
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
	CARE OF MARION			1264 AIRPORT ROAD MARION, NC 28752				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 514	Continued From page	e 167	F 514	1				
1 011		ain a complete and accurate	F 514		mont in			
		included documentation of		process the facility did not docu resident#71 chart concerning a				
		ications of the physician and		event, notification of M.D. and				
		d the resident's assessment		responsibile party and the resid	lents			
	for injury. This affect	ed 1 of 3 residents reviewed		assessment for injury. A late er	ntry has			
	for abuse (Resident #	¥71).		been added to the electronic ch				
				12/15/2017 for patient #71 rela				
	The findings included	1:		abuse event on 10/23/17 to ref				
	Resident #71 was ad	mitted to the facility on		resident assessments, MD and notification and summary of evo	•			
		oses included aphasia		current Director of Nursing.	Shi by			
		nfarction, muscle weakness		The Administrator and Director	of Nursing			
	and hemiplegia and h			have reviewed the abuse event	-			
				past 30 days and the Facility R				
		al Minimum Data Set (MDS)		Incident data to validate comple				
		d her with moderately		accurate documentation is pres	sent in the			
		nd requiring extensive activities of daily living skills.		medical record by 12/15/2017.				
	Deview of a 24 hours	initial report cont to the		Administrator and/or Director o	-			
		initial report sent to the el Investigations on 10/23/17		or designee have in-service De Heads and Nursing staff on cor				
	at 7:44 PM, revealed			accurate documentation in the				
		3/17 at 5:30 PM, Nurse Aide		Record of any abuse event incl				
	•	al tray across the hall and		resident assessment, MD and f	-			
	that the witness said	Resident #71 was wet with		notification and details of event				
	water.			in-service was completed for cu				
				on 12-08-2017 and all newly hi				
		gation revealed written ained by the nurse on duty		12-08-2017 forward will be edu the above information.	cated on			
	(Nurse #1), the Nurse			The Departments Heads will re	view abuse			
		nt, and NA #2 who was		event in morning Department F				
	alleged to throw the t	•		meeting to ensure complete an				
	-	-		documentation is completed. T	he			
	A written statement fr			Director of Nursing will maintain	-			
		30 PM she heard a loud		abuse event to include complet				
		dining room. The sound		required documentation in the				
	-	oom on the 100 hall. Nurse own the hall and Resident		record (resident assessment, N				
	# i wrote she went do	with the fiall and Resident		family notification and details of				

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DEPART CENTER	FOR	PRINTED: 12/21/2017 FORM APPROVED OMB NO. 0938-0391					
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		345165	B. WING			C / 19/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				1264 AIRPORT ROAD			
AUTOMIN				MARION, NC 28752			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
F 514	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 5 ⁻	I264 AIRPORT ROAD MARION, NC 28752 ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRI			

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DEPART CENTEF	FORM APPRO OMB NO. 0938-0	VED						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	(X3) DATE SURVEY COMPLETED		
		345165	B. WING		11/19/2017			
NAME OF F	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE				
AUTUMN CARE OF MARION				1264 AIRPORT ROAD MARION, NC 28752				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	TION		
F 514	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 169 was in the facility at the time of the incident. Review of the resident's medical records revealed no documentation about the incident that happened on 10/23/17 or if the physician or the responsible party were notified or if there was an assessment for injury completed on the resident.		F 5					

Event ID: 9KIX11

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