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as specified in §483.10(e)(6); or								
		as specified in §483.1	l0(e)(6); or					
						TITLE		(X6) DATE

Electronically Signed

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.

09/21/2020

PRINTED: 10/07/2020

	F DEFICIENCIES	MEDICAID SERVICES				OMB NO. 093 (X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			COMPLETE	
			A BOILDI			С	
		345280	B. WING			09/04/20	020
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
Αυτυмη (CARE OF RAEFORD				206 N FULTON STREET		
				R	AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) MPLETIOI DATE
F 580	Continued From pag	le 1	E F	580			
		dent rights under Federal or		000			
		ons as specified in paragraph					
	(e)(10) of this section						
	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident						
	representative(s).	resident					
	§483.10(g)(15)						
	Admission to a comp						
	that is a composite of						
	• ,	e in its admission agreement					
		ation, including the various					
		ise the composite distinct fy the policies that apply to					
		een its different locations					
	under §483.15(c)(9).						
		T is not met as evidenced					
	by:						
		view and staff interviews, the / the responsible party (RP)			The Responsible Party for Resident #1 was notified of diet downgrade in		
		idents (Resident #1 and			Resident's diet on 7/13/202 and the		
		ent #1 who had a downgrade			Responsible Party for Resident #2 was		
	in diet, and Resident #2 who had a dental				notified of dental appointment on 7/2/20		
	appointment.				via a concern/grievance response by the	e	
	The findings included:				facility's social worker.		
	-				All physician orders, scheduled		
		admitted to the facility on			appointments, room changes and any		
	÷	ses that included End Stage RD), Diabetes Mellitus type 2			changes in conditions were reviewed by the Director of Nursing for all residents of		
	(DM II), and Dement	, .			9/7/2020 to ensure that the RP notificati		
	Review of Resident	#1's quarterly Minimum Data			had occurred.		
	Set (MDS) assessme	ent dated 6/26/20 revealed			Education will be provided to all nurses		
		ively impaired and required			the Change on Condition policy and MD		
	extensive assistance	e with activities of daily living			notification by the DON or designee by		
		nt was coded as being			9/23/2020. All newly hired nurses will		

Event ID:0ETN11

Facility ID: 922954

If continuation sheet Page 2 of 7

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
		345280	B. WING		C 09/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP C	
	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376	
(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	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 580	Continued From page	e 2	F 58	30	
	revealed Resident #1 hydration risk related II. The goals were for stable, consume a the signs and symptoms Interventions included with diet guidelines, m increased nutrition, as supplements. Review of nursing not Resident #1 was coug diet texture was chan Further review of the Resident #1's family w the diet. A review of the Spee and plan of treatment Resident #1 had dysp mastication timing an meals. Further review revealed a mechanica liquids were recommend did not identify the RF recommendation. A review of physician revealed the diet text downgraded to mecha- of physician order dat	d encourage compliance nonitor the need for ssist with meals, and provide te dated 6/29/20 revealed ghing during meals, and his ged to mechanical soft. nursing note did not indicate was notified of a change in ch Therapist (ST) evaluation dated 6/29/20 revealed		requirements during orienta Transportation Scheduler we education that includes not scheduled appointments at notification and attempts to appointment communication The 24 hour report will be a times a week in the facility' meeting to ensure that all of condition, new orders, labs room changes are followed Responsible Party notificat change to the resident's ca transportation schedule an Communication Sheets for week will be reviewed wee or designee to ensure RP n occurred. An audit will be conducted designee 5X a week for 90 ongoing compliance with a notification. If failure to not the responsible employee to re-education and notification to the RP immediately. The audits will be reviewed facility's QAPI meeting for months. The facility's decis the audits will be based on the audits.	will receive tification of all and documented o notify on the on sheet. reviewed 5 s clinical changes in a, x-rays and d with tion of such are. The d Appointment the upcoming kly by the DON notification has by the DON or o days to ensure II RP ify is identified, will receive on will be made d monthly in the a period of 3 sion to extend
	dated 7/7/20 on beha	nce log revealed a concern If of Resident #1 by his RP. arding not being notified of a			

If continuation sheet Page 3 of 7

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/07/2020 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			-		C 04/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN CARE OF RAEFORD					206 N FULTON STREET			
				- R/	AEFORD, NC 28376			
(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 BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	3	F 5	80				
	form further revealed							
	in-serviced on notifica	ation of RP.						
	revealed Resident #1 to Puree on 7/3/20 du	se #1 on 9/2/20 at 2:30 PM 's diet was changed by ST ie to resident holding food in d she did not notify the RP						
	of the new order.							
	at 2:45 PM revealed F general decline. She upward position, thin quickly, and he was u well enough due to hi She stated she wrote soft diet on 6/29/20, a thick liquids on 7/3/20	Speech Therapist on 9/2/20 Resident #1 was having a stated his neck was in an liquids were running back to mable to swallow or chew s jaw muscles being tight. an order for a mechanical and a pureed diet and nectar b. She further stated she did the new orders because she reananaible						
	An interview with Nur- revealed the nurse or families of new orders #1's RP was difficult t were unable to leave stated she usually cho- meeting to see if any as family notification. had contacted resident the resident's downgr was aware that docur it to be considered do	se #2 on 9/3/20 at 3:00 PM in the floor would notify s. She stated that Resident o reach and sometimes they a message. She further ecked during the morning follow up was needed such She could not recall if she int #1's RP with regards to added diet. She stated she mentation was necessary for one.						
	on 9/3/20 at 11:55 AM noting the orders wou	Director of Nursing (DON) I revealed that the nurse Id notify the RP. She stated ould also notify families of						

If continuation sheet Page 4 of 7

ARED.		E CONSTRUCTION			
B. WI				(X3) DATE COMP	LETED
	ING		_	(09/0) 04/2020
	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
FULL PR		(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
	F 580				
ified of a here all the amily of / what ies of on specified DS) lent #2 ensive y barty) fied of cern ty and hung / up to n phone busy at ng the it to the of call.					
	/20 at iffied of a a here call the family of y what lies of on specified IDS) dent #2 ensive a y party)	ID PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG F 580 /20 at iffied of e a there call the family of y what ies of on specified IDS) dent #2 ensive A y party) fied of cern ty and thung v up to n phone busy at ng the v it to the of call. S note	ID PROVIDERS (EACH CORREC (CROSS-REFERENCE) /20 at iffied of e a here sall the family of y what ies of F 580 /20 at iffied of e a here sall the family of y what ies of F 580 /20 at iffied of e a here sall the family of y what ies of F 580 /20 at iffied of e a here sall the family of y what ies of F 580 /20 at iffied of cern ty and hung y up to n phone busy at ng the of call. F 580	PREFORD, NC 28376 SS ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) /20 at F 580 /20 at field of 2:a here a y ywhat ies of ron specified IDS) dent #2 ensive a ay yparty) fied of a ron specified	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376 FOLL PROVIDER'S PLAN OF CORRECTION (FULL ATTON) F 580 /20 at iffed of a a here iall the family of y what ies of r on specified DS) dent #2 ensive a y party) fied of cern ty and hung v up to n phone busy at ng the of call.

Facility ID: 922954

If continuation sheet Page 5 of 7

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 10/07/2020 MAPPROVED). 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_		C 04/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page dentures.	5	F	580				
	06/15/20 revealed Re appointment evaluation	ion request form dated sident #2 had a dental on to be performed by a up date was 07/07/20.						
	stated an attempt was	progress note dated 06/22/20 s made to notify responsible plan to replace dentures and n call.						
	09/04/20 at11:00 AM Manager. Nurse #3 st an order, the nurse or responsible for notifyi	ducted with Nurse #3 on revealed she was the Unit tated that whoever initiated unit manager, would be ng a resident's responsible ion should be documented						
	3:50 PM revealed the	cial Worker on 09/04/20 at Transportation Scheduler otifying the responsible coming appointments.						
	PM. The Transportation she was responsible for responsible party of a appointments as she them. She indicated the	uler on 09/04/20 at 4:05 on Scheduler stated that for notifying Residents ny residents upcoming scheduled them and logged						
	Nursing (DON) on 09/ DON stated that resp	ducted with the Director of /04/20 at 11:15 AM. The onsible party was to be es or appointments and that						

Facility ID: 922954

If continuation sheet Page 6 of 7

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 10/07/2020 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345280	B. WING		_	C 09/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
AUTUMN CARE OF RAEFORD				1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID		S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
F 500		0				
F 580		e 6 der was responsible for	F 58	30		
	notifying the responsi					

Facility ID: 922954

If continuation sheet Page 7 of 7