	-	& MEDICAID SERVICES				ORM APPR NO. 0938	
		(X1) PROVIDER/SUPPLIER/CLIA	(X 2) MU	тірі) DATE SURV	
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			COMPLETED	
		345553	B. WING			C 12/11/20 ′	14
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
A 1 1 T 1 1848				1	401 71ST SCHOOL ROAD		
AUTUMI	N CARE OF FAYETTE	VILLE		F	AYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMP	X5) LETION ATE
F 157 SS=G	· · · · ·		F 1	57		1/8/1	5
	consult with the rest known, notify the rest or an interested fan accident involving t injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life t clinical complication significantly (i.e., a existing form of trea consequences, or t treatment); or a dec	ediately inform the resident; ident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ificant change in the resident's r psychosocial status (i.e., a lth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge ne facility as specified in					
	and, if known, the r or interested family change in room or specified in §483.1 resident rights under	so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or sified in paragraph (b)(1) of					
	the address and ph	cord and periodically update one number of the resident's or interested family member.					
	This REQUIREMEN	NT is not met as evidenced					
	Based on record re	eview, staff and physician ity failed to notify the primary			F157		
		ty acquired pressure ulcer for			This plan of correction will serve as the	e	
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(X6) DA	TE
Electror	nically Signed					01/09	9/2015

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.

DEDADTMENT OF LIEALTH AND LUMANN SEDVICES

					OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY PLETED
						2
		345553	B. WING			11/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
AUTUMN	I CARE OF FAYETTE	VILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314	ı	
(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	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIOI DATE
F 157	Continued From pa	age 1	F 15	57		
	1 of 3 residents (R pressures ulcers. Resident #53 was cumulative cerebra anemia, left sided dementia and cont Data Set (MDS) da cognitive impairme coded as extensive and eating and tota toileting, hygiene a coded as non-amb bladder and bowel Record Review rev assessments. The completed 9/12/14 blisters or open are #53's body. The we completed 9/15/14	esident # 53) reviewed for Findings included: admitted 4/20/12 with al vascular accident (CVA), hemiplegia, dysphagia, ractures. The 30 day Minimum ated 11/24/14 indicated severe ent, no behaviors and he was e assistance with bed mobility al assistance with transfers, ind bathing. Resident #53 was pulatory and incontinent of		facilityOs allegation of requirements of 42 CF Subpart B for long term Preparation and subm correction is in respons for the 12-11-14 survey constitute an agreeme Autumn Care of Fayet the facts alleged or the conclusions stated on deficiencies. This plar prepared and submitte requirements of 42 CF Subpart B throughout the stated in the statement accordance with state however, submits this address the statement to serve as itOs allegat with the pertinent requirement ac of stated in the plan as fully completed as of	R, Part 483, n care facilities. ission of this plan of se to DHHS 2567 y and does not nt or admission of teville of the truth of e correctness of the the statement of n of correction is ed because of the R, Part 483, the time period t of deficiencies. In and federal law, plan of correction to of deficiencies and tion of compliance irements as of the n of correction and	
	9/18/14 at 2:34 PM developed an oper appearing to be a ' measured "3mm (r W" Width). The un apply wound gel (o damaged tissue) a pad and wrap area the nursing note ho changed or that the notified of the newl Resident #53's right	ealed a nursing note dated I indicating Resident #53 n are to the right outer ankle 'busted blister." The area millimeters) L (Length) and 2.3 it manager gave instructions to bintment use to hydrate nd cover with dry gauze, foam a. There was no indication in bw often the dressing was to be e primary physician was by acquired open area to nt outer ankle.		For the Resident affect developed a wound on treatment was initiated discovery per Wound (Orders. On 9-18-214 F notified regarding the the communication boy station per physicianOs physician visit on 9-19- initialed acknowledgme reviewed the entry and which was initiated per standing orders for pre Treatment of the affect continued including bo initial wound and furthe	9-18-2014, l at time of Care Standing Physician was wound via entry in ok at the nursesO s request. During -2014 physician ent that she had l the treatment the FacilityOs essure sores. ted resident has th treatment of the	

Facility ID: 060241

If continuation sheet Page 2 of 38

	-	AND HUMAN SERVICES			гоям <u>ОМВ NO.</u>	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	`́сом	E SURVEY PLETED
		345553	B. WING			C 11/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ΑυτυΜ	CARE OF FAYETTE	VILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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) COMPLETIO DATE
F 157	Resident #53's wou at 2:00 PM in a not assessment. The "c intact" and once ren described as an "ur The area was docu (centimeters) L x 4 watery clear) draina covered with soft ye tissue). An "unstag described as full thi exposed bone, tend Necrosis/eschar ma read treatment was moisten gauze daily Care Standing Ord pressure ulcer with to be treated using hydrocolloid or foar the Treatment/Proc for September 210 documented pressu 9/22/14. In an interview on 1 treatment nurse sta Resident #53 devel ankle on 9/18/14 ur skin alert sheet in h recalled she assess ankle and it was co considered an unst time. She stated sh primary physician a facility standing ord Resident #53 to the	und care needs was on 9/22/14 e labeled as a weekly wound dressing to the right leg was moved the wound was nstageable pressure wound." mented as measuring 2.0 cm cm W with serous (thin, age and the wound base was ellow to black eschar (dead geable" pressure ulcer may be ickness tissue loss with	F 157	designed to promote healing and additional wounds. These includ alternating air pressure mattress surgeon referral regarding ABI re- left/right ankle, multi vitamin daily C daily, zinc daily, lab work relate wound, and protective boots bilar For the Residents with the poten affected: Nursing staff was in-set 12-16-14, 12-20-14, and 1-7-14 r the charge nurse must notify the Physician about any/all new wou and/or worsening of an existing w Training included a review of the standing order to use based upo stage/type of pressure sore. All or residents with pressure wounds w reviewed by Administrator on 1-6 and 1-7-2015, to ensure the phys been notified and all notifications found to have been made. Measures Put in Place/System Of the Facility has updated Wound of Standing Orders to include a rem and confirmation that the Physici notified at the time Wound Care Orders are initiated. A Weekly Au being conducted by the DON to r Physician notifications of wounds time Wound care Standing Orde and to ensure that such notificati occurred. In-services were held to and/or SDC on 12-16-14, 12-20- 1-7-14 related to charge nurse m the Physician about any/all new v and/or worsening of an existing v Training included a review of the standing order to use based upo	e , vascular , vitamin ed to terally. tial to be viced on related to nds vound. proper n the urrent were -2015 ician has were thange: Care ninder an was Standing udit is review a at the r Initiated on has by DON 14, and ust notify vound. proper thange: care ninder an was Standing udit is review a t the r Initiated on has by DON 14, and ust notify vound. proper	

Facility ID: 060241

If continuation sheet Page 3 of 38

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		COMPLETED	
		345553	B WING				
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		1/2014	
				1401 71ST SCHOOL ROAD	·L		
AUTUMI	N CARE OF FAYETTE	VILLE		FAYETTEVILLE, NC 28314			
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 157	Continued From pa	age 3	F 15	7			
	manager recalled to to Resident #53's r appeared as an op nurse to put wound gauze until the prin contacted for addit did not contact the treatment orders b the physician. The gel was used for an keep them moist a changed every day stated she did not how often the area In an interview on recalled NA #2 info to Resident #53's r She recalled the un the assessment of unit manager told the area and wrap it wi write any orders ar that the unit manage and wrote any orders was during her wea 9/22/14 she compli in the treatment nu not think the area to ankle had been rec discovery on 9/18/ electronic medical given to Resident # documented treatment for September 201	12/11/14 at 11:13 AM, the unit being asked to assess the area ight outer ankle. She stated it en blister and she told the d gel on it and wrap it with nary physician could be ional orders. She stated she primary physician to get ut thought Nurse #1 contacted unit manager stated wound reas such as an open blister to nd normally were ordered to be v to maintain the moisture. She recall telling the floor nurse should re-dressed. 12/11/14 12:18 PM, Nurse #1 orming her of an opened area right outer ankle on 9/18/14. hit manager assisting her with the area. Nurse #1 stated the her to put wound gel on the ith gauze. She stated did not nd was under the impression ger contacted the physician ers given. Nurse #1 stated it ekly skin assessment dated eted a skin alert form and put it trses box. She stated she did to Resident #53's right outer dressed or assessed since its 14. Nurse #1 verified using the record to document the care #53 and there was no nent on the treatment record 4 until 9/22/14. She stated she y and treatment to the area in a		Monitoring: the DON or her Dereview 5 residents per week for then 2 residents a month for 2 ensure physician notification w Care Standing Order Initiated. A comprehensive review of the described above and the syster modifications we have made w discussed and monitored thro quality assurance meeting at I quarterly. Any further omission regarding physician notification addressed by the QA Commit determine if further systems in and/or training are in order.	or 4 weeks 2 months to when Wound e audits ems will be ugh our east ns n will be tee to		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	```		E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			IPLETED C
		345553	B. WING				0 /11/2014
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUM	N CARE OF FAYETTE	/ILLE			401 71ST SCHOOL ROAD AYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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)	D BE	(X5) COMPLETION DATE
F 157 F 224 SS=G	In an interview on 1 administrator, the D verified there was n pressure ulcer from 9/22/14, no evidence notified of the newly 9/18/14 until 9/22/14 the nursing note 9/2 referenced receiving In a telephone inter the primary physicia interventions as soon new pressure ulcer ankle and the delay place could have con the pressure ulcer a The primary physicia would have been for care standing order on Resident #53's r physician further inter gel to the area, wou minimum every othe promote healing an be notified when the pressure ulcer was 483.13(c) PROHIBI MISTREATMENT/N The facility must de policies and proced mistreatment, negle	2/11/14 at 12:50 PM the 2/11/14 at 12:50 PM the 2/11/14 at 12:50 PM the 2/18/14 until again on the evidence of treatment of the 9/18/14 until again on the that the physician was y identified pressure ulcer from 4. The DON verified writing 23/14 at 4:57 PM in which she g new physician orders. view on 12/12/14 at 11:48 AM an stated she ordered on as she became aware of a on Resident #53's right outer y in putting interventions in ontributed to the worsening of along with his co-morbidities. ian stated her expectation or the facility to use the wound is when the area was identified ight outer ankle. The primary dicated that by using wound and care would be indicated at er day but ideally daily to d she would have expected to e new facility acquired discovered. T NEGLECT/MISAPPROPRIATN	F 1				1/8/15

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		AND HUMAN SERVICES				FORM	01/22/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED C
		345553	B. WING	÷			_ 11/2014
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUM	CARE OF FAYETTE	VILLE			1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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 224	Continued From pa	ge 5	F	224			
	by: Based on record re and physician interv a new stage 2 pres 4 days; on 9/22/14, unstageable for 1 or reviewed for pressu A review of the facil Standing Orders" in open/ruptured seru a stage 2 pressure treatment was to cli (saline based woun apply a regular hyd non-breathable adh dressing should be then every week the Resident #53 was a cumulative cerebra anemia, left sided h dementia and contr Data Set (MDS) da cognitive impairment coded as extensive and eating and totat toileting, hygiene ar coded as non-ambit bladder and bowel. Record review reve 9/18/14 at 2:34 PM developed an open appearing to be a " measured "3mm (m	NT is not met as evidenced eview, observations and staff views, the facility failed to treat sure ulcer found on 9/18/14 for the wound was assessed as f 3 residents (Resident # 53) ures ulcers. Findings included: lity undated "Wound Care ndicated an intact or m filled blister was considered ulcer and the ordered eanse the area with Sea-Clens id cleaning agent), pat dry and rocolloid (biodegradable, nerent) or foam dressing. This changed on day 3, day 7 and ereafter until healed. admitted 4/20/12 with I vascular accident (CVA), nemiplegia, dysphagia, factures. The 30 day Minimum ted 11/24/14 indicated severe int, no behaviors and he was assistance with bed mobility I assistance with transfers, nd bathing. Resident #53 was ulatory and incontinent of ealed a nursing note dated indicating Resident #53 are to the right outer ankle busted blister." The area nillimeters) L (Length) and 2.3 it manager gave instructions			F224 This plan of correction will serve as facilityOs allegation of compliance requirements of 42 CFR, Part 483, Subpart B for long term care facilit Preparation and submission of this correction is in response to DHHS for the 12-11-14 survey and does r constitute an agreement or admiss Autumn Care of Fayetteville of the the facts alleged or the correctness conclusions stated on the stateme deficiencies. This plan of correction prepared and submitted because of requirements of 42 CFR, Part 483, Subpart B throughout the time peri- stated in the statement of deficience accordance with state and federal however, submits this plan of corre- address the statement of deficience to serve as itOs allegation of comp with the pertinent requirements as dates stated in the plan of correction as fully completed as of January 8 For the Resident affected: Resider developed a wound on 9-18-2014, treatment was initiated at time of discovery per Wound Care Standin Orders. On 9-18-214 Physician wa notified regarding the wound via er the communication book at the nur- station per physicianOs request. D physician visit on 9-19-2014 physic initialed acknowledgment that she	with ies. plan of 2567 not sion of truth of s of the nt of on is of the cies. In law, ection to ies and liance of the on and , 2015. nt #53	

Facility ID: 060241

If continuation sheet Page 6 of 38

		AND HUMAN SERVICES & MEDICAID SERVICES			OMB NO.	APPROVEI 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY PLETED		
		345553	B. WING					
	PROVIDER OR SUPPLIER	343333	B: WING _	STREET ADDRESS, CITY, STATE		11/2014		
	TROVIDEIN ON SUFFEIEN			1401 71ST SCHOOL ROAD	, ZIF CODE			
AUTUMN	I CARE OF FAYETTE	/ILLE	FAYETTEVILLE, NC 28314					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE		
F 224	damaged tissue) ar pad and wrap area. the nursing note ho changed. Record review reve Resident #53's wou at 2:00 PM in a note assessment. The "o intact" and once rer	ge 6 (ointment use to hydrate nd cover with dry gauze, foam There was no indication in w often the dressing was to be aled the next mention of ind care needs was on 9/22/14 e labeled as a weekly wound dressing to the right leg was moved the wound was instageable pressure wound."	F 22	24 reviewed the entry and which was initiated per standing orders for pre Treatment of the affect continued including bo initial wound and furthe designed to promote h additional wounds. Th alternating air pressure surgeon referral regard left/right ankle, multi vir C daily, zinc daily, lab v	the FacilityOs ssure sores. ed resident has th treatment of the er interventions ealing and prevent ese include mattress, vascular ding ABI results of tamin daily, vitamin			
	The area was docu (centimeters) L x 4 watery clear) draina covered with soft yet tissue). An "unstag described as full thi exposed bone, tend Necrosis/eschar mar read treatment was moisten gauze daily Treatment/Procedu	mented as measuring 2.0 cm cm W with serous (thin, age and the wound base was ellow to black eschar (dead leable" pressure ulcer may be ckness tissue loss with don or muscle. ay also be present. The note changed to Santyl and a y. A review of the re Administration Record for dicated the first documented		wound, and protective Measures Put in Place a new wound is identifi nurse is to immediately Care Standing Order F updated Wound care S include Enter standing Medical Health Record by DON and SDC 12-1 and 1-7-15 which inclu initiating any standing o order sheet must be in order placed in the elec- health record. Physicia	boots. /systems change: If ed, the charge / initiate Wound Protocol. Facility Standing Orders to order in Electronic I. In-services held 6-14, 12-20-14, ded that when orders a physician itiated and the ctronic medical			
	9/29/14 at 2:00 PM physician conducte continued the treatr described the woun necrosis" measurin without drainage.	aled a nursing note stated the wound care consultant d a bedside debridement and nents using Santyl. He d as being "unstageable g 1.9 cm L x 1.9 cm W and		notified of any/all new worsening of any exist Care Standing Orders to read notify physician wound is identified and wound and document nursing progress note. are then initiated from	wounds and/ or ing wound. Wound updated on 1-6-15 at the time a l/or worsening of physician notified in Treatment orders the order placed			
	treatment nurse sta Resident #53 devel ankle on 9/18/14 ur	on 12/11/14 at 9:35 AM, the ted she was not aware oped a blister to his right ntil she received a copy of a er box dated 9/22/14. She		into the Electronic Mec Monitoring: the DON o review 5 residents per then 2 residents a mor ensure physician notifie	r her Designee will week for 4 weeks oth for 2 months to			

Facility ID: 060241

If continuation sheet Page 7 of 38

		E & MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
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		345553	B. WING _			11/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	DDE	
AUTUMN	I CARE OF FAYETTE	VILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 224	Continued From pa	age 7	F 22	24		
	ankle and it was co considered an uns time. In another interview facility nurse consu- evidence of treatm record for the blister right outer ankle di initial treatment the floor nurse to perfor 9/22/14. In another interview unit manager recal area to Resident # stated it appeared the nurse to put wo gauze until the prin contacted for addit did not contact the treatment orders b the physician. The gel was used for at keep them moist a changed every day stated she did not how often the area manager state who on any resident, th	sed Resident #53's right out overed with eschar and tageable pressure ulcer at that w on 12/11/14 at 10:25 AM, the ultant confirmed there was no ent in the electronic medical ered area to Resident #53's scovered 9/18/14 after the e unit manager instructed the orm on 9/18/14 until again on w on 12/11/14 at 11:13 AM, the lled being asked to assess the 53's right outer ankle. She as an open blister and she told ound gel on it and wrap it with nary physician could be ional orders. She stated she primary physician to get ut thought Nurse #1 contacted e unit manager stated wound reas such as an open blister to nd normally were ordered to be v to maintain the moisture. She recall telling the floor nurse should re-dressed. The unit en a new area was discovered e floor nurse completed a skin he treatment nurse know there		Care Standing Order Initiate A comprehensive review of the described above and the system modifications we have maded discussed and monitored the quality assurance meeting a quarterly. Any further omiss regarding physician notificate addressed by the QA Common determine if further systems and/or training are in order.	the audits stems will be rough our t least ions ion will be hittee to	
	was able to pull up on the data entered confirmed if there y	. The unit manager stated she a report of daily alerts based d into the computer. She was no order written regarding essure ulcer, there would be no for follow up				

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		AND HUMAN SERVICES					FORM	APPROVED	
		& MEDICAID SERVICES				0	OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION			E SURVEY PLETED	
			A. BUILDI	NG	i			C	
		345553	B. WING					_ 11/2014	
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	5	STREET ADDRESS, CITY, STATE, ZIP C	ODE			
	CARE OF FAYETTE			1	1401 71ST SCHOOL ROAD				
AUTUWIN	ICARE OF FATELLE	VILLE		F	FAYETTEVILLE, NC 28314				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF COF	RECTION	١	(X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	X	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE			COMPLETION DATE	
TAG	REGULATORTOR	SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)	AFFROFF			
			l I						
F 224	Continued From pa	ae 8	F 2	21					
	Continued From pa	geo	1 2	27					
	In an interview on 1	2/11/14 12:18 PM, Nurse #1							
		rming her of an opened area							
	to Resident #53's ri	ght outer ankle on 9/18/14.							
		it manager assisting her with							
		the area. Nurse #1 stated the							
		er to put wound gel on the							
		th gauze. She stated did not diversion							
		er contacted the physician							
		rs given. Nurse #1 stated it							
		kly skin assessment dated							
		eted a skin alert form and put it							
		rses box. She stated she did							
		D Resident #53's right outer							
	discovery on 9/18/1	ressed or assessed since its							
		т.							
	In an interview on 1	2/11/14 at 12:50 PM the							
		OON and the facility consultant							
		o evidence of treatment of the							
		i 9/18/14 until again on							
	9/22/14.								
	In a telephone inter	view on 12/12/14 at 11:48 AM							
		an stated she ordered							
		on as she became aware of a							
		on Resident #53's right outer							
		in putting interventions in							
		ontributed to the worsening of							
		along with his co-morbidities. ian stated her expectation							
		or the facility to use the wound							
		s when the area was identified							
		ight outer ankle. The primary							
		dicated that by using wound							
	gel to the area, wou	and care would be indicated at							
		er day but ideally daily to							
	promote healing.								

Facility ID: 060241

If continuation sheet Page 9 of 38

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOR OMB N	D: 01/22/2015 M APPROVED O. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C		
		345553	B. WING		1	2/11/2014		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF FAYETTE	/ILLE			401 71ST SCHOOL ROAD AYETTEVILLE, NC 28314			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 226 SS=D	483.13(c) DEVELO ABUSE/NEGLECT		F 2	226		1/8/15		
	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.						
	by: Based on record refacility failed to prov verification of certifi 2 of 5 employees (I for abuse prohibitio The findings include 1a. A copy of the fa dated 1/17/14 (revis policy read in part patient has the righ sexual, physical, ar punishment, and in mistreatment, negle property. The facilit focus on seven com prevention, investig reporting/response. "All licensed and/or license and certifica employment." A review of the emp hire date of 6/13/14 employee file revea Aide 1 Registry dat				F226 This plan of correction will serve as the facilityOs allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan correction is in response to DHHS 2567 for the 12-11-14 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville of the truth of the facts alleged or the correctness of th conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. I accordance with state and federal law, however, submits this plan of correction address the statement of deficiencies an to serve as itOs allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of January 8, 2015 For the residents affected, an audit was performed on 1-3-2015, of all licensed and/or certified staff, which included NA#	of e n to d		

Facility ID: 060241

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	-	AND HUMAN SERVICES					APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		345553	B. WING			(12/1	C 11/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	I CARE OF FAYETTE	VILLE			401 71ST SCHOOL ROAD AYETTEVILLE, NC 28314		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 226	revealed the emplo 6/16/14 and 6/17/14 On 12/11/4 at 2:00	ed the employee worked on 6/13/14,		26	and Nurse #2, by DON and Administ of current licensed and/or certified employees to ensure verification of license and/or certification.	trator	
	verification of licens normally done befo She further stated t was the date of hire	sure or certification was re the first day of orientation. the first day of class orientation of or the new employee. The not know for sure why this			To ensure other residents are not affected, a log was created on 1-3-2 listing all steps an employee must complete prior to employment includ license and/or certification verification SDC was in-serviced on 1-7-2015 by administrator. This log will be mainta	ding on. y	
	administrator stated Staff Development	o on 12/11/14 at 2:49 pm, the d it was his expectation for the Coordinator to follow the erification of licensure and			by the facilityOs staff development coordinator and must be completed to any employee being hired. For on-going compliance, an audit w performed weekly, prior to orientatio the administrator, or designee, to en	oment ipleted prior audit will be ientation, by	
	dated 1/17/14 (revis policy read in part patient has the righ	by of the facility's policy on Abuse/Neglect 17/14 (revision date) was reviewed. The ad in part "The facility believes each as the right to be free from verbal, ohysical, and mental abuse, corporate			any newly hired employee have licer and/or certification verified prior to employment. The audits will be com weekly for 4 weeks and then monthl months.	nsure pleted	
	mistreatment, negle property. The facilit focus on seven con prevention, investig reporting/response. "All licensed and/or	ect, and misappropriation of y has developed policies that nponents: screening, training, jation, protection and . "The policy also indicated certified applicants have ation verified prior to			A comprehensive review of the audit described above and the systems modifications we have made will be discussed and monitored through ou quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modification	ur be	
	A review of the employee file for Nurse #2 revealed a hire date of 8/22/14. Further review of the employee file revealed a "License Verification" dated 9/23/14. Review of the handwritten time worked form for Nurse #2				and/or training are in order.		

Facility ID: 060241

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345553	B. WING		C 12/11/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUTUMN	I CARE OF FAYETTE	/ILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 226 F 274 SS=D	revealed the emplo 8/26/14, 8/27/14 an On 12/11/4 at 2:00 Development Coord verification of licens normally done befo She further stated t was the date of hire SDC stated she do was not done for N/ During an interview administrator stated Staff Development facility's policy for vi- certification. 483.20(b)(2)(ii) COI AFTER SIGNIFICA A facility must cond assessment of a re facility determines, that there has been resident's physical of purpose of this sect means a major dec resident's status that itself without further implementing stand interventions, that h one area of the resi requires interdiscipl care plan, or both.)	yee worked on 8/22/14, d 8/28/14. pm in an interview, the Staff dinator (SDC) stated sure or certification was re the first day of orientation. he first day of class orientation e for the new employee. The not know for sure why this A #3 and Nurse #2. on 12/11/14 at 2:49 pm, the d it was his expectation for the Coordinator to follow the erification of licensure and MPREHENSIVE ASSESS	F 22			1/8/15

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		& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	Сом	(X3) DATE SURVEY COMPLETED	
		345553	B. WING _			C 12/11/2014	
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	I CARE OF FAYETTE	VILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 274	Continued From pa	ge 12	F 27	74			
		I provider interviews and acility failed to complete and		F274			
	of 1 (Resident # 83 services. Findings i Resident #83 was a cumulative diagnos congestive heart fa The most recent Mi quarterly assessme indicated Resident impairment and rec with her activities of incontinent of bowe receiving hospice s less than 6 months indicated a hospice 12/13/13 and curren 12/30/14. Interventif for changes in her A as needed, assess caregivers were aw the family informed	Minimum Data Set (MDS) for 1) reviewed for hospice ncluded: admitted to the facility with les of osteoarthrosis, ilure (CHF) and Parkinson's. inimum Data Set (MDS) was a ent dated 9/23/14. This MDS #83 had severe cognitive guired extensive assistance f daily living, non-ambulatory, el and bladder and coded as ervices with a prognosis of . Resident #83 care plan e care plan was initiated nt with the next review of ions included the assessment ADL needs, provide assistance ment of pain, ensuring that vare of her wishes and keeping of changes in Resident #83 ons. A review of the hospice		This plan of correction will serve facilityOs allegation of compliar requirements of 42 CFR, Part 4 Subpart B for long term care fa Preparation and submission of correction is in response to DH for the 12-11-14 survey and do constitute an agreement or adu Autumn Care of Fayetteville of the facts alleged or the correct conclusions stated on the state deficiencies. This plan of correct prepared and submitted becau requirements of 42 CFR, Part 4 Subpart B throughout the time stated in the statement of defic accordance with state and fede however, submits this plan of correct address the statement of defic to serve as itOs allegation of correct with the pertinent requirements dates stated in the plan of corr as fully completed as of Janua	nce with 483, this plan of IHS 2567 es not mission of the truth of ness of the ement of ection is se of the 483, period sencies. In eral law, correction to iencies and ompliance a s of the ection and		
	provider care plan v dates from 8/10/14 Resident #83 was r twice weekly and ai weekly. On 12/08/14 at 1:47 provided entrance of Resident #83 as re- worksheet directed investigation of resi services.	 A Preview of the hospice was current with recertification to 10/0814 and indicated receiving nursing services ide services three times 7 PM, the administrator conference worksheet listed ceiving hospice services. This the survey process in the idents receiving specialized 		For the Resident affected: A Si Change MDS Assessment was on Resident #83 with an ARD of 12/10/14 and the assessment submitted on 12/17/14 and acc 12/19/2014 For the Residents with the pote affected and measures put in p Re-education was completed of by Regional QA Nurse with bot coordinators related to the requ a significant change being com timely and according to the RA	gnificant s completed date of was cepted on ential to be place: on 1-7-2015 h MDS uirement of pleted		

Facility ID: 060241

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	0938-039 SURVEY PLETED
		345553				(12/1	; 1/2014
NAME OF	PROVIDER OR SUPPLIER			ST	I TREET ADDRESS, CITY, STATE, ZIP CODE	14/1	1/2014
AUTUMI	CARE OF FAYETTE	VILLE		14	401 71ST SCHOOL ROAD AYETTEVILLE, NC 28314		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 274	dated 10/02/14 rea part (RP) was press termination of hosp the RP reviewed ar Medicare Non-cover The hospice nurse termination of hosp and to the facility si facility staff voiced discharge next wee Record review of th dated 10/6/14 read reminded of Reside hospice services of Record review of th dated 10/8/14 read when she was rem would no longer be Emotional support new concerns repo teaching was done verbalized understa Resident #83's was services. In an interview on 1 nurse stated Resid services and if she hospice, she would change MDS within plan. The MDS staf #83 was currently r In a telephone inter the hospice nurse s services started on	d Resident #83's responsible ent at the facility to discuss the bice services next week and nd signed the notice of erage Form effective 10/8/14. and RP explained the bice services to Resident #83 taff. The note indicated the understanding of the pending ek. The hospice nurse visit note the facility staff was again ent #83's discharge from	F 27	74	when an order is written to initiate or discontinue hospice services. A sign change assessment will be complete RAI guidelines on all residents who added or discontinued by hospice services in the future. Monitoring: An audit will be complete MDS Coordinator or designee week 3 months of all residents who have a added or discontinued from hospice services in the previous week. Durin audit MDS Coordinator or designee confirm any resident who has been or discontinued from hospice service since. Audits will monitored by Administrator weekly time 4 months then monthly for 2 months to ensure residents who have been added or discontinued from Hospice services ensure significant change assessme has been completed per RAI guideli A comprehensive review of the audi described above and the systems modifications we have made will be discussed and monitored through or quality assurance meeting at least quarterly. Any further omissions regarding physician notification will f addressed by the QA Committee to determine if further systems modific and/or training are in order.	hificant ed per are ed by ly for been will added es and es to ent ines ts ur	

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	-	AND HUMAN SERVICES					FORM	APPROVED
		& MEDICAID SERVICES				O		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION			E SURVEY PLETED
		345553	B. WING					C 11/2014
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZI	IP CODE	12/	11/2014
					401 71ST SCHOOL ROAD			
AUTUMN	CARE OF FAYETTE	VILLE		F	AYETTEVILLE, NC 28314			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF	CORRECTION	1	(X5)
PRÉFIX TAG			(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPF		COMPLETION DATE		
F 274	Continued From pa	ae 14	F 2	74				
		2/14 of the services ending on	1 2					
		Id at the facility with the family						
		2/10/14 at 4:50 PM Nurse #1						
	manager the week	aide informed her and the unit before hospice services						
		Ild not being providing						
		14 to Resident #83. She d the unit manager or the						
		e the order stopping hospice						
	services. Nurse #1	confirmed her name as listed						
		ospice note dated 10/8/14 in aching was done with her.						
		w on 12/10/14 at 4:15 PM with						
		vith the director of nursing, the she did not routinely review						
		lan completed by the providing						
	hospice agency and	d was unaware Resident #83						
		m hospice services. She						
		as written discontinuing ne would have completed a						
	•	MDS within 14 days after						
	Resident #83's disc							
		2/11/14 at 11:13 AM the unit was aware that hospice was						
		she did not recall the Nurse						
	#1 or the hospice n	urse providing a definite date.						
		pice nurse or Nurse #1 should						
	have written the orc	ler stopping hospice services.						
		2/11/14 at 12:50 PM with the						
		ON and the facility nurse						
		ity nurse consultant stated a						
		been written discontinuing r Resident #83 and a						
		VDS should be completed						

Facility ID: 060241

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		AND HUMAN SERVICES			FORM	01/22/2018 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE C		
		345553	B. WING			」 11/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
AUTUMN	I CARE OF FAYETTE	VILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 274	Continued From pa	ge 15	F 27	74			
	within 14 days after discharged from ho	any resident was admitted for					
F 279 SS=G	483.20(d), 483.20(k COMPREHENSIVE	()(1) DEVELOP	F 27	9		1/8/15	
		the results of the assessment and revise the resident's n of care.					
	plan for each reside objectives and time medical, nursing, a	ity must develop a comprehensive care each resident that includes measurable is and timetables to meet a resident's nursing, and mental and psychosocial at are identified in the comprehensive tent.					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are ttain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment .).					
	by: Based on record re interviews, the facil potential for the dev in a resident identif 53) for 1 of 3 reside ulcers. Findings inc Resident #53 was a	NT is not met as evidenced eview, observations and staff ity failed to address the velopment of a pressure ulcer ied as "high risk" (Resident # ents reviewed for pressures cluded: admitted 4/20/12 with I vascular accident (CVA),		F279 This plan of correction will ser facilityOs allegation of complia requirements of 42 CFR, Part Subpart B for long term care f Preparation and submission o correction is in response to DI for the 12-11-14 survey and do	ance with 483, acilities. f this plan of HHS 2567		

Facility ID: 060241

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	H AND HUMAN SERVICES			FORM	01/22/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED
	345553	B. WING			C 11/2014
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZI		
AUTUMN CARE OF FAYETT	EVILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
dementia and co Data Set (MDS) of Resident #53 trig development of p Assessment (CA requiring staff as relieve pressure, bed or chair all of a pressure relieve risk factors includ and incontinence #53 to be care pl interventions. The weekly skin a indicated no redr anywhere of Res skin assessment redness, no bliste Resident #53's b Record review re 9/18/14 at 2:34 P developed an op appearing to be a measured "3mm W" Width). The u apply wound gel damaged tissue) pad and wrap are the nursing note changed. Resident #53's cl onset of a right o effective 9/22/14 cleaning area wit	A hemiplegia, dysphagia, htractures. His annual Minimum completed 4/22/14 indicated gered as "high risk" for the ressure ulcers. The Care Area A) listed extrinsic risk factors as sistance to move sufficiently to he was coded as confined to most of the time and as having ng mattress to his bed. Intrinsic led cognitive loss, hemiplegia . The CAA directed Resident anned for the risk potential with assessment completed 9/12/14, ess, no blisters or open areas to dent #53's body. The weekly completed 9/15/14 indicated no ers or open areas to anywhere to		 279 constitute an agreement Autumn Care of Fayettev the facts alleged or the conclusions stated on the deficiencies. This plan of prepared and submitted by requirements of 42 CFR, Subpart B throughout the stated in the statement of accordance with state an however, submits this plat address the statement of to serve as itOs allegation with the pertinent require dates stated in the plan of as fully completed as of a For the Resident affected #53Os care plan for wour right outer ankle was upor 2014. For the Residents with th affected: In-service was of -2015 with MDS coordinat updating residentOs care resident is identified as h was completed by the DO Coordinators, and Region 12-30-14, 1-5-15, and 1-6 Measures Put in Place/sy Weekly Audit was initiate review/update residentOs ensure orders/intervention wounds are included. Th conducted by DON or De Monitoring: the DON or h review 5 residents per we then 2 residents a month ensure physician notificar 	ville of the truth of orrectness of the e statement of f correction is because of the Part 483, e time period f deficiencies. In d federal law, an of correction to f deficiencies and n of compliance ments as of the of correction and January 8, 2015. d: Resident nd treatment to dated on 9-23- the potential to be completed on 1-6 ators regarding e plans when a ligh risk. An Audit DN, MDS nal QA nurse on 6-15. ystems change: A d, on 1-5-15 to s Care Plan to ons relating to his audit will be esignee. her Designee will eek for 4 weeks for 2 months to	

Facility ID: 060241

ATEMENT OF DEFICIENCIE	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED	
	345553				C 11/2014	
NAME OF PROVIDER OR SU			STREET ADDRESS, CITY, STATE, ZIP C		11/2014	
AUTUMN CARE OF FA			1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314			
PREFIX (EACH DE	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETIC DATE	
and as need intervention wound meas refusal of ca Record revie Resident #5 at 2:00 PM i assessment intact" and c described as The area wa (centimeters watery clear covered with tissue). An described as exposed boy Necrosis/es Physician or mattress wa activities of c Record for S alternating a 9/25/14. The include the a Review of th stated 9/29/ consultant p debridemen Santyl. He o	rom page 17 ain foam and secure with tape daily ed. The only other indicated dated 9/22/14 included a weekly urement. There was no care plan for re regarding his lower extremities. w revealed the next mention of d's wound care needs was on 9/22/16 a note labeled as a weekly wound The "dressing to the right leg was noce removed the wound was an "unstageable pressure wound." s documented as measuring 2.0 cm 0 L x 4 cm W with serous (thin, drainage and the wound base was soft yellow to black eschar (dead unstageable" pressure ulcer may be full thickness tissue loss with e, tendon or muscle. har may also be present. ders revealed an alternating air s ordered 9/24/14 and a review of the aily living (ADLs) Administration eptember 2014 indicated the r mattress was in place as of current care plan was updated to lternating air mattress on 10/1/14. e record revealed a nursing note 4 at 2:00 PM the wound care hysician conducted a bedside and continued the treatments using escribed the wound as being necrosis" measuring 1.9 cm L x 1.9 thout drainage. This consult note ed bunny boots. w revealed a physician order dated	· 4	Care Standing Order Initiate A comprehensive review of described above and the sy modifications we have mad discussed and monitored th quality assurance meeting a quarterly. Any further omis regarding physician notifica addressed by the QA Comr determine if further systems and/or training are in order.	the audits vstems e will be nrough our at least sions tion will be nittee to s modifications		

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345553	B. WING			C 11/2014
		/// E		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD		
AUTUMN				FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	tolerated with skin of and the care plan w the bunny boots.	ge 18 oots to bilateral feet as checks to the feet every shift vas updated 10/1/14 to include wound care observation on	F 279			
	the area was consid developed at the fa	-				
F 309 SS=D	nurse consultant ar Resident #53 was in pressure ulcers on dated 7/21/14, 10/2 The facility nurse co provide any policy of implementation of in identified as a "high pressure ulcer.	nterventions for resident risk" for the development of a CARE/SERVICES FOR	F 309			1/8/15
	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment				
	by: Based on observat record the facility fa scheduled care plan	NT is not met as evidenced ions, staff interviews and iled to include hospice staff in n meeting and the facility the planned hospice		F309 This plan of correction will serve as facilityOs allegation of compliance v requirements of 42 CFR, Part 483,		

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		AND HUMAN SERVICES				FORM	01/22/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMF	E SURVEY PLETED
		345553	B. WING			(12/1	, 1/2014
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUM	CARE OF FAYETTE	VILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROPF DEFICIENCY)	(X5) COMPLETION DATE	
F 309	 83) reviewed for horincluded: Resident #83 was a cumulative diagnost congestive heart fat The most recent M quarterly assessment indicated Resident impairment and receiving hospice stans of months indicated a hospice stans needed, assess that caregivers were keeping the family if Resident #83 and in the hospice provide recertification dates indicated Resident services twice week times weekly. On 12/08/14 at 1:47 provided entrance of Resident #83 as reworksheet directed investigation of resist services. In an observation of Resident #83 was interface and the service set for the set for the service set for the set for the service set for the service set for the service set for the set for the service set for the set for the set for the service set for the se	age 19 ervices for 1 of 1 (Resident # spice services. Findings admitted to the facility with tes of osteoarthrosis, ilure (CHF and Parkinson's. inimum Data Set (MDS) was a ent dated 9/23/14. This MDS #83 had severe cognitive guired extensive assistance f daily living, non-ambulatory, el and bladder and coded as ervices with a prognosis of . Resident #83 care plan e care plan was initiated int with the next review of ions included the assessment ADL needs, provide assistance ment of pain pain, ensuring e aware of her wishes and informed of changes in in her medications. A review of er care plan was current with a from 8/10/14 to 10/0814 and #83 was receiving nursing kly and aide services three 7 PM, the administrator conference worksheet listed ceiving hospice services. This the survey process in the idents receiving specialized in 12/8/14 at 3:52 PM, n bed. She appeared clean eds or discomfort. In another	F	309	Subpart B for long term care facilitie Preparation and submission of this correction is in response to DHHS 2 for the 12-11-14 survey and does m constitute an agreement or admissi Autumn Care of Fayetteville of the f the facts alleged or the correctness conclusions stated on the statement deficiencies. This plan of correction prepared and submitted because or requirements of 42 CFR, Part 483, Subpart B throughout the time perior stated in the statement of deficience accordance with state and federal 1 however, submits this plan of corre- address the statement of deficienci to serve as itOs allegation of compli- with the pertinent requirements as of dates stated in the plan of correction as fully completed as of January 8, For the resident affected: Order wri 12/11/14 to discontinue Hospice se for resident #83. For the resident with the potential to affected: Hospice was contacted fo current residents receiving Hospice Services to confirm when each resi Hospice recertification to ensure coordination of planned discontinuation/continuation of Hos Services. A Care Plan meeting will scheduled at the time of recertificat include a Hospice Representative a least quarterly. An order will be writ timely by a licensed nurse for any ro who is discontinued from hospice services. This order will then be transcribed into the electronic healt	plan of 2567 ot ion of truth of of the it of n is f the od ies. In aw, ction to es and iance of the n and 2015. tten on rvices o be r all dents pice be ion to and at ten esident	

Facility ID: 060241

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM OMB NO.	0938-039	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	СОМ	E SURVEY PLETED	
		345553	B. WING _			C 11/2014	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	CODE		
AUTUMI	N CARE OF FAYETTE	VILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314			
(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 C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE) (EACH CORRECTIVE) (EACH CORRECTIVE) (EACH CORRECTIVE) (EACH CORRECTIVE) (EACH CORRECTIVE) (EACH CORRECTIVE ACTION (EACH CORRECTIVE) (EACH CORRECTIVE ACTION (EACH CORRECTIVE) (EACH COR	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIOI DATE	
F 309	observation on 12/9 was again observer confused and report of bed today but report of bed today but report of bed today but report Record review of the dated 10/02/14 read part (RP) was present termination of hosp the RP reviewed and Medicare Non-cover The hospice nurse termination of hosp and to the facility staff voiced discharge next week Record review of the dated 10/6/14 read reminded of Reside hospice services on Record review of the dated 10/8/14 read when she was rem would no longer be Emotional support new concerns report teaching was done verbalized understa Resident #83 was of services. In an interview on the manager stated Report receiving any hosping	9/14 at 9:50 AM, Resident #83 d in bed. She was pleasantly rted she did not wish to get out ported no discomfort. The hospice nurse visit note d Resident #83's responsible ent at the facility to discuss the bice services next week and nd signed the notice of erage Form effective 10/8/14. and RP explained the bice services to Resident #83 taff. The note indicated the understanding of the pending ek. The hospice nurse visit note the facility staff was again ent #83's discharge from	F 30	09 record. Measures put in place: Re completed on 1-6-15 by R Administrator with both Mi regarding the responsibilit hospice representatives to conferences for all resider hospice services. Monitoring: DON or design monthly for 3 months to e appropriate hospice comp requested to attend meeti or designee will also audit resident charts monthly fo ensure the facility appropr coordinates the planned h discontinuation of services resident who is discontinu services in the future. A comprehensive review of described above and the s modifications we have ma discussed and monitored quality assurance meeting quarterly. Any further omi regarding physician notific addressed by the QA Com determine if further syster and/or training are in orde	egional QA and DS coordinators y of inviting the o all care plan ints receiving nee will audit nsure oany has been ing timely. DON appropriate r 3 months to iately iospice s for each ed from hospice of the audits systems ide will be through our g at least stion will be mittee to ins modifications		

			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
A. BOILDING C 345553 B. WING 12/11/2014	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		LE CONSTRUCTION	(X3) DATE SURVEY		
							(С	
	NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN CARE OF FAYETTEVILLE 1401 71ST SCHOOL ROAD					1	401 71ST SCHOOL ROAD			
FAYETTEVILLE, NC 28314	AUTUWIN	CARE OF FATELLEN	VILLE		F	AYETTEVILLE, NC 28314			
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGID PREFIX TAGPROVIDER'S PLAN OF CORRECTION 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT		
 F 309 Continued From page 21 In an interview on 12/10/14 at 12:30 PM, nursing assistant (NA) #4 confirmed she had worked with Resident #83 regularly and that she had not received any hospice services for a "couple of months." In another interview on 12/10/14 at 12:40 PM, Nurse #2 stated she had only recently graduated from nursing school but since she worked with Resident #83 for past few months, she had not been receiving hospice services. In a telephone interview on 12/10/14 at 3:00 PM, the hospice nurse supervisor confirmed hospice services started 12/13/13 and ended on 10/8/14 for Resident #83 for past few months, she had not been receiving hospice services confirmed hospice services started 12/13/13 and ended on 10/8/14 for Resident #35 was supervisor also confirmed no documented evidence of the facility mas made aware on 10/2/14 of the services ending on 10/8/14 in a visit held at the facility with the family present. The hospice nurse supervisor also confirmed no documented evidence of the facility notifying hospice staff of any scheduled care plan conferences to discuss Resident #83 was on hospice services and if she was discontinued from hospice, she would have to complete a significant change MDS within 14 days and update her care plan. The MDS nurse stated she was "certain" Resident #83 was currently receiving hospice services. In another interview on 12/10/14 at 4:15 PM with MDS nurse along with the director of nursing and the facility nurse consultant, the MDS nurse along with the director of nursing and the facility nurse endow with the own the Source stated she was 'certain' Resident #83 was currently receiving hospice care plan completed by the providing hospice agency. The MDS nurse along with the director of nursing and the facility nurse consultant, the MDS nurse along with the director of nursing and the facility nurse consultant, the MDS nurse along with the director of nursing and the facility nurse consultant, the MDS nurse along with	F 309	In an interview on 1 assistant (NA) #4 cd Resident #83 regula received any hospic months." In another interview Nurse #2 stated she from nursing schoo Resident #83 for pa been receiving hospic ln a telephone inter the hospice nurse s services started 12/ for Resident #83. S made aware on 10/ 10/8/14 in a visit he present. The hospic confirmed no docur notifying hospice sta conferences to disc on hospice effective In an interview on 1 nurse stated Reside services and if she hospice, she would change MDS within plan. The MDS nurse Resident #83 was co services. In another interview MDS nurse along w the facility nurse co stated she did not re- care plan completed	2/10/14 at 12:30 PM, nursing onfirmed she had worked with arly and that she had not ce services for a "couple of on 12/10/14 at 12:40 PM, e had only recently graduated I but since she worked with ast few months, she had not pice services. view on 12/10/14 at 3:00 PM, supervisor confirmed hospice (13/13 and ended on 10/8/14 She stated the facility was 2/14 of the services ending on Id at the facility with the family ce nurse supervisor also mented evidence of the facility aff of any scheduled care plan cuss Resident #83's care while e 12/13/13. 2/10/14 at 3:10 PM, the MDS ent #83 was on hospice was discontinued from have to complete a significant 14 days and update her care se stated she was "certain" currently receiving hospice	F 3	09				

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DEPARTMENT OF HEALTH AND HU CENTERS FOR MEDICARE & MEDI						FORM	01/22/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROV	/IDER/SUPPLIER/CLIA	. ,		LE CONSTRUCTION	0	(X3) DATI COM	E SURVEY PLETED
	345553	B. WING	i				C 11/2014
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE,	ZIP CODE		
AUTUMN CARE OF FAYETTEVILLE				1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314			
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE DECLINATORY OR LSC IDENTIFIC	PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN O (EACH CORRECTIVE AC	CTION SHOULD	BE	(X5) COMPLETION DATE
TAG REGULATORY OR LSC IDENTIF	TING INFORMATION)	TAG		CROSS-REFERENCED TO DEFICIEN			27112
F 309 Continued From page 22 care plan meeting was sche resident, her expectation wa party to notify the hospice pr scheduled care plan meeting she was not aware that Resi longer receiving hospice ser In a interview on 12/10/14 at stated the hospice aide infor manager the week before ho ended that she would not be services after 10/8/14 to Resi stated she assumed the unit hospice nurse wrote the ord services. Nurse #1 confirme on the discharge hospice no which discharge teaching wa In an interview on 12/11/14 a manager stated she was aw discontinuing hospice servic recall Nurse #1 or the hospic definite date. She stated the Nurse #1 should have writte hospice services. In an interview on 12/11/14 a administrator, the DON and consultant, the facility consu order was written, it would have services. The facility nurse of and there was no order disc services. The facility nurse of and there was no order disc services. The facility did not ma or hard copy of physician ord once the order was written a electronic medical record, tw verify that the order was corr order was no longer needed	s that the responsible ovider of the g. The DON verified ident #83 was no vices. 4:50 PM Nurse #1 med her and the unit ospice services ing providing sident #83. She t manager or the er stopping hospice d her name as listed te dated 10/8/14 in as done with her. at 11:13 AM the unit are that hospice was es but she did not ce nurse providing a hospice nurse or n the order stopping at 12:50 PM with the the facility nurse Itant stated that if an ave identified in hospice caseload ontinuing hospice consultant further intain any handwritten ders. She stated that ind entered into the vo nurses had to rect then the written	F3	309				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345553	B. WING	,		C 11/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
ΔΗΤΗΜΝ		/!! ! E		1401 71ST SCHOOL ROAD		
70101				FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 F 314 SS=G	facility has a daily s implemented a corr changes regarding alerts, new orders, stated it would be h hospice services we have been made av in order to ensure th the care no longer b The facility nurse corr responsibility of the providers to care pl facility communication 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facility all the word the word the word individual's clinical of they were unavoida prevent new sores facility and physician interv implement pressure new stage 2 pressure treat a new stage 2 9/22/14, the wound unstageable for 1 o	tand up meeting and she imunication board for any new residents based on computer consults or incidents. She er expectation that before ere terminated, she would ware of the upcoming end date he facility staff was providing being provided by hospice. Dosultant stated it was the MDS nurse to invite hospice an meetings in orders to ion between the agencies. ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing. NT is not met as evidenced eview, observations and staff views, the facility failed to a relief upon the discovery of a ire ulcer on 9/18/14, failed to pressure ulcer for 4 days; on	F 309)	with es. plan of 2567	1/8/15

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	-	AND HUMAN SERVICES			I	FORMA	01/22/2019 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (>	COMF	SURVEY
		345553	B. WING			C 12/1	; 1/2014
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUM	CARE OF FAYETTE	VILLE			401 71ST SCHOOL ROAD AYETTEVILLE, NC 28314		
(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 314	Standing Orders " open/ruptured seru a stage 2 pressure treatment was to cl (saline based wour apply a regular hyd non-breathable adh dressing should be then every week th Resident #53 was a cumulative cerebra anemia, left sided h dementia and contr Data Set (MDS) da cognitive impairme coded as extensive and eating and tota toileting, hygiene an coded as non-amb bladder and bowel. having a stage 3 pr cm x 3.2 cm with sl for pressure relievin bed. Record Review rev assessments. The completed 9/12/14, blisters or open are #53's body. The we completed 9/15/14 blisters or open are #53's body.	age 24 lity undated "Wound Care indicated an intact or m filled blister was considered ulcer and the ordered eanse the area with Sea-Clens ad cleaning agent), pat dry and rocolloid (biodegradable, nerent) or foam dressing. This changed on day 3, day 7 and ereafter until healed. admitted 4/20/12 with I vascular accident (CVA), nemiplegia, dysphagia, ractures. The 30 day Minimum ted 11/24/14 indicated severe nt, no behaviors and he was e assistance with bed mobility I assistance with transfers, nd bathing. Resident #53 was ulatory and incontinent of Resident #53 was coded as ressure ulcer measuring 2.0 lough present. He was coded ng devices to his chair and ealed evidence of weekly skin ewekly skin assessment indicated no redness, no eas to anywhere of Resident exkly skin assessment indicated no redness, no eas to anywhere to Resident exel a nursing note dated indicating Resident #53	F3	314	constitute an agreement or admissio Autumn Care of Fayetteville of the tru the facts alleged or the correctness of conclusions stated on the statement deficiencies. This plan of correction prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies accordance with state and federal law however, submits this plan of correct address the statement of deficiencies to serve as itOs allegation of complia with the pertinent requirements as of dates stated in the plan of correction as fully completed as of January 8, 2 For the Resident affected: Resident af developed a wound on 9-18-2014, treatment was initiated at time of discovery per Wound Care Standing Orders. On 9-18-214 Physician was notified regarding the wound via entry the communication book at the nurse station per physicianOs request. Dur physician visit on 9-19-2014 physicia initialed acknowledgment that she has reviewed the entry and the treatment which was initiated per the FacilityOs standing orders for pressure sores. Treatment of the affected resident has continued including both treatment of initial wound and further interventions designed to promote healing and pre additional wounds. These include alternating air pressure mattress, vas surgeon referral regarding ABI result left/right ankle, multi vitamin daily, vit	uth of of the of is the d es. In w, tion to s and ance f the and 2015. #53 #53 ry in esO ring an ad t s s esent s scular ts of	

Facility ID: 060241

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						<u>/IB NO. 0938-03</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
				·		С	
		345553	B. WING _			12/11/2014	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, (CITY, STATE, ZIP CODE	12/11/2014	
				1401 71ST SCHOO			
AUTUMN	CARE OF FAYETTE	VILLE		FAYETTEVILLE,	NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COI	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO	
F 314	Continued From pa	age 25	F 31	1			
	0 0	busted blister." The area	1 31		protective boots. Reside	ontOs	
		nillimeters) L (Length) and 2.3			dated on 12-10-14 to r		
		hit manager gave instructions			ompliance with treatme		
		(ointment use to hydrate			und care needs.	110	
		nd cover with dry gauze, foam			dents with the potential	to be	
		. There was no indication in			current residents with w		
		by often the dressing was to be			ed by DON and Adminis		
	changed.				5, and 1-8-15, to ensu		
	onangea.				reatment orders are in		
	Resident #53's cur	rent care plan included the			scription of wound. All		
	onset of a right outer ankle unstageable wound			orders were found to be			
		ith interventions to include		place.			
		Sea Clens, pat dry, apply			it in Place/systems cha	nge: If	
		debriding ointment), cover with			l is identified, the charg		
		am and secure with tape daily			mediately initiate Wou		
		e only other indicated			g Order Protocol. The		
		9/22/14 included a weekly			pdated its Wound Care	e	
		ent. There was no care plan for			lers to include Enter sta		
		arding his lower extremities.			tronic Medical Health R		
					eld by DON and SDC 1		
	Record review reve	ealed the next mention of			, and 1-7-15 that includ		
		und care needs was on 9/22/14			aff that when initiating a		
		e labeled as a weekly wound			ers a physician order sl		
		dressing to the right leg was			ated and the order place		
		moved the wound was			c medical health record		
	described as an "u	nstageable pressure wound."			PA must be notified of		
		imented as measuring 2.0 cm			and/ or worsening of a		
		cm W with serous (thin,			nd. The FacilityOs Wo		
		age and the wound base was			g Orders were updated		
		ellow to black eschar (dead			de that staff must notify		
		geable" pressure ulcer may be		physician at t	he time a wound is ide	ntified	
	described as full th	ickness tissue loss with		and/or worse	ning of wound and doc	ument	
	exposed bone, ten	don or muscle.			ician has been notified		
		ay also be present. The note			ress note. Treatment of		
		s changed to Santyl and a			ated from the order place		
	moisten gauze dail				ronic Medical Health R		
		ire Administration Record for			ne DON or her Designe		
		dicated the first documented			dents per week for 4 w		
	pressure ulcer trea	tment was 9/22/14		then 2 reside	nts a month for 2 mont	ths to	

Facility ID: 060241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM		
345553 B. WING 12 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD AUTUMN CARE OF FAYETTEVILLE FAYETTEVILLE, NC 28314 FAYETTEVILLE, NC 28314 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X3) DATE SURVEY COMPLETED C	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUTUMN CARE OF FAYETTEVILLE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314 FAYETTEVILLE, NC 28314 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	(11/2014	
AUTUMN CARE OF FAYETTEVILLEFAYETTEVILLE, NC 28314(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE		
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	(X5) COMPLETION DATE	
F 314 Continued From page 26 F 314 ensure treatment order entered into		
 Physician orders revealed an alternating air mattress was ordered 9/24/14 along with a circulatory studies and vascular consult. Ankle brachlai index (ABI) testing was completed 9/24/14 with inconclusive results and a referral to a vascular surgeon. A review of the activities of daily living (ADLs) Administration Rectord for September 2014 indicated the alternating air mattress was in place as of 9/25/14. Other ADL interventions documented on this record was heel checks every shift ongoing since 11/11/13. Review of the record revealed a nursing note stated 9/29/14 at 2:00 PM the wound care consultant physician conducted a bedside debridement and continued the treatments using Santyl. He described the wound as being "unstageable necrosis" measuring 1.9 cm L x 1.9 cm W and without drainage. This consult note recommended bunny boots and repositioning. Record review revealed a physician order dated 10/1/14 for bunny boots to bilateral feet as tolerated with skin checks to the feet every shift. The facility wound care consultant physician andre dated 10/1/14 for bunny boots and repositioning. Record review revealed another wound consultant physician is on 10/20/14 described the wound condition. Record review revealed another wound consultant physician is in 0.1/20/14 described the wound condition. Record review revealed another wound consultant physician is in 0.1/20/14 described the wound condition. Record review revealed another wound consultant physician is in 0.1/20/14 described the wound condition. Record review revealed another wound consultant physician is infected and deteriorated. It was also described with unstageable necrosis measuring 2.5 cm L x 3.0 cm W with no drainage. The note read Resident #35's lies on his right stide causing undue 		

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		AND HUMAN SERVICES				FORM	: 01/22/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		345553	B. WING	÷			C 11/2014
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
AUTUM		/ILLE			1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	the area surroundin bed. It was docume "kick off" his boots a discussed with Res and keep off his rig Resident #53 A nurses note dated indicated the prima and was made awa in the wound since and subsequent on was no change in o Record review reve by a vascular surge impaired circulation the ABI completed of from the vascular s studies were norma spontaneously and circulatory impairme In an interview and 12/10/14 at 9:15 AM the area was consid developed at the fa a blister measuring (depth) with undern position. There was right upper edge of drainage appeared was no evidence of nurse verified he pr in bed and in his real	There was deep tissue injury to be the wound and the wound ented that Resident #53 would and the wound physician ident #53 the need to off load ht side. It was documented d 10/20/14 at 11:00 AM ry physician was at the facility ire of the lack of improvement the wound culture on 10/13/14 going antibiotic therapy. There orders. ealed Resident #53 was seen eon on 11/6/14 to rule out and follow up of the results of on 9/24/14. The progress note urgeon indicated the ABI al, the wound should heal there was no evidence of ent to the right lower extremity. wound care observation on A the treatment nurse stated dered a pressure ulcer and it cility. She recalled it started as 2cm L x 4 cm W x 0.8 cm D nining noted at the 2 o'clock is yellowish slough noted to the the wound bed and the watery, pale red/pink. There odor or pain. The treatment referred to be on his right side	F	314			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/22/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345553	B. WING				C 11/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ΑυτυΜ	N CARE OF FAYETTE	VILLE			401 71ST SCHOOL ROAD AYETTEVILLE, NC 28314		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	on Resident #53 rig ulcer and he had no ulcers anywhere off to his left hand prio area to his right out #53's tendency to li his dementia and to assistance were co development of the unable to recall doo understood his inst side during his bed In another interview treatment nurse sta Resident #53 devel ankle on 9/18/14 ur skin alert sheet in h recalled she assess ankle and it was co considered an unst time. The treatmen when the protective but the staff had be heels in the bed an she could recall. In another interview facility nurse consu evidence of treatmen record for the bliste right outer ankle dis initial treatment the floor nurse to perfo 9/22/14. She also o to the blister on 9/1 the facility's standin	age 28 ght outer ankle was a pressure o history of any other pressure her than a few incidental areas or to the development of the ter ankle. He noted Resident ie on his right side along with otal assistance for ADL ontributing factors to the e pressure ulcer. He was cumenting Resident #53 rructions to stay off of his right side visit on 10/20/14. v on 12/11/14 at 9:35 AM, the ated she was not aware loped a blister to his right ntil she received a copy of a ner box dated 9/22/14. She sed Resident #53's right out overed with eschar and tageable pressure ulcer at that it nurse stated she was unsure boots were actually ordered een floating Resident #53's id reclining chair for as long as v on 12/11/14 at 10:25 AM, the litant confirmed there was no ent in the electronic medical ered area to Resident t#53's scovered 9/18/14 after the unit manager instructed the rum on 9/18/14 until again on confirmed the treatment done 8/14 was not consistent with ng wound care orders, no mattress ordered until 9/25/14.	F	314			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			IPLETED
		345553	B. WING				C 11/2014
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN		/ILLE			1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
0(4) 15		TEMENT OF DEFICIENCIES		r	PROVIDER'S PLAN OF CORRECTION		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pa	ae 20	F 3	01 <i>1</i>			
1 014		view on 12/11/14 at 10:55 AM,	гс	14			
	the vascular surged	on recalled seeing Resident					
		11/6/14 to rule out vascular					
		compromise. He stated studies were normal and the					
	area was pressure	related but contributing factors					
	to the development and left sided weak	of the area was his dementia					
	and left sided weak	11655.					
		on 12/11/14 at 11:13 AM, the					
		ed being asked to assess the i3's right outer ankle. She					
		as an open blister and she told					
	the nurse to put wo	und gel on it and wrap it with					
		ary physician could be onal orders. She stated she					
		primary physician to get					
		it thought Nurse #1 contacted					
		unit manager stated wound eas such as an open blister to					
		nd normally were ordered to be					
		to maintain the moisture. She					
		ecall telling the floor nurse should re-dressed. The unit					
	manager state whe	n a new area was discovered					
		e floor nurse completed a skin					
		e treatment nurse know there needed to be assessed for					
	wound care needs.	The unit manager stated she					
		a report of daily alerts based					
		into the computer. She vas no order written regarding					
	a new identified pre	ssure ulcer, there would be no					
	alert on the report f	or follow up.					
	In an interview on 1	2/11/14 12:18 PM, Nurse #1					
	recalled NA #2 infor	ming her of an opened area					
		ght outer ankle on 9/18/14. it manager assisting her with					

Facility ID: 060241

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		AND HUMAN SERVICES				FORM	01/22/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COM	E SURVEY PLETED
		345553	B. WING				_ 11/2014
NAME OF F	PROVIDER OR SUPPLIER	·			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	I CARE OF FAYETTE	VILLE			1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314 F 334 SS=D	unit manager told h area and wrap it wit write any orders an that the unit manag and wrote any order was during her wee 9/22/14 she complet in the treatment num not think the area to ankle had been red discovery on 9/18/1 In an interview on 1 administrator, the D verified there was r pressure ulcer from 9/22/14. In a telephone inter the primary physicia interventions as soon new pressure ulcer ankle and the delay place could have co the pressure ulcer a The primary physic would have been for care standing order on Resident #53's r physician further im gel to the area, wou minimum every oth promote healing. 483.25(n) INFLUEN IMMUNIZATIONS	the area. Nurse #1 stated the er to put wound gel on the th gauze. She stated did not d was under the impression er contacted the physician rs given. Nurse #1 stated it ekly skin assessment dated eted a skin alert form and put it rses box. She stated she did o Resident #53's right outer iressed or assessed since its		314			1/8/15

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		AND HUMAN SERVICES					FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	0		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			COM	PLETED
		345553	B. WING					C 11/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
AUTUMN	I CARE OF FAYETTE	/ILLE			401 71ST SCHOOL ROAD AYETTEVILLE, NC 28314			
(X4) ID			ID					(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	K	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPF		DATE
F 334	Continued From pa		F 3	34				
1 001	that ensure that	geor	гэ	54				
	(i) Before offering th	ne influenza immunization,						
	each resident, or th	e resident's legal ives education regarding the						
	benefits and potent	ial side effects of the						
	immunization;	offered an influenza						
		ber 1 through March 31						
	annually, unless the	e immunization is medically						
	immunized during t	he resident has already been his time period:						
	(iii) The resident or	the resident's legal						
	representative has immunization; and	the opportunity to refuse						
		nedical record includes						
		indicates, at a minimum, the						
	following: (A) That the reside	ent or resident's legal						
	representative was	provided education regarding						
	the benefits and pot immunization; and	tential side effects of influenza						
		ent either received the						
		tion or did not receive the						
	influenza immuniza contraindications or							
		evelop policies and procedures						
	that ensure that (i) Before offering th	ne pneumococcal						
		resident, or the resident's						
		e receives education regarding						
	immunization;	tential side effects of the						
	(ii) Each resident is	offered a pneumococcal						
	-	ss the immunization is icated or the resident has						
	already been immu							
	(iii) The resident or	the resident's legal						

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		AND HUMAN SERVICES				FORM	01/22/2015 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			COMF	E SURVEY PLETED
		345553	B. WING			(12/1	_ 1/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	14-/	172014
AUTUMN	I CARE OF FAYETTE	VILLE			401 71ST SCHOOL ROAD AYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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)	BE	(X5) COMPLETION DATE
F 334	immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po pneumococcal imm (B) That the reside pneumococcal imm the pneumococcal imm the pneumococcal imm the pneumococcal imm the pneumococcal imm years following the immunization, unless	the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F3	334			
	by: Based on record re facility failed to adm vaccination to 1 of with a signed conse immunizations. The findings includ A review of the faci Pneumococcal Dise reviewed. The polic	ed: lity policy on "Influenza and ease" dated 10/01/2006 was cy read in part "It is the policy himize the risk of patients			F334 This plan of correction will serve as facilityOs allegation of compliance w requirements of 42 CFR, Part 483, Subpart B for long term care facilitie Preparation and submission of this p correction is in response to DHHS 2 for the 12-11-14 survey and does no constitute an agreement or admission Autumn Care of Fayetteville of the to the facts alleged or the correctness conclusions stated on the statement deficiencies. This plan of correction	vith plan of 2567 ot on of ruth of of the t of	

Facility ID: 060241

		& MEDICAID SERVICES	r –			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COMF	SURVEY PLETED
					(
		345553	B. WING			1/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
AUTUMN	CARE OF FAYETTE	/ILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	PROVIDER'S PLAN OI X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 334	Continued From pa	ge 33	F 3	34		
	complications from pneumonia by assu- informed about the immunizations and (unless medically ca already immunized) pneumococcal imm patient's legal repre- regarding the benefit of the immunization obtained from the c site). Upon admissi a pneumococcal imm immunization is me patient has already years. The patient of representative has immunization." The patient's medical re documentation that following: the patier representative was the benefits and por pneumococcal imm received the pneum not receive the pne- to medical contrained Resident # 53 was 10/27/14. The most Set (MDS) assess documented Reside cognitively impaired record revealed a s	influenza and pneumococcal iring that each patient is benefits and risks of has the opportunity to receive ontraindicated or refused or) the influenza and funization. Before offering the funization, each patient, or the sentative receives education fits and potential side effects a. (This information will be surrent data on the CDC web on each patient will be offered munization, unless the dically contraindicated or the been immunized in the past 5 or the patient's legal the opportunity to refuse the e policy also indicated "the cord will include indicates, at a minimum, the nt or patient's legal provided education regarding tential side effects of funization. The patient either nococcal immunization or did umococcal immunization due dication or refusal."		 prepared and submitted requirements of 42 CFF Subpart B throughout th stated in the statement accordance with state a however, submits this p address the statement of to serve as itOs allegati with the pertinent require dates stated in the plan as fully completed as of For the residents affected given pneumococcal va 12-11-2014. To ensure other resident affected, an audit was of entire facility on1-6-15, to ensure all residents w the pneumococcal vaco For on-going compliance created to track pneumo- forms. These logs will b DON or designee. Whe received it will be given then be recorded onto t administered according An in-service with unit n completed 1-7-15 regar vaccine consent/declinat as applicable. An audit weekly by DON or desig was completed and ver- vaccine was given via re- record. This audit will be 	R, Part 483, he time period of deficiencies. In and federal law, lan of correction to of deficiencies and on of compliance ements as of the of correction and ¹ January 8, 2015. ed, resident was accination on ats are not completed of the 1-7-14, and 1-8-15 who wish to receive ine received it re, a log was ococcal consent be maintained by n consent is to DON. It will he log and to consent form. nanagers ding pneumonia ation, to administer will be performed gnee to ensure log ify pneumococcal esidentOs medical	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345553	B. WING			C 11/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	I CARE OF FAYETTE	/ILLE		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334 F 431 SS=D	During an interview Nurse Manager #1 consent for the pne further stated "I wa QA nurse that I nee pneumonia shot too In an interview on 1 Director of Nursing expectation for the pneumococcal vaco consent was receiv her expectation for medical record if the administered for an On 12/11/14 at 12:0 Regional QA Nurse Manager to adminis vaccination today. 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order controlled drugs is n reconciled. Drugs and biological labeled in accordan professional princip appropriate access	on 12/11/14 at 11:45am, stated she overlooked the umococcal vaccination. She s told today by the Regional d to give (Resident # 53) the day." 2/11/14 at 12:07 pm, the (DON) stated it was her nurse to administer the cination at the time the ed. She further stated it was the nurse to document in the e vaccination was not y reason. 09 pm during an interview, the stated she advised the Nurse ster the pneumonia 0RUG RECORDS, UGS & BIOLOGICALS nploy or obtain the services of cist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be ice with currently accepted les, and include the	F 334	A comprehensive review of the aud described above and the systems modifications we have made will be discussed and monitored through of quality assurance meeting at least quarterly. Any further omissions regarding physician notification will addressed by the QA Committee to determine if further systems modifi and/or training are in order.	e bur be	1/8/15

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/22/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL			SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		345553	B. WING			(12/1	C 11/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
AUTUM		/ILLE			401 71ST SCHOOL ROAD		
				-	AYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	applicable.	ge 35 State and Federal laws, the	F 4	31			
	facility must store a locked compartmer	Il drugs and biologicals in its under proper temperature t only authorized personnel to					
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri	ovide separately locked, I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can					
	by: Based on observation interviews, the facilit dispose of two tube Resident #124 (who 9, 2014) from 1 of 7 The findings include The facility's policy Pharmacy" undate- read in part "All me expired residents slipharmacy in 3 days An observation of that 10:23 am revealed	on "Returning Meds to the d was reviewed. The policy edications for discharged or hould be returned to the			F431 This plan of correction will serve as facilityOs allegation of compliance w requirements of 42 CFR, Part 483, Subpart B for long term care facilitie Preparation and submission of this p correction is in response to DHHS 2 for the 12-11-14 survey and does no constitute an agreement or admission Autumn Care of Fayetteville of the tr the facts alleged or the correctness conclusions stated on the statement deficiencies. This plan of correction prepared and submitted because of requirements of 42 CFR, Part 483, Subpart B throughout the time perior stated in the statement of deficiencies	vith es. plan of 2567 ot on of ruth of of the t of is the	

Facility ID: 060241

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DEPAR ⁻ CENTEI	RINTED: 01/22/2015 FORM APPROVED MB NO. 0938-0391								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		345553	B. WING			12/11/2014			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
AUTUMN CARE OF FAYETTEVILLE					1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)) BE	(X5) COMPLETION DATE		
F 431	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA		ection to cless and bliance of the on and , 2015. was b-14 ed on, -15, log back audited nsure need of audit g to be will be or e month, ck all ed. dits e our			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES										
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTI	UI PLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		NG		COMPLETED				
		345553	B. WING		C 12/11/2014					
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/11/2014					
AUTUMN	I CARE OF FAYETTE	/ILLE	1401 71ST SCHOOL ROAD							
			ID	FAYETTEVILLE, NC 28314						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						
F 431										
1 -01	31 Continued From page 37			31 determine if further systems modifie and/or training are in order.						

Facility ID: 060241