DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMF	E SURVEY PLETED
		345567	B. WING				C / 14/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		14/2015
	CARE OF CORNELIUS			19	9530 MOUNT ZION PARKWAY		
AUTOWIN	CARE OF CORNELIUS			С	ORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIF (INJURY/DECLINE/R		F 1	57			8/24/15
	consult with the resid known, notify the resi or an interested famil accident involving the injury and has the pol intervention; a signific physical, mental, or p deterioration in health status in either life thr clinical complications significantly (i.e., a ne existing form of treatr consequences, or to	nent due to adverse commence a new form of ion to transfer or discharge					
	and, if known, the rest or interested family m change in room or root specified in §483.15(resident rights under regulations as specifi- this section.	Federal or State law or ed in paragraph (b)(1) of					
	the address and phor	rd and periodically update ne number of the resident's or interested family member.					
	This REQUIREMENT	is not met as evidenced					
	Based on record revi responsible party and	iews and physician, I staff interviews the facility ysician when attempts to			Preparation and submission of this pla of correction constitutes my written allegation	in	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
	cally Signed						08/26/2015

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.

PRINTED: 08/31/2015

			0.00			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
			A. BUILDING	<u> </u>		
		345567	B. WING			C
		545507		STREET ADDRESS, CITY, STATE, ZI		8/14/2015
NAME OF PI	ROVIDER OR SUPPLIER				PCODE	
	CARE OF CORNELIUS			19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031		
						0/5)
(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) COMPLETIO DATE
F 157	Continued From page	e 1	F 15	57		
	administer intravenou	is fluids were unsuccessful		of compliance for the def	iciencies cited.	
	and failed to notify a	responsible party that a new		However,		
		ementia was being used for		submission of this plan o	f correction is not	
	1 of 3 sampled reside	ents (Resident # 3).		an		
				admission that a deficien	icy exists or that	
	The findings included			one was	- f	
	1 Desident #2 was a			cited correctly. This plan	of correction is	
	02/21/15 with diagno	dmitted to the facility on		submitted	tabliabad by the	
		kidney disease, chronic		to meet requirements es state and	labiished by the	
		, high cholesterol, heart		federal law.		
		allowing, dehydration and				
	-	C-Diff) a bacterial infection		F 157: Notify of Changes	8	
		causes infectious diarrhea.		It is the policy of this fac		
	A review of the most	recent quarterly Minimum		patient, consult with the	patient¿s	
	Data Set (MDS) date			physician and notify the		
		erely impaired in cognition		representative or an inte	2	
		king and required limited		member when there is a	•	
	assistance with eating	g.		significant change in the		
	A			physical, mental or psych		
		an's order dated 05/13/15		need to alter treatment s		
		s (IV) fluids of normal saline r 2 liters of fluids (2,000 ml).		decision to transfer or dis from the facility. Facility		
				patient and patient¿s leg	-	
	A review of a physicia	an's order sheet dated		or interested family mem		
		indicated peripherally		a change in room or roor		
		eter (PICC) insertion related		assignment and if there i		
	to difficult IV sticks (u oral fluid intake.	insuccessful) and encourage		Patient Rights under Feo	leral or State law.	
				Resident # 3 no longer r	esides in this	
	A review of a nurse's			facility and was discharg		
		by Nurse #3 revealed		complaint survey of 8/6/1		
		ave IV access when she		was sent to hospital for e	evaluation	
		t 11:00 PM on 05/13/15. The		5/20/15.		
		d she attempted twice to				
		nsuccessful and would		For other residents with t		
	report to oncoming n	ursing stall.		affected by this cited def the supervision of the Di	-	
	A review of a nurse's			100% audit was complet		

Facility ID: 061188

If continuation sheet Page 2 of 35

					CONSTRUCTION	1	0. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	· /	E SURVEY PLETED
			A. BUILDING	G			С
		345567	B. WING				0 /14/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				19	530 MOUNT ZION PARKWAY		
AUTUMN	CARE OF CORNELIUS			С	ORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 157	Continued From pag	o 2		E 7			
1 157			F 1	57	to review orders since 5/13/15 to ensu		
		by Nurse #4 indicated IV not nd Mobilex (mobile x-ray)			no other	11 C	
	was scheduled to arr				IV fluid order concerns. Since the order	er of	
		-,			5/13/15 for IV fluids for resident #3, or		
	During an interveiw of	on 08/06/15 at 2:07 PM with			other IV fluid was identified. The order	for	
	Nurse #3 she confirm			IV fluids was received 8/10/15 and no			
		until 3:00 PM on 05/13/15			concerns for this order were identified		
	-	Resident #3. She stated			The Director of Nurses on 8/07/15 in-		
		sident #3 did not eat or drink he recalled a conversation			serviced licensed Nurses of the facility policy to notify physicians, the response		
	-	oner (NP) who no longer			party, or family member for significant		
		about IV fluids for Resident			change of condition or medication as		
	-	IP said she wanted to give			defined in the federal regulation.		
	Resident #3 IV fluids	of normal saline but she did					
		them and did not say how					
		or how fast to give them.			To enhance currently compliant		
		should have asked the NP			operations and prevent further recurre of this cited deficiency, under the	ence	
		amount of fluids to give and t as a verbal order but she			supervision of the Director of Nurses t	he	
		nought the NP would write an			following systems have been placed:	iic ii	
		ed she reported to Nurse #2			audits of all nurse narrative notes, and	ł	
		nd shift from 3:00 PM to			new orders have been reviewed 5 day		
		IP had said and she thought			per week to ensure physician and or		
	-	for the IV but later heard that			responsible party/family member is		
		to start the IV but they were			notified of significant orders for		
	unsuccessful.				medication and care changes.		
	Nurse #2 was no lon	ger employed at the facility			Reviewing the daily progress notes re and	ροπ	
		e reached for an interview.			orders within a specified duration repo	ort a	
					100% audit is completed Monday thro		
	During a telephone in	nterview on 08/06/15 at 3:59			Friday to ensure notification of signific	-	
	PM with Nurse #6 sh	e confirmed she worked			change is ongoing to both the physicia	an	
		M to 7:00 AM and was			and responsible party/family member.		
	-	Resident #3. She stated she			Further the Director of Nurses has		
		ils about IV fluids but after			created a quality assurance audit tool	aad	
	review of her nurses				placed at each nurse¿s station. Licens nurses were in-serviced to complete the		
		she only attempted to try and ce. She further stated Nurse			audit tool when an RP/family member		

Facility ID: 061188

If continuation sheet Page 3 of 35

						NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
			A. DOILDING			С
		345567	B. WING		08/14/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				19530 MOUNT ZION PARKWAY		
AUTUMN	CARE OF CORNELIUS			CORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 157	Continued From page	e 3	F 15	7		
-	call when she couldn'	't get the IV started on the		federal regulation.		
	3:00 PM to 11:00 PM shift on 05/13/15. Nurse #6 verified she did not call the on call physician to let them know the IV had not been started but thought she had reported to the day shift nurse			Effective 8/10/15 a quality ass program was implemented un supervision of the Director of N	ider the	
	during the change of During an interview o	shift report. n 08/06/15 at 4:21 PM with		monitor /audit progress notes a physician orders to ensure the and responsible party have be	physician	
	Nurse #4 she explain care for Resident #3	ed she was not assigned to on 05/14/15 but was asked IV on Resident #3. She		for significant changes in care treatment. The Director of Nur designated quality assurance		
	stated she tried but R collapsing so the Dire	Resident #3's veins were ector of Nursing (DON) tried n. Nurse #4 verified mobile		representative will perform the systematic changes: review 10 progress notes for content, a) nurse	
	x-ray was called on 0 insert the PICC line a	5/14/15 at 11:53 AM to and they arrived at the facility PM. Nurse #4 also verified		physician orders daily Monday Friday x1 month then 3 days p 4 weeks, then 10 progress not	r through er week for	
		request mobile x-ray place		physician orders weekly x 4 we random weekly audits to ensure	eeks, then re	
	DON stated it was he staff to follow physicia	n 08/06/15 at 4:30 PM the er expectation for nursing an's orders to administer IV		compliance and follow through concerns/deficiencies are imm addressed and corrected on th the staff member involved. The	nediately the spot with e findings of	
	on call to report they getting the IV started	d have called the physician were unsuccessful with so additional orders could She explained a physician		these quality assurance audits documented and submitted at quarterly quality assurance co meeting for further review and	the mmittee	
	or NP was in the facil Monday, Tuesday, W	ity 4 days a week on /ednesday and Friday and on call 24 hours a day 7 days		action. The Director of Nursing responsible for monitoring, foll compliance.	g is	
	PM with the facility M he was also Resident					
	Monday, Tuesday, W	physicians or nurse cility 4 days per week on /ednesday and Friday and on call 24 hours a day for 7				

Facility ID: 061188

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES	-			FORM): 08/31/2015 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION			SURVEY LETED
		345567	B. WING		_		_ 14/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
AUTUMN	CARE OF CORNELIUS			19530 MOUNT ZION PARK CORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	for IV fluids for Reside nursing staff to let him physician know if they they could discuss a c provide other oral fluid hydrate her to make h to discuss need to set for evaluation. He fur could have been impr dehydration. 2. Resident #3 was a 02/21/15 and discharg #3's diagnoses includ Alzheimer's disease a Set (MDS) dated 05/1 had severely impaired demographic sheet sp Responsible Party (R Review of Resident # revealed: - A physician's ord Nurse #2 to start Exel Further review of the there was no docume RP was notified of the On 08/06/15 at 1:00 F (DON) was interviewed were expected to noti parties of medication by calling and that the documented in the material explained that when a	ed when orders were given ent #3 he expected for a know or the on call v could not start them so contingency plan such as to ds or other options to her veins more prominent or nd to the emergency room ther stated communication oved to treat Resident #3's dmitted to the facility on ged on 05/20/15. Resident ed Diabetes Mellitus type 2, and others. A Minimum Data 8/15 specified the resident d cognition. Resident #3's becified she had a P). 3's physician's orders er dated 05/05/15 noted by ion patch (to treat dementia) medical record revealed ntation that Resident #3's	F 15	7			

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		D HUMAN SERVICES MEDICAID SERVICES				RINTED: 08/31/2015 FORM APPROVED MB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	PLE CONSTRUCTION		3) DATE SURVEY COMPLETED
		345567	B. WING			C 08/14/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
AUTUMN	CARE OF CORNELIUS			19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 157 F 309 SS=D	She added that if the the RP by end of shift the next shift nurse to Nurse #2 was no long and unable to be read On 08/14/15 at 11:30 interviewed on the tell she was not notified of patch being ordered be explained that she ob #3's body and asked a and the nurse stated the Alzheimer's Disease a had been in place for spoke with other famil not aware of the new 483.25 PROVIDE CA HIGHEST WELL BEIN Each resident must re provide the necessary or maintain the highes mental, and psychoso accordance with the of and plan of care.	ng the RP of the change. nurse was unable to notify then the nurse should have notify. er employed at the facility thed for an interview. AM Resident #3's RP was ephone and reported that if Resident #3's Exelon by the physician. She served a patch on Resident a nurse what the patch was that it was to treat and added that the patch a while. The RP stated she by members and they were order. RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical, beial well-being, in comprehensive assessment is not met as evidenced ews and physician and staff failed to assess a resident when attempts to administer	F 15	57 57 57 F 309: Provide care/se wellbeing. It is the policy of this fa	ervices for highest acility that each	8/24/15
		e unsuccessful for 1 of 3 dehydration. (Resident		patient receives and thi provide the necessary		

Facility ID: 061188

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		ID HUMAN SERVICES MEDICAID SERVICES	_			FORM	0: 08/31/2015 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		SURVEY LETED
		345567	B. WING				_ 14/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF CORNELIUS			19	9530 MOUNT ZION PARKWAY		
				С	ORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	9 6	F	309			
	#3).				services to attain or maintain the highe	st	
					practicable physical, mental, and		
	The findings included				psychosocial well-being, in accordance		
	Resident #3 was adm	itted to the facility on			with the comprehensive assessment a plan of care. This facility will ensure that		
	02/21/15 with diagnos	-			the patient obtains optimal improvement		
		kidney disease, chronic			or does not deteriorate within the limits		
		high cholesterol, heart			a patient¿s right to refuse treatment, a		
		allowing, dehydration and C-Diff). A review of the			within the limits of recognized patholog	У	
		Minimum Data Set (MDS)			and the normal aging process. Resident #3 was discharged from the		
	dated 05/18/15 indica				facility prior to the complaint survey of		
		cognition for daily decision			8/6/15. Resident #3 was sent to hospi	tal	
	making and required leating.	limited assistance with			for evaluation on 5/20/15.		
					Because other residents who have a		
		s note for nutritional needs			previous history for dehydration, are		
		8 PM by a former dietary sident #3 ' s oral intake			dependent for care or who require extensive assistance with nutritional ar	nd	
	-	ue to resident consuming 25			hydration assistance are at risk for this	-	
		ost occasions. The notes			cited deficiency, under the supervision		
	indicated Resident #3	needed maximum			the Director of Nursing, a 100% audit v	vas	
		eals and recommended that			done for each resident who triggers on		
		ted with all meals by nursing			census and condition reports as extens		
	staff to increase oral i	ntake.			assistance or dependence for nutrition and hydration needs was completed	ai	
	A review of a physicia	in's order dated 05/13/15			08/24/15 by the Regional Nurse		
		(IV) fluids of normal saline			Consultant to ensure resident needs a	re	
		2 liters of fluids (2,000 ml).			assessed to maintain their highest leve	el	
					of wellbeing.		
	A review of a physicia				The Director of Nurses further retrained	d	
	05/13/15 at 4:30 PM i	ter (PICC) insertion related			the licensed nurses, and aides for the facility policy to provide services to		
		nsuccessful) and encourage			maintain a resident¿s highest wellbein	a	
	oral fluid intake.				specifically hydration on 8/07/2015.	5	
					Retrained staff for assessing hydration	,	
		s note for nutritional needs			signs, symptoms dehydration, and		
		2 PM by a former dietary			monitoring fluid intake to maintain		
	manager indicated fai	mily was concerned			hydration and communicating concerns	3	

Facility ID: 061188

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		<u>D. 0938-03</u> E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3		PLETED	
			A. BUILDING			с	
		345567	B. WING			(/ 14/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		/14/2013	
				19530 MOUNT ZION PARKWAY			
AUTUMN	CARE OF CORNELIUS			CORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 000		_					
F 309			F 30				
		3's condition and poor oral		with dietary manager as in			
	intake. The notes rev	,		Upon admission to the fac	-		
		remely dehydrated and she n hold a drink glass which		resident is assessed by the Manager for hydration ne			
		y the former dietary manager		full dietary assessment qu			
		he resident. The notes		the electronic healthcare			
	further indicated Res			resident is assessed by a			
	ordered.			on the date of admission			
				concerns based on physic	•		
	A review of a nurse's	progress note dated		hospital labs if available,			
		by Nurse #3 revealed		summary, and diagnosis			
		nave IV access when she		To enhance current comp			
		t 11:00 PM on 05/13/15. The		and under the supervisior			
		d she attempted twice to		of Nurses, Licensed nurse			
		Insuccessful and would		retrained to thoroughly as			
	report to oncoming n			skin turgor, oral mucosa, available hospital labs up			
	A review of a laborate	ory report dated 05/14/15		the facility and prn for sig			
		3's Blood Urea Nitrogen		in condition. Resident hy			
) (normal range 5-25) and		assessed using the MDS			
		at 1.8 (normal range 0.6-1.3).		Nurse aides were re-educ			
	•	blood tests were done to see		importance of documenta	tion of fluid		
	how well the kidneys	were working.		intake during meals and p	orn in the		
				electronic medical record	•		
		an with a focus statement of		the nurse when a residen			
	nutritional needs indi	•		in the amount of liquids th			
	adequate fluid intake			usually consumed during			
	intervention which wa	as updated 05/14/15 ml per hour for 2 liters of		Effective 08/21/15 a quali program was implemente			
	fluid.			supervision of the directo			
				monitor residents identifie			
	A review of a psychia	tric consult note dated		concerns: The Director o			
		esident #3's family reported		Certified Dietary Manager			
	she had been very de	ehydrated and reported there		3 months to review reside	-		
	was an IV hanging in	the room but it was not		risk for dehydration to ens	sure		
		ty getting IV started in veins.		interventions are immedia			
		Resident #3's mental status		care plans and care guide	-		
		activity was sluggish and a		These residents are ident			
	section labeled care	treatment plan indicated staff		from the electronic record	reports and		

Facility ID: 061188

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/31/2015 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345567	B. WING				C / 14/2015
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF CORNELIUS				9530 MOUNT ZION PARKWAY ORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	A review of a nurse's 05/14/15 at 2:39 PM placed at this time an was scheduled to arri A review of a physicia 05/15/15 indicated Re and feed self a week and would drink if end indicated Resident #3 poor turgor (degree of there was moderate to of the skin that was p elevated and only slo position). A section R indicated to monitor of deterioration in condi A review of a progress dated 05/19/15 at 4:4 manager indicated sh family and they express Resident #3 ' s intake anyone came in the r Resident #3 drinks of The stated Resident a needed maximum en assistance. A review dated 05/19/15 at 10: #13 complained of st small amount of liquid A review of nurse's p 05/20/15 at 10:15 AM	ncerns about dehydration. progress note dated by Nurse #4 indicated IV not ad Mobilex (mobile x-ray) ive by 4:30 PM. an's progress notes dated esident #3 was able to walk ago but was now bed bound couraged. The notes 3's skin was dry and had of elasticity of skin and when to severe hydration a portion inched up remained wly returned to its flat abeled assessment and plan closely for signs of tion. as note for nutritional needs 7 PM by a former dietary the spoke with Resident #3's essed concerns about a and requested when to om they should offer f water. #3 had been very weak and couragement and of a nurse's progress note 52 PM indicated Resident omach upset and vomited a d and ginger ale was offered. rogress notes dated 1 indicated Resident #3 was	F	309	monitoring documentation of physicia and nurse progress notes. The Direct nursing is responsible for compliance will document and submit findings to t quarterly quality assurance committee further review and corrective action.	or of and he	
	small amount of liquid A review of nurse's p 05/20/15 at 10:15 AM transferred by emerg	d and ginger ale was offered. rogress notes dated					

		D HUMAN SERVICES			FC	TED: 08/31/2015 DRM APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) D	NO. 0938-0391 ATE SURVEY DMPLETED
		345567	B. WING			C 08/14/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				19530 MOUNT ZION PARKWAY		
AUTUMN	CARE OF CORNELIUS			CORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From page side of abdomen.	9	F 30	9		
	Nurse #3 she confirm and changes in a resi supposed to be docur She stated nursing sta residents on their shif #3 could feed herself not eat or drink a lot a She stated she recalle #3 to have IV fluids bu getting the IV started any nursing assessme Resident #3. She sta #2 who worked on se 11:00 PM and she tho for an IV and later she made to start the IV b Nurse #2 was no long and was unable to be During a telephone in PM with Nurse #6 she night shift from 11 PM she remembered she Resident #3 but could resident because it ha stated after review of could not get Residen did not recall doing ar #3's hydration becaus documented it in her n During an interview of DON stated she state	nented in the nurses notes. aff were expected to assess t. She explained Resident but she was very slow, did and needed encouragement. ed the NP ordered Resident at they were unsuccessful at and she did not recall doing ents for dehydration for ted she reported to Nurse cond shift from 3:00 PM to ought Nurse #2 got orders a heard that attempts were ut they were unsuccessful. Her employed at the facility reached for an interview. terview on 08/06/15 at 3:59 a confirmed she worked I to 7:00 AM. She stated was assigned to care for I not recall details about the ad been too long ago. She her progress notes she at #3 's IV started but she n assessment of Resident se if she had she would have nurse's notes. n 08/06/15 at 4:30 PM the d it was her expectation for				
	DON stated she state nursing staff to asses					

Facility ID: 061188

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/31/2015 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345567	B. WING		_		C 14/2015
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
AUTUMN	CARE OF CORNELIUS			9530 MOUNT ZION PARK ORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	with nursing assessm During a telephone in PM with Nurse #5 she second shift from 3:00 explained she remem was not assigned to p She stated Nurse #2 #3 and she told her sl Resident #3 but she of because Resident #3 further stated Nurse # start Resident #3's IV Resident #3's level of During a telephone in PM with the facility M he was also Resident he expected nursing s condition and to call h when there was an ac further stated he expec ordered for Resident s staff to let him or the of they could not start th discussed a contingen other oral fluids or oth	terview on 08/06/15 at 5:05 e verified she worked D PM to 11:00 PM. She bered Resident #3 but she provide care to Resident #3. was assigned to Resident the had tried to start an IV for couldn't get the IV in 's veins were rolling. She #2 did not ask her to try to and she did not assess 'hydration. terview on 08/06/15 at 5:14 edical Director he confirmed staff to assess resident's nim or the physician. He stated staff to assess resident's nim or the physician on call cute change in condition. He eeted when IV fluids were #3 he expected for nursing on call physician know if nem so they could have ncy plan such as to provide her options to hydrate her to prominent or to discuss	F 309				
F 323 SS=E	evaluation. 483.25(h) FREE OF A HAZARDS/SUPERVI		F 323				8/24/15
	as is possible; and ea	as free of accident hazards					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 08/31/2015 1 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345567	B. WING				C 14/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				19	530 MOUNT ZION PARKWAY		
AUTUMN	CARE OF CORNELIUS			С	ORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page prevent accidents.	• 11	F	323			
	by: Based on observation interviews and record keep water temperatures idents' rooms, in a hallway sink. The findings included On 08/06/15 at 10:30 hot water in the visitor intersection of the 700 water was too hot to the from the sink. On 08/06/15 at 10:45 Director was interview tried to keep the hot w Fahrenheit. He explain randomly checked the residents' rooms. He concerns had been id 700 and 800 Halls. He company was at the fi- hot water concerns. The reported that each residents with its own sink and the temperature levels wo that the facility did har tubs but the residents since they had their or	review the facility failed to ire at safe levels for 3 of 3 visitor bathroom and in a AM an observation of the bathroom at the 0 and 800 Halls revealed the ouch and had steam rising AM the Maintenance ved and reported that he vater at/around 116 degrees ined that every Monday he e water temperatures in specifically said that entified on the 500, 600, e added that the plumbing acility last week to address the Maintenance Director sident room was equipped shower and that the puld be the same. He added ve shower rooms with bath did not use those rooms			F 323: Free of accidents hazards/supervision/devices: This facility believes the patient environment should remain as free from accident hazards as is possible and the each patient receives adequate supervision and assistance devices to prevent accidents ¿ The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision at assistive devices assistive devices to each patient to prevent avoidable accidents. No residents were injured, nor had any residents, families, or staff voiced concerns that water temperatures were too hot. All residents have the potential to be affected by this cited deficiency. To achieve compliance for this cited deficiency. The plumber adjusted the water temperature and the temperature high level is set within the range of 100 116 degrees. Signage placed on the boiler by the plumber that read ¿Do no adjust mixing valve. Keep set at 120 degrees Fahrenheit, thanks plumber; was removed by the Maintenance Dire	at om / nd , e e -	

Facility ID: 061188

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM): 08/31/2015 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		SURVEY LETED
		345567	B. WING			_ 14/2015
NAME OF PF	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF CORNELIUS			19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	 bathroom sink water to by the Maintenance Director temperature of 118.4 Maintenance Director water temperature and too hot. The Residen was interviewed and the have problems with the bathroom. During the Maintenance Director along the 600 would he 118 degrees. b. On 08/06/15 at 1 bathroom sink water of Fahrenheit. The Maintenance Director along the temperature wooccupied at the time to be interviewed. The explained that the roo also have water temp degrees. c. On 08/06/15 at 1 sink water measured The Maintenance Director also have water temp degrees. d. On 08/06/15 at 1 sink on access hall aw checked and the hot was book and the hot was book and the hot we have be be and the hot we have be be	And random residents' ked that revealed the 0:51 AM room 601's emperature was measured birector and reached a degrees Fahrenheit. The was interviewed about the d stated 118 degrees was t #4 residing in room 601 reported that she did not ne water being too hot in her explained that all the rooms have water temperature at 0:53 AM room 701's measured 119.8 degrees ntenance Director reported was too hot. Room 701 was but the resident was unable e Maintenance Director ims on the 700 hall would eratures close to 119 0:56 room 403's bathroom 119.3 degrees Fahrenheit. ector reported that the hot. 1:07 AM the wall-mounted vailable to residents was water measured 119 The Maintenance Director	F 323	 08/06/15 during the complaint survey Under supervision of the Maintenance Director water temperatures are check and recorded daily. Immediate adjustments are made to correct any identified concerns for hot water temp The plumber was recalled to facility o 08/11/15 when water temp concerns widentified. The mixing valve was chan out during this maintenance visit. Under the supervision of the Maintena Director water temps are recorded ea shift daily for 2 weeks, then water tem are recorded 5 days per week for 4 w then 3 days weekly for 4 weeks then weekly ongoing per protocol. Any identified concerns are immediately addressed by the Maintenance Direct The Administrator and Assistant Maintenance Director are trained to s water off in the facility in the event wa temperatures concerns are identified is a new backup system. Training was performed by the Maintenance Direct 8/07/15). All concerns are presented to the quarterly quality assurance committee review and further corrective action if needed. The administrator is respons for compliance. 	e ked s. n vere ged ance ch aps eeks or. ter (this s or on e for	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 08/31/2015 1 APPROVED 0. 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345567	B. WING			08/ ⁻	C 14/2015
NAME OF PRO	VIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE	•	
				19530 MOUNT ZION PARE	KWAY		
AUTUMN CA	ARE OF CORNELIUS			CORNELIUS, NC 2803	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
r t r c r r c r r c r r r r r r r r r r	eported that he did me he hot water in the visi- esidents did not used Dn 08/06/15 at 11:10 made of the facility's to one boiler was used to ditchen area. The mix- was set to 120 degree have a cardboard sign mixing valve. Keep su Fahrenheit), thanks P Director was interview explained that he was 120 degrees Fahrenh- be making adjustment because of the new un Maintenance Director valve was set too high he facility would be 1 added that when he ne water on to allowing the he hot water stored in he water to be cooled Director stated that he esidents complain ab not water. Director shared water evealed the weekly weithin acceptable rang Director explained that measuring the hot wa allow the water to run diluted then he checked	ns the Maintenance Director of check the temperature of sitor bathrooms because the areas. AM observations were poiler room that revealed to heat the facility and the king valve of the boiler unit as Fahrenheit and noted to that read "Do not adjust et at 120 (degrees lumber." The Maintenance ved about the sign and he told to keep the valve set to eit and that he should not ts to the mixing valve nit's warranty. The confirmed that the mixing that all the hot water in 20 degrees Fahrenheit. He oticed the water was too hot upied rooms, turn the hot ne water to flow, emptying the holding tank causing d. The Maintenance the had not had staff or roout the temperature of the	F 32	23			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 08/31/2015 1 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345567	B. WING			-		C 14/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	•	
AUTUMN	CARE OF CORNELIUS				9530 MOUNT ZION PARKV ORNELIUS, NC 28031	VAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRI/ EFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	e 14	F	323				
		AM the Administrator was ted that he was not aware er temperatures.						
	a calibrated digital the water of the 700 and 3 sink that after the Mai allowed the water to r	PM the Administrator used ermometer to check the hot 800 hall visitor bathroom intenance Director had un to lower the temperature Iding. The water measured wheit.						
	assigned to the 500 a interviewed and repor	ted that she had not ith the hot water being too						
	700 and 800 Halls was she did not have cond being too hot and that concerns. The NA sta checked the water be get wet and would as was okay. She also s too hot she notify the	fore allowing a resident to k them if the temperature stated that if the water was						
	to assess the mixing v interviewed and state Maintenance Director the mixing valve. He the facility 4 times in r concerns. On 08/06/	valve. The Plumber was d that he had told the not to make adjustments to added that he had been to						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/31/2015 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		LETED	
		345567	B. WING					C 14/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				19	9530 MOUNT ZION PARKWAY			
AUTUMN	CARE OF CORNELIUS			С	ORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 325 SS=D			F	325				8/24/15
	status, such as body unless the resident's demonstrates that this	ty must ensure that a ble parameters of nutritional weight and protein levels, clinical condition						
	by: Based on staff interv facility failed to obtain weight loss as ordere waited 7 days before interventions for a res body weight in one m residents (Resident # The findings included Resident #3 was adm 02/21/15 and dischar #3's diagnoses includ Alzheimer's disease, others. A Minimum D 05/18/15 specified the impaired cognition, re with activities of daily significant weight loss not the result of a phy	itted to the facility on ged on 05/20/15. Resident ed Diabetes Mellitus type 2, clostridium difficile and			F 325: Maintain nutritional status unavoidable: It is the policy of this facility to as patients who experience significa unplanned or undesired weight lo weight gain, and insidious weight to follow recommendations and o Dietician consults, and suppleme indicated. Resident #3 was discharged from facility prior to the complaint surv 8/6/15. Resident #3 was sent to for evaluation on 5/20/15. For other residents with the poter affected by this cited deficiency, to supervision of the director of nurs following has been achieved: 100% audit of all orders since Ma 2015 completed to ensure all com orders had been transcribed and scheduled in the electronic health under consults. Further the Direct	ssess int boss or closs al orders fi ents as m the ey of hospita htial to under t ses the ay 13, isult	nd or al be he	

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		ID HUMAN SERVICES			PRINTED: 08/31/20 FORM APPROVE
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345567	B. WING		C 08/14/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
				19530 MOUNT ZION PARKWAY	
AUTUMIN	CARE OF CORNELIUS			CORNELIUS, NC 28031	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 325	Continued From page	1 6	E 30	25	
F 325	03/05/15 133.2bs 04/02/15 129.4bs 05/07/15 114.5bs Further review of Res Resident #3 was order receive a mechanical nurse practitioner (NF fortified ice cream) to weeks due to anorexi order was written to g for 2 weeks due to ar Resident #3 was diag infection (UTI) and st A document titled "Mo Report" for 04/01/15 th Resident #3 received times a day for 10 da through 04/17/15. Ac Assessments Report" ~75% of the ice creat	bunds (lbs) sident #3's medical revealed ered by the physician to soft diet. On 04/03/15 the P) ordered "Magic Cup" (a be given with meals for 2 ia. On 04/08/15 a second give "Magic Cup" with meals horexia. During this time gnosed with a urinary tract arted on antibiotics. build of 20/15 specified the fortified ice cream 3 ys starting on 04/08/15 ccording to the "Monitoring ' the resident consumed	F 32	 Nursing or designee inform Dietary Manager for nutriti communication box has be each nurse;s station for c of nursing to dietary so the Dietary Manager is inform consults and dietary chang Certified Dietary Manager designee retrieves commu from the nurse;s station 7 Dietary staff and licensed in-serviced for this addition 8/24/15. 100% audit for all supplem completed to ensure they scheduled under monitorin assessments, in order to n amount of the supplement the supervision of the Dire all licensed nurses were in enter all supplement order under the monitor assess electronic record. All new residents are weig hours of admission and we week;s total, then monthly 	onal consults. A een placed at ommunication e Certified ed for nutrition ges. The or dietary unication slips days per week. nurses were hal process ment orders are accurately ng ecord the intake. Under ctor of Nurses, i-serviced to s for nutrition ment tab of the hed within 48 eekly x 4
	04/07/15. Review of the medica Resident #3 was diag	d on 04/03/15 through al specified that on 04/20/15 gnosed with clostridium arted on antibiotics to treat		significant weight concerns Residents identified on the weight loss report are plac weights, the family/RP and informed. Other interventio scheduled as ordered by t The care plan and care gu by a licensed nurse or Cer	e significant eed on weekly d MD are ons are he physician. ide are revised
	completing antibiotics documented in the pr #3 continued to have	reviewed Resident #3 after s for the C-diff and ogress note that Resident decreased by mouth intake umented that Resident #3		Manager to reflect weight nutritional needs. This is a process and required to m resident weight per state a regulation.	n ongoing onitor each

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345567 B. WING 08/14/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 19530 MOUNT ZION PARKWAY AUTUMN CARE OF CORNELIUS CORNELIUS, NC 28031 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 325 Continued From page 17 F 325 had lost weight from 135.6 pounds to 129.4 Under supervision of the Director of pounds and ordered weekly weights, Remeron Nurses and the Certified Dietary Manager (an antidepressant medication that can stimulate the following systematic changes were appetite) and a "Dietitian" consult. implemented to prevent recurrence: communication box at each nurse station. Review of Resident #3's medical record revealed In-service of additional process to dietary that Resident #3 was not assessed by a and licensed nurses. Registered Dietitian (RD) after the 05/05/15 Effective 08/24/15 a quality assurance order. program was implemented as above under the supervision of the Director of Nurses. The Director of Nurses is On 05/07/15 Resident #3's weight was 114.5 pounds; an 11.5% loss of body weight from responsible for compliance and 04/02/15. documents and submits concerns identified to the quality assurance On 05/12/15 Resident #3 was reviewed by the committee quarterly for further review and facility's Dietary Manager (DM) for weight loss corrective action. and anorexia. The DM documented that Resident #3's intake was very poor and that the resident consumed 25% or less on most occasions. The DM also documented that the weight loss was likely associated with C-diff and poor intake and recommended Magic Cup three times a day with meals and finger foods when possible and to continue to monitor. Review of Resident #3's medical record, there was no order for the Magic Cup on 05/12/15 and the Magic Cup was not indicated on the "Monitoring Assessments Report." On 05/13/15 the DM documented in Resident #3's medical record that she met with Resident #3's family due to concerns with the resident's condition and poor intake. The DM documented that she informed the family of the recommendations she made. The DM's progress note specified the resident was "extremely dehydrated and was too weak to hold a glass" and that Resident #3 had tested positive for C-diff

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		ID HUMAN SERVICES				FORM): 08/31/2015 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	LETED
		345567	B. WING				C 14/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
			1	530 MOUNT ZION PARKW	AY		
AUTUMN	CARE OF CORNELIUS			ORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FFICIENCY)		(X5) COMPLETION DATE
F 325	Continued From page again.	9 18	F 325				
		ident #3's medical record tional changes were made ion regimen.					
	significant weight loss progress note that the been extremely poor weekend from encour The NP ordered a hig	eviewed Resident #3 for s and documented in the e resident's appetite had but had improved over the ragement of family and staff. h calorie fortified en three times a day by the					
	abdominal mass. Re	t #3 was sent to the ent for evaluation of an sident #3 was admitted to ot return to the facility.					
	The NP was no longe and unable to be inter	r employed by the facility rviewed.					
	The DM was no longe and unable to be inter	er employed by the facility rviewed.					
	Registered Dietitian (I explained that she wa month for 12 hours. T her visits she reviewe residents with pressu significant weight loss notified of such reside added that if a Dietitia the physician then she for completing the cor month visits but that it	PM the facility's consultant RD) was interviewed and as in the facility twice a The RD reported that during dube fed residents, re ulcers and residents with s. She stated that she was ents by the DM. The RD an consult was ordered by e would also be responsible nsult during her twice a f the consult was ordered e to visit then the facility's					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/31/2015 / APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345567	B. WING					C 14/2015
NAME OF PF	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CO	JDE		
	CARE OF CORNELIUS				19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031			
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF			(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BI		COMPLETION DATE
F 325		do the consult. The RD	F	325	5			
	notify her of a Dietitian May she visited the fa 05/20/15. The RD wa	e the DM's responsibility to n consult. She added that in acility on 05/05/15 and as unaware of a consult #3 on 05/05/15 while she						
	was in the facility and not review Resident # on her visit to the faci	the RD stated that she did for significant weight loss lity on 05/20/15 because leaving the facility on a						
	stretcher.							
		PM the facility's Corporate and reported that a physician						
	ordered "Dietitian" con Registered Dietitian h	nsult did not mean a ad to review the resident						
	because the term "Die	etitian" was used "loosely."						
	was ordered a "pink s	plained that when a consult lip" was delivered to the						
	dietary manager and assess the resident; b	that the DM could attempt to but if in reviewing the						
	medical record the DM	I felt the issue was "more						
	contact the Consultan Corporate RD stated	e" then he/she should It RD or Corporate RD. The that when a Dietitian consult ted it to be addressed as						
	quickly as possible. The comment on the 7 day	The Corporate RD did not						
	ordered.							
	• •	Resident #3's tray card that eceive Magic Cups with no monitoring of the						
E 007	supplement.	-	-	207	7			9/24/45
F 327 SS=D	483.25(j) SUFFICIEN HYDRATION	T FLUID TO MAINTAIN		327				8/24/15

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		MEDICAID SERVICES	(X2) MI II TIP	LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · /	OMPLETED
						С
		345567	B. WING			08/14/2015
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	CARE OF CORNELIUS			19530 MOUNT ZION PARKWAY		
AUTOMIN				CORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 327	Continued From page	e 20	F 32	7		
		ride each resident with				
	, , , , , , , , , , , , , , , , , , ,	to maintain proper hydration				
	and health.					
		is not met as evidenced				
	by: Based on record roy	iews and physician and staff		F 327: Sufficient fluid to ma	intain	
		failed to provide a resident		hydration:	IIIdiii	
		intain hydration and failed to		This facility has a policy whi	ch reveals the	
		is fluids for dehydration as		facility must provide each pa		
	ordered by a physicia	-		sufficient fluid intake to mair		
	sampled for dehydrat	ion. (Resident #3).		hydration and health. The in		
				policy is to assure that the p		
	The findings included	:		receives sufficient amount o on individual needs to preve		
	Resident #3 was adm	nitted to the facility on		dehydration.	111	
	02/21/15 with diagnos	5		Resident #3 was discharged	I from the	
		kidney disease, chronic		facility prior to the complaint		
	pain, type 2 diabetes	, high cholesterol, heart		8/6/15. Resident #3 was se	nt to hospital	
		allowing, dehydration and		for evaluation on 5/20/15. R		
		C-Diff) a bacterial infection		have a PICC line inserted of		
		causes infectious diarrhea.		received IV fluids via this ro		
		recent quarterly Minimum		was assessed on the full die	•	
	Data Set (MDS) date	erely impaired in cognition		assessment 2/24/15 for hyd by the registered dietician.	auon needs	
		king and required limited		For other residents with the	potential to be	
	assistance with eating	-		affected by this cited deficie		
				following has been achieved		
	A review of a laborate	ory report dated 04/23/15		100% audit of all Physician		
		3's Blood Urea Nitrogen		5/13/15. One IV order was r		
		17 (normal range 5-25) and		written on 8/10/15 and no co		
		al at 1.1 (normal range		identified. This IV was schee		
	-	eatinine blood tests were		electronic record as ordered		
	uone to see now well	the kidneys were working.		scheduled hourly for 100ccz		
	A review of a progress	s note dated 05/05/15 by a		liter of fluid. This resident re as ordered. All new admiss		
		no no longer worked at the		hydration needs assessed b		

Facility ID: 061188

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TID	LE CONSTRUCTION	(X3) DATE SU	0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLE		
					с		
		345567	B. WING		08/14/201		
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
	CARE OF CORNELIUS			19530 MOUNT ZION PARKWAY	PARKWAY		
				CORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 327	Continued From page	e 21	F 32	7			
	decreased oral intake			assessment questionnaire withi	n 5 davs		
				of admission. Licensed nurses a	-		
		locument titled "Monitoring		to evaluate resident hydration b	ased on		
	Assessment Report"	for daily fluid intake		physical appearance, skin turgo			
	revealed:			mucosa, dry eyes, mental status	-		
		(ml) for breakfast, 50 ml for		and clinical labs 08/07/15. Licer			
	ml.	inner for a daily total of 140		nurses were trained by Legacy IV nurse on July 1 and 2, 2015			
		akfast, 240 ml for lunch and		therapy, including hyperdermac			
		a daily total of 600 ml.		To enhance the current complia	-		
		preakfast, 360 ml for lunch		operations and under the direct			
		for a daily total of 720 ml.		Director of Nurses on 08/07/15			
		preakfast, 360 ml fluid intake		Licensed nursing staff were in-s			
		fluid intake for dinner for a		importance and professional sta			
	daily total of 840 ml.	preakfast, 25 ml for lunch		practice for initiating orders and through for calling and documer			
		for a daily total of 245 ml.		physician when the order canno			
		preakfast, 120 ml for lunch		completed i.e: starting IV¿s. Dir			
		for a daily total of 340 ml.		staff were in serviced for docum			
		ast, 240 ml for lunch and		oral fluid intake and importance			
	100 ml for dinner for a	a daily total of 340 ml.		maintaining hydration needs for	each		
	A			resident 8/7/15.			
		s note for nutritional needs 8 PM by a former dietary		Effective 8/10/15 a quality assur program was implemented under			
		esident #3's oral intake		supervision of the Director of Nu			
	-	ue to resident consuming 25		monitor /audit progress notes a			
		ost occasions. The notes		physician orders to ensure that			
	indicated Resident #3			orders are initiated as ordered.			
		eals and recommended that					
		ted with all meals by nursing		Audit 10 mine are set	for		
		intake. There was no timated fluid needs for		Audit 10 nurse progress notes content, and 10 physician orde			
	Resident #3.			Monday through Friday x1 mont	-		
				days per week for 4 weeks, the			
	A review of a facility of	locument titled "Monitoring		progress notes and 10 physicial			
	•	for daily fluid intake revealed		weekly x 4 weeks, then random			
		breakfast, 240 ml for lunch		audits to ensure compliance an			
	and 240 ml for dinner	for a daily total of 480 ml.		through. Any concerns/deficience	cies are		

Facility ID: 061188

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TATEMENT (F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CO	MPLETED
		345567	B WING			С
	ROVIDER OR SUPPLIER	545507		STREET ADDRESS, CITY, STATE, ZIP COL		8/14/2015
				19530 MOUNT ZION PARKWAY		
AUTUMN	CARE OF CORNELIUS			CORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 327	Continued From page	22	F 32	7		
		an's order dated 05/13/15		the spot with the staff member	er involved.	
	indicated intravenous	(IV) fluids of normal saline		The findings of these quality		
	at 100 ml per hour for	2 liters of fluids (2,000 ml).		audits are documented and s		
	A roviow of a physicic	an's order sheet dated		the quarterly quality assurance meeting for further review an		
	05/13/15 at 4:30 PM i			action. The Director of Nursir		
		eter (PICC) insertion related		responsible for monitoring, for	•	
	to difficult IV sticks (u oral fluid intake.	nsuccessful) and encourage		compliance.		
		s note for nutritional needs 2 PM by a former dietary				
		3's condition and poor oral				
	intake. The notes rev Resident #3 was extr	emely dehydrated and she				
		hold a drink glass which				
		/ the former dietary manager				
	•	ne resident. The notes				
	further indicated Resi					
	ordered. There was n estimated fluid needs					
		document titled "Monitoring				
	-	dated 05/13/15 for daily fluid nl for breakfast, 240 ml for				
		dinner for a daily total of 600				
	A review of a facility of	locument titled "Monitoring				
	Assessment Report" indicated 150 ml IV in	dated 05/13/15 at 6:24 PM take was given.				
	A review of a nurse's 05/14/15 at 6:55 AM	by Nurse #3 revealed				
		ave IV access when she 11:00 PM on 05/13/15. The				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 08/31/2015 1 APPROVED 2: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345567	B. WING		_	08/ [.]	C 14/2015
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF CORNELIUS			9530 MOUNT ZION PARK ORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 327	indicated Resident #3 (BUN) was high at 50 Creatinine was high a BUN and Creatinine to how well the kidneys A review of a care plan nutritional needs indic adequate fluid intake. intervention which was indicated IV fluid 100 fluid. A review of a psychia 05/14/15 indicated Res she had been very de was an IV hanging in started due to difficult The notes indicated F exam revealed motor section labeled care to and family voiced com A review of a nurse's 05/14/15 at 2:39 PM F placed at this time an was scheduled to arri	ursing staff. by report dated 05/14/15 I's Blood Urea Nitrogen (normal range 5-25) and it 1.8 (normal range 0.6-1.3). blood tests were done to see were working. In with a focus statement of cated in part to offer A section labeled is updated 05/14/15 ml per hour for 2 liters of tric consult note dated esident #3's family reported theydrated and reported there the room but it was not y getting IV started in veins. Resident #3's mental status activity was sluggish and a reatment plan indicated staff incerns about dehydration. progress note dated by Nurse #4 indicated IV not d Mobilex (mobile x-ray) ve by 4:30 PM.	F 327				
	Access Insertion Doc at 4:30 PM revealed t of a PICC line in Resi was for hydration.	nt titled Mobilex Vascular umentation dated 05/14/15 he indication for placement dent #3's right upper arm locument titled "Monitoring					
		dated 05/14/15 for daily fluid					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/31/2015 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345567	B. WING		_	(08/	C 14/2015
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			1	9530 MOUNT ZION PARK	WAY		
AUTUMN	CARE OF CORNELIUS		c	ORNELIUS, NC 28031	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 327		e 24 nl for breakfast, 0 ml for inner for a daily total of 330	F 327				
	A review of a physicia 05/15/15 indicated Re and feed self a week and would drink if end indicated Resident #3 poor turgor (degree o there was moderate to of the skin that was p elevated and only slov position). A section la indicated to monitor of deterioration in condit A review of a nurse's 05/15/15 at 3:00 PM i infusion complete and removed tubing from	B's skin was dry and had f elasticity of skin and when o severe hydration a portion inched up remained wly returned to its flat abeled assessment and plan closely for signs of tion. progress note dated indicated 500 ml saline d locked PICC line and room.					
	05/15/15: 240 ml for th and 240 ml for dinner 05/16/15: 240 ml for th and 90 ml for dinner f 05/17/15: 240 ml for th and 90 ml for dinner f 05/18/15: 360 ml for th and 240 ml for dinner A review of a progress dated 05/19/15 at 4:4 manager indicated sh family and they expre	breakfast, 360 ml for lunch for a daily total of 840 ml. breakfast, 240 ml for lunch for a daily total of 570 ml. breakfast, 360 ml for lunch for a daily total of 690 ml. breakfast, 480 ml for lunch for a daily total of 1,080 ml. s note for nutritional needs 7 PM by a former dietary be spoke with Resident #3's sessed concerns about and requested when anyone					

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		ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 08/31/2015 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345567	B. WING			C / 14/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF CORNELIUS			19530 MOUNT ZION PARKWAY		
				CORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 327	Continued From page came in the room they drinks of water. They been very weak and r encouragement and a A review of a facility of Assessment Report" of intake indicated 0 ml lunch and 90 ml for di ml. A review of nurse's pr 05/20/15 at 10:15 AM transferred by emerge hospital for evaluation side of abdomen. Du 08/06/15 at 2:07 PM v she was the day shift 3:00 PM on 05/13/15 Resident #3. She sta Resident #3 did not e explained she recalled Nurse Practitioner (NI the facility about IV flu stated the NP said sh #3 IV fluids of normal an order for them and fluid to give or how fa- stated she should hav rate and amount of flu written it as a verbal of she thought the NP w She stated she report on second shift from 3	e 25 y should offer Resident #3 stated Resident #3 had needed maximum assistance. locument titled "Monitoring dated 05/19/15 for daily fluid for breakfast, 360 ml for inner for a daily total of 450 ogress notes dated indicated Resident #3 was ency medical services to the n of a large mass on right ring an interview on with Nurse #3 she confirmed nurse from 7:00 AM until and provided care to ted she remembered at or drink a lot and d a conversation with a P) who no longer worked at uids for Resident #3. She e wanted to give Resident saline but she did not write I did not say how much IV st to give them. Nurse #3 ve asked the NP about flow uids to give and should have order but she didn't because ould write an order for it. ed to Nurse #2 who worked 3:00 PM to 11:00 PM what	F 327	DEFICIENCY)		
		she thought Nurse #2 got later heard that attempts e IV but they were				

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CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC): 08/31/2015 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			SURVEY LETED
		345567	B. WING		_		_ 14/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST			
AUTUMN	CARE OF CORNELIUS			19530 MOUNT ZION PARK CORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 327	the facility and was un interview. During an interview of facility's consultant Re- interviewed and expla- facility twice a month- not review Resident # on 05/20/15 because leaving the facility on During an interveiw of Nurse #3 explained R herself but she was ve a lot and needed enco- recalled the NP order fluids but they were u started and she did no assessments for dehy She further stated Re- sips of water when she and they usually did n liquid she swallowed ve The NP was no longe and was unable to be Nurse #2 was no longe and was unable to be During a telephone in PM with Nurse #6 she night shift from 11 PM she remembered she Resident #3 but could fluids however, after n	anager no longer worked for nable to be reached for nable to be reached for no 08/06/15 at 2:00 PM the egistered Dietitian (RD) was alined that she was in the for 12 hours. She stated did 3 on her visit to the facility she met Resident #3 a stretcher. In 08/06/15 at 2:07 PM with tesident #3 could feed ery slow, did not eat or drink buragement. She stated she ed Resident #3 to have IV nsuccessful at getting the IV of recall doing any nursing vdration for Resident #3. sident #3 would only take here received her medications not document how much with her medications. It employed by the facility reached for an interview. ger employed at the facility reached for an interview. terview on 08/06/15 at 3:59 e confirmed she worked I to 7:00 AM. She stated was assigned to care for a not recall details about IV review of her nurses	F 32				
	and was unable to be During a telephone in PM with Nurse #6 she night shift from 11 PM she remembered she Resident #3 but could fluids however, after r progress note dated 0	reached for an interview. terview on 08/06/15 at 3:59 e confirmed she worked I to 7:00 AM. She stated was assigned to care for I not recall details about IV					

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CENTER STATEMENT (AND PLAN OF		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345567	A. BUILDING	E CONSTRUCTION		FORM OMB NO (X3) DATE COMP): 08/31/2015 1 APPROVED 0. 0938-0391 SURVEY LETED C 14/2015
AUTUMN	CARE OF CORNELIUS			19530 MOUNT ZION PARK CORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 327	started she asked and not remember if she a thought she reported during the change of a she did not recall doin Resident #3's hydratic have documented it in During an interview of Nurse #4 she explained care for Resident #3 of by a nurse to start an stated she tried but R collapsing and she co verified mobile x-ray w 11:53 AM to insert the at the facility on 05/14 also verified there we x-ray place a PICC lin 05/14/15. During an interview of DON stated she state nursing staff to follow administer IV fluids an stated nursing staff sh physician to report the unsuccessful and sho orders. During a telephone in PM with Nurse #5 she second shift from 3:00 05/13/15. She explain physician ordered IV f	he could not get an IV other nurse to try but she did asked another nurse but it to the day shift nurse shift report. She explained ag an assessment of on but if she had she would a her nurse's notes in 08/06/15 at 4:21 PM with ed she was not assigned to on 05/14/15 but was asked IV on Resident #3. She esident #3's veins were build not get it in. Nurse #4 was called on 05/14/15 at e PICC line and they arrived B/15 at 4:30 PM. Nurse #4 re no calls to request mobile the before 11:53 AM on in 08/06/15 at 4:30 PM the d it was her expectation for physician's orders to not they should attempt an IV of 3 times. She further hould have called the e IV sticks were build have requested new terview on 08/06/15 at 5:05 e verified she worked	F 327				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/31/2015 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345567	B. WING				C 14/2015
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF CORNELIUS				9530 MOUNT ZION PARKWAY ORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 327 F 490 SS=E	Nurse #2 told her she Resident #3 but she of because Resident #3' Nurse #2 did not ask #3's IV. During a telephone in PM with the facility M4 he was also Resident when orders were giv staff to follow them. He expected when IV flui Resident #3 he expect him or the on call phy start them so they could contingency plan such fluids or other options veins more prominent to the emergency roo 483.75 EFFECTIVE ADMINISTRATION/R A facility must be adme enables it to use its re efficiently to attain or	had tried to start the IV for couldn't get the IV in s veins were rolling and her to try to start Resident terview on 08/06/15 at 5:14 edical Director he confirmed #3's physician. He stated en he expected for nursing He further stated he ds were ordered for sted for nursing staff to let sician know if they could not uld have discussed a h as to provide other oral to hydrate her to make her or to discuss need to send m for evaluation. ESIDENT WELL-BEING hinistered in a manner that esources effectively and maintain the highest nental, and psychosocial		327	DEFICIENCY)		8/24/15
	by: Based on observation record review the faci maintain the hot wate failed to have a proce Administrator when the resolved. The Admini	-			F 490: Effective administration/residen well-being: It is this facility policy to be administere in such a manner that enables it to use resources effectively and efficiently to attain or maintain the highest practicab physical, mental, and psychosocial	d its	

Event ID: L0NS11

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/31/2015 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345567	B. WING			08	C / 14/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF CORNELIUS			19	530 MOUNT ZION PARKWAY		
AUTOWIN				C	ORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	Continued From page	e 29	F4	190			
	bathroom or the acce				wellbeing of each patient. This facility	will	
	The findings included				be licensed under applicable State an local laws.		
	Cross refer to F 323				No residents were harmed related to reited deficiency.	this	
	Based on observation	ns, staff and resident			All residents have a potential risk to b affected by this cited deficiency. To	e	
		review the facility failed to			enhance the current compliant operat		
		ure at safe levels for 3 of 3			In order to achieve compliance, under		
		a visitor bathroom and in a			direction of the Administrator, departm	nent	
	hallway sink.				managers were in serviced by the Administrator for facility policy for		
		AM the Administrator was			reporting all incidents immediately to		
	-	rted that he was unaware of			Administrator or designee. Any incide	nt	
		ter being too hot in the			that has potential to harm a resident,		
	-	unaware that the hot water degrees Fahrenheit by the			visitor, or staff member is immediately reported to the Administrator for corre		
		hat weekly checks were			intervention.	ouve	
		intenance Director and that			Further the department heads were		
		temperatures were within			in-serviced by the Administrator per		
	acceptable ranges le	-			Federal regulation that a facility has a		
		ministrator added that if			responsibility to be administered in a		
		dentified then he would			manner that enables it to use its		
	expect the Maintenar	nce Director to notify him.			resources effectively and efficiently to attain or maintain the highest practica		
	On 08/06/15 at 3:05 l	PM the Maintenance Director			physical, mental, and psychological	510,	
		reported that he had told the			well-being of each resident.		
		needed the plumbing			Effective 8/10/15 a quality assurance		
		t to check the mixing valve			program was implemented under the		
		uld handle the situation			supervision of the Administrator to mo		
	•	olve the Administrator since			and record all staff, visitor, or resident		
	he was the Departme	ent Head.			reports of concerns for safety issues t	nat	
					could have a potential for a negative outcome. The administrator has crea	ted	
					a quality assurance tool to record all		
					concerns and to ensure safe facility		
					practice. Concerns are documented	on	
					the form on the date brought to the		
					Administrator. Interventions are		

Event ID: L0NS11

Facility ID: 061188

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/31/201 M APPROVEI O. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345567	B. WING			C / 14/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	Continued From page	e 30	F 49	immediately placed in order to pre harm to the resident, visitor, or sta concerns documented on the tool reviewed in the quarterly quality assurance meeting for further revi corrective action. This will be an of process for this facility in order to continued compliance.	aff. Any are iew or ongoing	
F 514 SS=D	RECORDS-COMPLE LE The facility must mair resident in accordance standards and practice accurately documente systematically organit The clinical record main information to identify resident's assessment services provided; the preadmission screenit and progress notes.	ust contain sufficient the resident; a record of the hts; the plan of care and	F 51	4		8/24/15
	interviews the facility orders for intravenous document unsuccess and failed to docume pressure and assess	ful attempts to start an IV nt a recheck of a low blood ment of a resident for 1 of 3 r dehydration. (Resident		F 514: Resident records complete/accurate accessible: It is the policy of this facility to ma electronic, clinical records on each in accordance with accepted profe standards and practices which are complete, accurate documented, accessible and systematically org Resident #3 was discharged from facility prior to the complaint surve	h patient essional e: readily anized. the	

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							<u>0. 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· /	E SURVEY PLETED
			A. BUILDING	A. BUILDING			C
		345567	B. WING			C 08/14/2015	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	1 08	14/2013
					530 MOUNT ZION PARKWAY		
AUTUMN	CARE OF CORNELIUS				DRNELIUS, NC 28031		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	l	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETIO
F 514	Continued From page	e 31	F 51	14			
					8/6/15. Resident #3 was sent to hosp	ital	
	Resident #3 was adm	nitted to the facility on			for evaluation on 5/20/15. Resident #		
	02/21/15 with diagnos	ses which included			have a PICC line inserted on 5/14/15	and	
	Alzheimer's disease,			received IV fluids via this route. Resid	ent		
	pain, type 2 diabetes			was assessed on the full dietary			
	disease, difficulty swa			assessment 2/24/15 for hydration nee	ds		
	Clostridium Difficille (by the registered dietician.			
		causes infectious diarrhea.			All residents have the potential to be	r the	
	Data Set (MDS) date	recent quarterly Minimum			affected by this cited deficiency. Unde direction of the Director of Nursing		
		erely impaired in cognition			licensed nurses were in-serviced for		
		king and required limited			Accurate and complete documentation	ı	
	assistance with eating				according to professional standard of	-	
		-			practice. With hiring of current Directo	r of	
	A review of a physicia	an's order dated 05/13/15			Nurses this has been a major focus si		
	indicated intravenous	s (IV) fluids of normal saline			May 2015. Documentation training		
		r 2 liters of fluids (2,000 ml).			continues to be going an ongoing proc as identified through the current daily	cess	
		an's order sheet dated			audits of documentation.		
		indicated peripherally			To enhance the current compliant		
		eter (PICC) insertion related			operations and under the direction of t	the	
	to difficult IV sticks (u			Director of Nurses on 08/07/15 all	-l - f		
	oral fluid intake.				Licensed nursing staff were in-service		
	A review of nurse's p	rogress notes dated			importance and professional standard practice for initiating orders and follow		
		ere was no documentation of			through for calling and documenting th		
		ts to start Resident #3 's IV			physician when the order cannot be		
		sident #3 ' s condition.			completed. Documenting changes in		
		ocumentation of attempts to			resident conditions and assessments	of	
	request placement of	-			residents to paint a picture of the resid		
					Reviewed the board of nursing		
	A review of nurse's p				expectation for documentation with		
		by Nurse #3 revealed			licensed nurses 08/7/15.		
		nave IV access when she					
		t 11:00 PM on 05/13/15. The					
		d she attempted twice to			Under the supervision of the Director		
		Insuccessful and would			Nurses the following is achieved: Audi		
		ursing staff. There was no			nurse progress notes for content, Mor		
	uocumentation regard	ding assessment of Resident			through Friday x1 month then 3 days	per	

Facility ID: 061188

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/31/2015 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345567	B. WING				C 14/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ΔΗΤΗΜΝ	CARE OF CORNELIUS			19	9530 MOUNT ZION PARKWAY		
AUTOMIN				С	ORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page #3's condition. A review of a care pla nutritional needs indic adequate fluid intake. intervention which wa indicated IV fluid 100 fluid. A review of nurse's pr 05/14/15 revealed the regarding staff attemp IV, or assessments of offers of fluid intake b A review of a Monitori dated 05/14/15 revealed the pressure was 125/72 range of blood pressu Resident #3. A review of nurse's no PM by Nurse #5 reveal pressure was low 97/0 signs were within norm There was no docume Resident #3's blood p and there was no docume Resident #3 she confirm nurse from 7:00 AM u	e 32 an with a focus statement of cated in part to offer A section labeled as updated 05/14/15 ml per hour for 2 liters of rogress notes dated ere was no documentation ots to start Resident #3 ' s f Resident #3's condition or by staff to Resident #3. ing Assessments Report led Resident #3's blood which was in the average ures documented for otes dated 05/16/15 at 6:42 aled Resident #3's blood 68 this shift but other vital mal limits for this resident. entation for a recheck of oressure in the nurse's notes cumentation of an	TAG		CROSS-REFERENCED TO THE APPROPR	ATE ptes y v e on d. e at ttee ve	DATE
	a lot and explained sh with a Nurse Practitio worked at the facility a	sident #3 did not eat or drink ne recalled a conversation ner (NP) who no longer about IV fluids for Resident P said she wanted to give					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/31/2015 1 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345567	B. WING		_	(08/	C 14/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
			1	9530 MOUNT ZION PARKV	VAY		
AUTUWIN	CARE OF CORNELIUS		C	ORNELIUS, NC 28031			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 514	not write an order for much IV fluid to give of Nurse #3 stated she s about flow rate and an should have written it didn't because she the order for it. She state who worked on secon 11:00 PM what the NF Nurse #2 got orders for The NP was no longe and was unable to be Nurse #2 was no long and was unable to be During a telephone in PM with Nurse #6 she night shift from 11:00 she remembered she Resident #3 and could fluids but after review notes she remembered start Resident #3's IV assessed Resident #3's IV assessed Resident #3's documented it but she because it had been to During an interview of Nurse #4 she explain care for Resident #3 of by a nurse to start an stated she tried but R collapsing and could in stated she should have	of normal saline but she did them and did not say how or how fast to give them. should have asked the NP mount of fluids to give and as a verbal order but she ought the NP would write an ad she reported to Nurse #2 ad shift from 3:00 PM to P had said and she thought or the IV. r employed by the facility reached for an interview. ger employed at the facility reached for an interview. terview on 08/06/15 at 3:59 e confirmed she worked PM to 7:00 AM. She stated was assigned to care for d not recall details about IV of her nurse's progress ed she attempted to try to . She stated if she had 3 she should have e could not recall anything too long ago. n 08/06/15 at 4:21 PM with ed she was not assigned to on 05/14/15 but was asked IV on Resident #3. She esident #3's veins were not get it in. She further ve documented her attempts	F 514				
	stated she tried but R collapsing and could r stated she should hav at starting Resident #	esident #3's veins were not get it in. She further					

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		ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 08/31/2015 FORM APPROVED MB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		3) DATE SURVEY COMPLETED
		345567	B. WING			C 08/14/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
ΔυτυμΝ	CARE OF CORNELIUS			9530 MOUNT ZION PARKWAY	,	
				CORNELIUS, NC 28031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 514	Continued From page PICC line in.		F 514			
	PM with Nurse #5 she second shift from 3:00 05/16/15 and rememb pressure was low and nurse's progress note Resident #3's blood p and it had come up be because she got busy stated she also forgot assessment of Reside was aware she neede her nurse's progress in During an interview of Director of Nursing (D new in the facility but documentation was a had been working wit document but they ha it was a work in progr expected for staff to d condition, assessment	D PM to 11:00 PM on bered Resident #3's blood I she documented it in her es. She stated she checked ressure again in 30 minutes ut she did not document it y and forgot. She further to document her ent #3's condition and she ed to put more information in notes. In 08/06/15 at 4:30 PM the DON) explained she was had identified that problem. She stated she h nurses to get them to id a lot of staff turnover and ess. She stated she locument changes in its, the attempts to start notification of the physician				

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