		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB NC</u>	<u>). 0938-0391</u>
-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>			COMP	LETED
		345129	B. WING _				-
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MOCKSVILLE			10	007 HOWARD STREET		
AUTUMIN				Μ	IOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
					DEFICIENCY)		
F 000	INITIAL COMMENTS		FC	000			
	1. 483.10 (F 157) at	1					
		began on 01/31/16 when					
		urine output and was not					
		e in condition and the					
	physician was not cor						
		d on 03/24/16 when the				OMB NO. 0938- (X3) DATE SURVEY COMPLETED C 03/24/2016 ITY, STATE, ZIP CODE EET 27028 VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE	
		a credible allegation of					
	compliance. The faci	-				COMPLETED C 03/24/2016	
	-	r scope and severity level D the potential for more than					
		not immediate jeopardy) to					
		ind resident education and					
		stems in place are effective.					
	2. 483.13 (F 224) at	J					
		egan on 01/31/16 when					
		urine output and was not					
	-	e in condition. Immediate					
		d on 03/24/16 when the					
	compliance. The faci	a credible allegation of					
	-	r scope and severity level D					
		the potential for more than					
		not immediate jeopardy) to				DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	
		nd resident education and					
	ensure monitoring sys	stems in place are effective.					
	3. 483.25 (F 315) at						
		began on 01/31/16 when					
		urine output and was not					
		e in condition. Immediate					
		d on 03/24/16 when the					
	compliance. The faci	a credible allegation of lity remains out of					
	-	r scope and severity level D					
		the potential for more than					
	-	not immediate jeopardy) to					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE				(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

04/11/2016

TATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	8-039 Y
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					С	
		345129	B. WING		03/24/201	16
NAME OF P	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MOCKSVILLE			Y HOWARD STREET CKSVILLE, NC 27028		
(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 COMPL	X5) PLETION ATE
F 000	Continued From page	e 1	F 000			
		and resident education and				
F 157	•••	stems in place are effective.	F 157		4/1/16	2
SS=J	(INJURY/DECLINE/R		F 157		4/1/10)
	A facility must immed	liately inform the resident;				
	consult with the resident's physician; and if					
	known, notify the resident's legal representative or an interested family member when there is an					
		y member when there is an e resident which results in				
		tential for requiring physician				
	intervention; a signific	cant change in the resident's				
		osychosocial status (i.e., a				
		n, mental, or psychosocial reatening conditions or				
); a need to alter treatment				
	significantly (i.e., a ne					
	existing form of treatr					
		commence a new form of				
		sion to transfer or discharge facility as specified in				
	§483.12(a).	racinty as specified in				
		promptly notify the resident sident's legal representative				
	or interested family m	nember when there is a				
		ommate assignment as				
	specified in §483.15(
	U U	Federal or State law or ed in paragraph (b)(1) of				
	this section.					
	The facility must reco	ord and periodically update				
	the address and phor	ne number of the resident's				
	legal representative c	or interested family member.				

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/13/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING		C 03/24/2016
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
	CARE OF MOCKSVILLE		1	007 HOWARD STREET	
			г	MOCKSVILLE, NC 27028	
(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 SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 157	Continued From page by:		F 157		
	record review the fac physician when a res The resident had dec increase in pain and 1 of 3 sampled reside Resident #28 was dia from a urinary tract in	complained of being sick for		This plan of correction constitutes r written allegation of compliance for deficiencies cited. However, submis of the plan of correction is not an admission that a deficiency exists of one was cited correctly. This plan of correction is submitted to meet requirements established by state a federal law.	sion r that
	Resident #28 had no assessed for a chang physician was not con jeopardy was remove facility implemented a compliance. The faci compliance at a lowe (no actual harm with minimal harm that is a complete employee a ensure monitoring sys The findings included Resident #28 was ad 09/20/15 with diagnos disease, history of un neuropathic bladder, and others. The mos (MDS) dated 01/12/11 moderately impaired speech and able to m required extensive as	ed on 03/24/16 when the a credible allegation of ility remains out of r scope and severity level D the potential for more than not immediate jeopardy) to and resident education and stems in place are effective.		It is the policy of this facility to notify resident s physician immediately u change in resident s status. 1. Resident #28 no longer resides facility. 2. For other resident s with the pro- to be affected by this cited deficience following has been accomplished. (C 3/22 and3/23, 2016 all residents we observed by the Licensed Nursing s determine if they had a significant of in their physical or mental status. Residents with catheters were further assessed with the Nursing Change Status Assessment and any identifier status change was followed up on b notification of Physician. 3. The Licensed Nursing staff were in-serviced by the Director of Nursing/Designee on March 22 thru 1, 2016 on use of the Nursing Change Status Assessment, the policy for Notification of the Physician for a sta- change and use of the 24 Hour repo- identify changes in status from shift	pon in the otential y the Dn re staff to hange er in ed y e April ge of atus ort to to
		#28's total daily fluid intake		shift. New hired licensed nurses will complete inservice during orientatio	

Facility ID: 922953

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/13/2016 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345129	B. WING			03	C 6/24/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MOCKSVILLE			1	007 HOWARD STREET		
ACTORIN				N	IOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 157	milliliters and docume revealed: Date Fluid in 1/31/16 720ml 2/01/16 440ml 2/02/16 0ml 0ml On 01/31/16 review of output revealed the F no urine output. No of the medical record or assessment had beel output or that the phy On 02/01/16 review of output revealed the F and only had 50ml of documentation that a completed for the deo the physician had beel - On 02/02/16 at 1 complained of pain at Nurse #2. - On 02/02/16 at 3 complained of pain at Nurse #2. - On 02/02/16 at 6 continued to complain Oxycodone again by There was no docum record that Nurse #2 and had not contacte	Urine output (measured in ented by the nurse aides) Urine out Oml 50ml of Resident #28's urine Resident went 24 hours with documentation was made in n 01/31/16 that an n completed for no urine risician had been contacted. Of Resident #28's urine Resident #28 went 24 hours urine. There was no n assessment had been creased urine output or that en contacted. medical record revealed: :25 AM the resident nd was given Oxycodone by s:15 AM the resident nd was given Tylenol by s:37 AM the resident n of pain and was given	F	1157	The Director of Nursing/Designee will review the twenty-four hour report to identify any changes in status and wil validate Notification to MD has been made by review of the residents Media Record. 4. The Director of Nursing/Designee complete an audit 2X a week for 2 we and then weekly x 4 weeks of the Twenty-Four Hour Report to validate Physician has been Notified of Reside Change in Condition. Results of audits be submitted to Quality Assurance Committee x 2 months for trending an tracking and on-going monitoring.	cal will eks nt s will	

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/13/2016 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		345129	B. WING			_		C 24/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE			1	007 HOWARD STREET			
				N	MOCKSVILLE, NC 2702	8		
(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 CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	the nurse supervisor of Resident #28 was vis resident was not actir resident be sent to the Resident #28's blood temperature was 99.4 rate was 115 beats per respirations were 34. have 0 ml in urinary of The Emergency Medir report" dated 02/02/10 Resident #28 was sor 100.3 degrees Fahren given 200ml of norma documented the resid urine in catheter bag much. On 02/02/16 Residen Emergency Departmen notes dated 02/02/16 presented with severe due to urinary tract in attempted to get a uri documented that then Resident #28 was als renal failure from the the ED, Resident #28 changed and the hosp "reddish pussy urine." admitted to the Intens Resident #28 was dis on 02/11/16 to anothe potential for rehab. On 02/05/16 Nurse #2	PM a nurse's entry made by specified the family of iting and reported that the og right and demanded the e Emergency Department. pressure was 95/54 and degrees Fahrenheit, heart er minute and resting The resident was noted to atheter bag. cal Services (EMS) "run 5 at 6:15 PM specified molent and had a fever of otheit. The Resident was I saline intravenously. EMS ent had "thick discolored" but did not specify how t #28 was transported to the ent (ED). Review of the ED specified the resident e sepsis and in septic shock fection (UTI). In the ED they ne specimen but e was not enough urine. o diagnosed with acute sepsis and dehydration. In 's urinary catheter was bital was able to obtain ' Resident #28 was ive Care Unit (ICU). charged from the hospital	F	157				

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		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY MPLETED
			A. BUILDIN	G		
		245420				С
		345129	B. WING			3/24/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET		
				MOCKSVILLE, NC 27028		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES	ID PREFIX		SHOULD BE	(X5) COMPLETIO DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
F 157	Continued From page	e 5	F 1	57		
-	her needs known, the nurse aide (NA) reported					
		of pain all over and was				
		odone. The entry specified				
		rt and verbal and noted to be				
		Urinary catheter noted with				
	cloudy urine approxir	•				
	centimeters) output."	,				
		n of pain. Resident was				
		iaphoretic (sweating) and				
		was elevated. "Resident				
	appears in no distres					
	On 03/21/16 at 4:00 l	PM Nurse #2 was				
		lephone and stated that she				
		< 02/01/16 at 11 PM to				
	•	vhich was a double shift (16				
		urse explained that she did				
		hall with Resident #28 and				
		ar with the resident. The				
		ght she was assigned to				
		r numerous complaints of				
		ed that she asked the nurse				
		ent's complaints of pain and				
		hat the resident "always"				
		nd that it was normal for her.				
	The nurse explained	that when a resident				
		he would administer pain				
	medication if ordered	, wait 30-60 minutes to				
	assess effectiveness	of the pain medication. She				
		was not resolved she would				
		. She stated that in the case				
		did not call the physician				
		feel anything was wrong with				
		e end of her shift (7 AM) the				
		e and 1 dose of Tylenol				
		ared to be effective because				
		onger complaining of pain.				
		t Resident #28's urine output				
	bad been near during	g the same shift and the				

Facility ID: 922953

If continuation sheet Page 6 of 44

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S COMPLE	
	STALETION				C	0
		345129	B. WING		03/24	4/2016
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODI	E	
AUTUMN	CARE OF MOCKSVILLE			07 HOWARD STREET OCKSVILLE, NC 27028		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLI E APPROPRIATE DAT	
F 157	Continued From page	9 6	F 157			
	nurse aides reported had been poor. The r wasn't concerned with	that the resident's intake nurse explained that she h the low urine output since was poor and that during				
	Review of Resident #28's Medication Administration (MAR) record for January 2016 and February 2016 revealed the resident received "as needed" pain medication less than daily expect on 02/02/16 she received 3 doses of "as needed" pain medication.					
	to 3 PM. The Nurse et the majority of the shi intake and this was un Nurse #4 explained the nurse aide #2 reporter catheter bag was emp this was concerning to had been drinking flui need to be called. The the end of her shift wh the no urine output are along in report and ex- follow-up by assessin contacting the physici she did not call the ph because there was "m #4 stated that if the nu	d she was the nurse #28 on 02/02/16 from 7 AM explained the resident slept ift and was refusing all nusual for the resident. hat at the end of the shift d to her that Resident #28's pty. The nurse stated that o her because the Resident ids and the physician would he nurse stated that it was hen she became aware of hd she passed the concern expected that Nurse #3 ing the resident and ian. Nurse #4 stated that hysician earlier in the shift hothing to call about." Nurse urse aide had reported ad no urine output then she on the resident and				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/13/2016 APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345129	B. WING		_		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET			
				MOCKSVILLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	ACTION SHOULD BE COMPL TO THE APPROPRIATE DA	
F 157		care for Resident #28 on	F 157	7			MAPPROVED 0. 0938-0391
	when she arrived for l that a pharmacy cons her on her medication that she was not give about her residents of stated she did not ass contact the physician	ft was very hectic because her shift she was notified ultant would be following n pass. The nurse stated n any concerns in report r Resident #28. The nurse					
	output and/or was cor	PM the Director of Nursing					
	(DON) was interviewed would expect nurse a no urine output to the follow-up with that con resident to determine be contacted. The Do assessment would ind to make sure it was p for signs of a change abdomen newness of concerns were identiff expected to call the p	ed and reported that she ides to report concerns of nurse and for the nurse to ncern by assessing the if the physician needed to ON explained that an clude checking the catheter atent (able to flow) and look such as distended pain. She added that if ied the nurse would be hysician.					
	a resident was having would be expected to unable to provide exp output then contact th stated that the need to would rely on nursing assessment with data resident's condition.	AM the physician was ephone and explained that if a no urine output the nurse assess the catheter and if lanation for the no urine the physician. The physician o contact the physician judgement and a clinical to support a change in the PM the Administrator was					

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/13/2016 // APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345129	B. WING					C 24/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE	E, ZIP CODE	•	
				.	1007 HOWARD STREET			
AUTUMN	CARE OF MOCKSVILLE				MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 157	compliance on 03/24/ interventions were pui immediate jeopardy. F-157 Failure to notify 1. Resident #28 no Resident was transfer did not return to this fa hospital. The alleged a change in condition, resident related to dea changes which were a and identified and rep 2. All residents have by the alleged deficient 3/23/16 all residents were change in their physic resident observed wit their physical or ment assessed utilizing the Assessment. This ass comprehensive asses systems, vital signs, r functional status as we resident's Physician (I (RP) notification. All a have been assessed 22 thru March 23, 201 Change in Status Ass 2016 to identify any c Nursing change in status	jeopardy. The facility ble credible allegation of (16. The following it into place to remove the y MD of status change longer resides in the facility. rred to hospital 2/2/16 and acility upon discharge from deficient practice included /overall status of the crease output and mental not immediately assessed borted to the MD. e the potential to be affected nt practice. On 3/22/16 and were observed by licensed nine if they had a significant cal or mental status. Any h a significant change in tal status was further e Change Status sessment is a ssment including all body medications and labs and vell as documentation of the MD) and Responsible Party residents with a catheter by licensed nurses March 16 using the Nursing sessment tool 3/22 & 23, hanges in status utilizing the atus form. The Care plans eters have been revised by	F	157		-ICIENCY)		
	include notification of	MD for decreased output or changes including pain, chill,						

Facility ID: 922953

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	S FOR MEDICARE & I					10.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			TE SURVEY MPLETED
			A. BUILDING	G		0
		345129	B. WING			C
	ROVIDER OR SUPPLIER	545125		STREET ADDRESS, CITY, STATE, ZIP COD		3/24/2016
VAIVIE OF PI	ROVIDER OR SUPPLIER			1007 HOWARD STREET		
AUTUMN	CARE OF MOCKSVILLE			MOCKSVILLE, NC 27028		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE	COMPLETIO DATE
F 157	Continued From page	9	F 1	57		
	change in color, consistency of urine or mental status changes.					
	22, 2016 thru March 2 scheduled shift to wor Nursing/Designee on and RP when a reside change in status inclu- residents with catheter status assessment wh output each shift and when decreased outp changes occur includ color consistency of u changes. Licensed n on the use of the Cha form and the utilizatio as communication too resident status chang Director of Nursing. T were in-serviced by D 2016 thru March 23rd how to identify a signi condition including, bu following: no urinary of consistency of the uri nausea, vomiting, and immediate notification	notifying the resident 's MD ent experiences a significant uding assessment of ers utilizing the Change of hich includes assessment of notification of MD and RP but or other identified status ing pain, chills change in urine or mental status ursing staff also in-serviced unge in status assessment on of the 24 hour shift report bls to report and document les on March 22-23 by the The Nursing assistants (NA) Director of Nursing March 22, I on what constitutes and ificant change in resident ut not limited to the putput, change in color or ne, mental status changes, d pain and the need for n of the Licensed Nurse				
	status. Licensed nurs in-serviced will be req in-service prior to wor	uired to complete the king their next scheduled allowed to work until they				
		identified in the alleged e in-serviced by the Director				

Facility ID: 922953

If continuation sheet Page 10 of 44

		MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	· · · ·	E SURVEY PLETED
			A. BUILDING			
		345129	B. WING			С
		545125			03	/24/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE			007 HOWARD STREET		
				·		
(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 SF CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 157	Continued From page	e 10	F 157			
		essment which becomes a				
		medical record and includes				
	· ·	and RP when a change is				
		ied NA has been in-serviced				
	the Director of Nursin	g March 23 on what				
	constitutes a significa	ant change in resident status				
		tification of the Licensed				
		ed change in the resident				
		rinary output, change in				
	-	odor of urine, mental status				
	they see as a change	miting, vital signs or anything				
	liney see as a change					
	The facility will utilize	the 24 Hour shift to shift				
		cation tool to document				
		nurse will document any				
	changes that occur d	uring their shift and verbally				
		es in status of residents from				
		o shift report at shift change.				
		nurses will be required to				
		eside each residents name				
	and information on th	• •				
	Director of Nursing/D	eport of status changes.				
		of the 24 Hour report.				
		was removed on 03/24/16 at				
		cility provided evidence of ovided to the nursing staff				
		e aware of the new system				
		ician of a resident's change				
	in condition.					
F 224	483.13(c) PROHIBIT		F 224			4/1/16
SS=J		GLECT/MISAPPROPRIATN				
	The facility must deve	elop and implement written				
	policies and procedu					
	mistreatment, neglec					

Facility ID: 922953

If continuation sheet Page 11 of 44

-				FOF	ED: 04/13/20 RM APPROVE <u>O. 0938-03</u>
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		· · ·	E SURVEY IPLETED C
	345129	B. WING		03	3/24/2016
ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CO		
CARE OF MOCKSVILLE					
			-		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
		F 224			
by: Based on staff, phys and record review the medical intervention v resident had been dri output for 8 hours and well. The resident 's Emergency Medical S resident was admitted (ICU) diagnosed with	ician and family interviews e facility neglected to seek when it was reported that a inking fluids but had no urine d complained of not feeling family requested Services (EMS) and the d to Intensive Care Unit septic shock and acute		 residents are provided with t services necessary to avoid harm, mental anguish or me 1. Resident #28 no longer facility. 2. For other resident switt to be affected by this cited d following has been accomplii 3/22 & 3/23 all residents were Licensed Nursing staff to de 	he goods and physical ntal illness. resides in the th the potential eficiency the shed. On e observed by etermine if	
Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition. Immediate jeopardy was removed on 03/24/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. The findings included: Resident #28 was admitted to the facility on 09/20/15 with diagnoses that included Alzheimer's disease, history of urinary tract infections, flaccid		 with catheters were assessed Nursing Change in Condition to identify any changes in the mental status. Residents wii identified significant change mental status had a nursing completed by a licensed nur Nursing Change in Condition on March 22&23, 2016. Physi notified for any identified Char Condition on March 22 & 23 3. Licensed Nurses were in the Director of Nursing/Desig 	d utilizing the n Assessment eir physical or th an in physical or assessment se utilizing the n Assessment sician was ange in , 2016. n-serviced by gnee on		
	S FOR MEDICARE & S FOR MEDICARE & PF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER CARE OF MOCKSVILLE SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page and misappropriation This REQUIREMENT by: Based on staff, phys and record review the medical intervention y resident had been dri output for 8 hours any well. The resident 's Emergency Medical S resident was admitted (ICU) diagnosed with renal failure for 1 of 1 #28). Immediate jeopardy to Resident #28 had no assessed for a change jeopardy was removed facility implemented a compliance. The faci compliance at a lowed (no actual harm with minimal harm that is complete employee a ensure monitoring sy The findings included Resident #28 was ad	CORRECTION IDENTIFICATION NUMBER: 345129 ROVIDER OR SUPPLIER CARE OF MOCKSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff, physician and family interviews and record review the facility neglected to seek medical intervention when it was reported that a resident had been drinking fluids but had no urine output for 8 hours and complained of not feeling well. The resident 's family requested Emergency Medical Services (EMS) and the resident was admitted to Intensive Care Unit (ICU) diagnosed with septic shock and acute renal failure for 1 of 1 sampled resident (Resident #28). Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition. Immediate jeopardy was removed on 03/24/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. The findings included: Resident #28 was admitted to the facility on	S FOR MEDICARE & MEDICAID SERVICES IF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLI A BUILDING 345129 B. WING 345129 B. WING CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 11 and misappropriation of resident property. F 224 This REQUIREMENT is not met as evidenced by: Based on staff, physician and family interviews and record review the facility neglected to seek medical intervention when it was reported that a resident had been drinking fluids but had no urine output for 8 hours and complained of not feeling well. The resident 's family requested Emergency Medical Services (EMS) and the resident was admitted to Intensive Care Unit (ICU) diagnosed with septic shock and acute renal failure for 1 of 1 sampled resident (Resident #28). Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition. Immediate jeopardy was removed on 03/24/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. The findings included: Resident #28 was admitted to the facility on	S FOR MEDICARE & MEDICAID SERVICES IF DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLIERCLIA DENTFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BUILDING SWMARDS STRUCTION 345129 BVING CARE OF MOCKSVILLE STREET ADDRESS, CITY, STATE, ZIP CO 1007 HOWARD STREET MOCKSVILLE, NC 27028 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIEW RESCONT TAG PROVIDER'S PLAN OF C (EACH CORRECTIVE ADDR CROSS-REFERENCED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This REQUIREMENT is not met as evidenced by: Based on staff, physician and family interviews and record review the facility neglected to seek medical intervention when it was reported that a resident habeen drinking fluids but had no urine output for 8 hours and complained of not feeling well. The resident's family requested Emergency Medical Services (EMS) and the resident was admitted to Intensive Care Unit (ICU) diagnosed with septic shock and acute reand failure for 1 of 1 sampled resident (Resident #28). F or other resident: s wit to be affected by this cited d following has been accomplia 3/22 & 3/23 all residents wen Licensed Nursing staff to de they experienced a significa their physical or mental status. Resident #28 had no urine output and was not assessed for a change in condition. Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition. Immediate jeopardy began on 01/31/16 when Resident #28 has do a rusting the potential for more than minimal harm with the potential for more than minimal harm that is not immediate jeopardy by complete analory with condetile of horany identified Ch Condition on March 228 2	MENT OF HEALTH AND FUMAN SERVICES FOOR S FOR MEDICARE & MEDICALD SERVICES OME N CORRECTION (X) PROVIDERSUPPLERCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE CONDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2IP CODE 100 PMOARD STREET MOCKSVILLE, NC 27028 (X0) CORRECTION REGULATION OF DEPICIENCIES (X2) OUT STATE, 2IP CODE SUMMARY STATEMENT OF DEPICIENCIES IDE PROVIDERS, CITY, STATE, 2IP CODE 100 PMOARD STREET MOCKSVILLE, NC 27028 (X2) OUT STATE, 2IP CODE SUMMARY STATEMENT OF DEPICIENCIES IDE PROVIDERS, CITY, STATE, 2IP CODE (X2) OUT STATE, 2IP CODE (X2) OUT STATE, 2IP CODE SUMMARY STATEMENT OF DEPICIENCIES IDE PROVIDERS, CITY, STATE, 2IP CODE (X2) OUT STATE, 2IP CODE (X2) OUT STATE, 2IP CODE SUMMARY STATEMENT OF DEPICIENCIES IDE PROVIDERS, CITY, STATE, 2IP CODE (X2) OUT STATE, 2IP CODE (X2) OUT STATE, 2IP CODE SUMMARY STATEMENT OF DEPICIENCIES IDE PROVIDERS, CITY, STATE, 2IP CODE (X2) OUT STATE, 2IP CODE (X2) OUT STATE, 2IP CODE Continued From page 11 and record review the facility interviews and record review the facility on the assessed on staft, physical and anoute resident H28 had no urine output and was no services necesseary to avoid physical ither physical or mental illines

Event ID: C5C911

Facility ID: 922953

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						OMB NO	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDIN	IG			С
		345129	B. WING				24/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	03/	24/2010
0.002 01 1					007 HOWARD STREET		
AUTUMN	CARE OF MOCKSVILLE		MOCKSVILLE, NC 27028				
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 224	Continued From non	- 40					
Г 224	Continued From page		F 2	24			
		roidism, hypertension,			when a resident has a change in	٨	
	•	nd a sacral ulcer. The most a Set (MDS) dated 01/12/16			status/condition including when a C.N. reports a change in resident □s condition		
					In-service including use of the Nursing		
	specified the resident had moderately impaired cognition but had clear speech and able to make				Change in Condition Assessment and		
	•	he required extensive			use of the Twenty-four Hour report to		
		ties of daily living but was			identify changes in status from shift to		
		vith setup from staff; and had			shift was completed by Director of Nur	sing	
a	an indwelling urinary	catheter. The MDS also			on March 22 thru April 1, 2016. New h	nired	
	specified the resident	received as needed pain			licensed nurses will complete inservice	9	
	medication and was r	not on Hospice.			during orientation. Any licensed nurse	•	
					who has not completed in-service will		
		are plan for her urinary 01/26/16 that specified the			complete prior to next scheduled shift.		
		ed every shift and to provide			The C.N.A. staff were in-serviced by th	ne	
	catheter care as orde	red. The care plan goal was			Director of Nursing/Designee on March	h 22	
	that the resident woul	ld not experience catheter			thru April 1, 2016 on how to identify a		
	relates issues such a	s failure to drain.			significant change in resident⊡s status/condition and what constitutes a	a	
	Resident #28 receive	d a therapeutic.			significant change in condition includin		
		diet with regular liquids.			but not limited to the following: no uring	-	
					output, changes in color, consistency of	-	
	On 01/31/16 review o	of Resident #28's urine			odor of urine, mental status changes,		
	· ·	Resident went 24 hours with			nausea, vomiting, and pain and to noti		
	-	documentation was made in			the Licensed Nurse immediately of any		
	the medical record or				change they identify. New hired CNAs	will	
		n completed for no urine			be inserviced during orientation.		
	output or that the phy	vsician had been contacted.			The Nursing staff will utilize the		
	On 02/01/16 roview a	of Resident #28's urine			Twenty-four Hour Report as a communication tool to document change	000	
		Resident #28 went 24 hours			in status/condition from shift to shift an	-	
		urine. No documentation			will initial each resident on the Twenty-		
		ad been completed for the			hour report to verify Changes in		
		ut or that the physician had			Resident s status/condition are		
	been contacted.	. ,			communicated and followed up on shif	ft to	
					shift. The Director of Nursing/Designee		
	On 02/02/16 at 5:00 F	PM a nurse's entry made by			will review the Twenty-four hour Repor		
		specified the family of			identify Resident changes in		
	Resident #28 was vis	iting and reported that the			status/condition and validate assessme	ont	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIE	PLE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	OMPLETED
						С
		345129	B. WING			03/24/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page	2 13	F 22	24		
	resident was not actir resident be sent to the	ng right and demanded the e Emergency Department.		and follow up including Phys notification.	ician	
	Resident #28's blood pressure was 95/54 and temperature was 99.4 degrees Fahrenheit, heart rate was 115 beats per minute and resting respirations were 34. The resident was noted to have 0 ml in Foley catheter bag.			4. The Director of Nursing/ complete audits 2x a week x then weekly x 1 month utilizin Twenty- four hour Report to identified changes in Resider	2 weeks and ng the validate	
	The Emergency Medical Services (EMS) ' report" dated 02/02/16 at 6:15 PM specifie Resident #28 was somnolent and had a fe 100.3 degrees Fahrenheit. The Resident given 200ml of normal saline intravenousl documented the resident had "thick discol urine in catheter bag but did not specify he much.	6 at 6:15 PM specified mnolent and had a fever of		status/condition are identified follow-up including assessme Physician notification is com those residents with an ident	d and ent and oleted for	
		lent had "thick discolored"		in status/ condition. Results of be reviewed by the QA comm months for trending and track on-going monitoring.	nittee x 2	
	Emergency Departme notes dated 02/02/16	t #28 was transported to the ent (ED). Review of the ED specified the resident				
	due to urinary tract in attempted to get a uri documented that ther	e sepsis and in septic shock fection (UTI). In the ED they ne specimen but e was not enough urine. o diagnosed with acute				
	renal failure from the the ED, Resident #28	sepsis and dehydration. In 's urinary catheter was pital was able to obtain				
	admitted to the Intensive Care Unit (ICU). Resident #28 was discharged from the hospital on 02/11/16 to another facility with a "fair" potential for rehab.	sive Care Unit (ICU). charged from the hospital				
	and reported that the	M a family member of erviewed on the telephone family visited twice daily. xplained that on 02/02/16				

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		3	· · · ·	MPLETED
			A. BUILDING			С
		345129	B. WING			
		545125		STREET ADDRESS, CITY, STATE, ZIP COL		3/24/2016
NAME OF PI	ROVIDER OR SUPPLIER				JE	
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET		
				MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 224	Continued From page	- 14	F 22	4		
1 22 1			F 22			
		usual self. She explained very lethargic and did not				
		on with the family as she				
		ily member added that she				
		irse and the nurse told her				
		edication pass. The family				
		rse supervisor and asked				
	that the resident be tr	ansported to the ED. The				
	family stated that sind	ce the hospitalization and				
	time in ICU the reside	ent's cognition was not the				
	same.					
	On 3/22/16 at 10:15	AM Nurse #4 was				
	interviewed and state	d she was the nurse				
	assigned to Resident	#28 on 02/02/16 from 7 AM				
		explained the resident slept				
		ift and was refusing all				
		nusual for the resident				
		ly at least accept bites of				
	food. Nurse #4 repor					
	•	nent on Resident #28 that				
		r catheter or assessing her				
		e shift had been very busy not appear to be in distress.				
		by the end of the shift she				
		It drank a combined total of				
		uring the shift. Nurse #4				
		end of the shift nurse aide				
	-	at Resident #28's catheter				
	-	nurse stated that this was				
		cause the Resident had				
	•	ind the physician would need				
		the shift the nurse aide had				
		e resident and according to				
		ere "okay." The nurse				
		end of her shift when she				
		no urine output and she along in report and expected				
	Dassed the concern a		1	1		1

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		MEDICAID SERVICES				IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G		
						С
		345129	B. WING		0	3/24/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
	CARE OF MOCKSVILLE			1007 HOWARD STREET		
AUTUMIN				MOCKSVILLE, NC 27028		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH		COMPLETIO DATE
IAG	REGULATORTOR		IAG	DEFICIENCY		
F 224	Continued From page	e 15	F 22	24		
	and contacting the ph	nysician. Nurse #4 stated				
		he physician earlier in the				
		as "nothing to call about."				
		she wished the nurse aide				
		n the shift the poor urine				
	-	so stated that she had been				
		a "few times" during the				
		alized the catheter bag				
		e other side of the bed and				
		d Resident #28's catheter or				
	abdomen.					
	On 03/22/16 at 10:30) AM Nurse #3 was				
		lephone and reported that				
		care for Resident #28 on				
	02/02/16 from 3 PM t					
		ift was very hectic because				
	•	her shift she was notified				
		sultant would be following				
		n pass. The nurse stated				
		en any concerns in report				
		and therefore did not conduct				
		r residents to check them.				
		at it was her usual practice				
	to make a brief round	•				
		stated that she was not told				
		nt #28 had gone 8 hours with				
	· ·	se #3 proceeded to explain				
		ting her medication pass				
		ent #28 arrived. She added				
	-	ie nurse supervisor asked				
		Resident #28 because she				
		Nurse #3 stated she had to				
		he medications already				
		could attend to Resident				
		ates she waited 5 to 10				
		onding to concern about the				
		tated that this was around				
	1 100 000 011. INULOC π 0 0		1			1

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	OF DEFICIENCIES			LE CONSTRUCTION		10. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345129	B. WING			3/24/2016
	ROVIDER OR SUPPLIER	0.0.120		STREET ADDRESS, CITY, STATE, ZIP CODE		3/24/2010
				1007 HOWARD STREET	-	
AUTUMN	CARE OF MOCKSVILLE			MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 224	Continued From page	e 16	F 22	4		
		first time since her shift had				
		visualized the resident.				
		at when she went into the				
		s not her usual self, less				
		se was very slow. Nurse #3				
	did not know how lon	g the resident had been in				
ti h n	that condition. The n	urse also was not aware of				
		in the catheter bag and did				
	-	assess because the family				
	was insistent n calling	g 911.				
	-	ned to Resident #28 on o 11 PM was no longer				
		ty unable to be interviewed.				
	chiployed at the lacin	ty unable to be interviewed.				
	On 03/22/16 at 1:00 F	PM the nurse supervisor was				
		rted that she was working on				
		recall any concerns being				
	reported that day abo	out Resident #28. The nurse				
		that around 5 PM the				
	-	e and expressed concern				
		not acting right and wanted				
		te ED. She added that she				
		to Nurse #3 who was busy				
		tion pass. And added that busy she went to the room to				
		28. The nurse supervisor				
		ily was concerned that the				
	-	ak but when the nurse				
	supervisor called the					
	•	turn her head and respond.				
		lanced at the catheter bag				
	and noted that it was					
	-	t after the incident she				
		ne resident had gone a few				
		nuch urine output. She				
		ne output in 8 hours would be				
	a "flag" and the physi	CIAN WOULD NEED TO DE	1			1

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						IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
			AL DOLEDING			С
		345129	B. WING		0	3/24/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CARE OF MOCKSVILLE			1007 HOWARD STREET		
AUTOMIN				MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 224	Continued From page	e 17	F 224	4		
· ·		been declining in health.	1 22			
		explained the process for				
		nitoring fluid intake and				
	urine output for reside	ents with urinary catheters.				
		urse aides were responsible				
		cumenting the total amount				
		er bag into the computer.				
		hat if a concern was noted It such as being less than				
		opearance or not urine				
	÷ .	would report the concern to				
		e supervisor stated that the				
		are and educated to be				
	accurate with their do	ocumentation.				
	On 03/22/16 at 4.10 I	PM the Director of Nursing				
		ed and reported that she				
		ides to report concerns of				
	•	nurse and for the nurse to				
		ncern by assessing the				
		if the physician needed to				
	be contacted. The D					
		clude checking the catheter atent (able to flow) and look				
	for signs of a change	· · · · · ·				
		f pain. She added that if				
		fied the nurse would be				
	expected to call the p	hysician.				
	On 03/23/16 at 8:48 /	AM the physician was				
		lephone and explained that if				
		g no urine output the nurse				
	•	assess the catheter and if				
		blanation for the no urine				
		ne physician. The physician				
		o contact the physician				
		a to support a change in the				
	assessment with date	a to capport a change in the		1		1

Facility ID: 922953

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/13/2016 1 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345129	B. WING		_		C 24/2016
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	007 HOWARD STREET			
AUTUMN	CARE OF MOCKSVILLE		N	OCKSVILLE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	9 18	F 224				
	and reported that on 0 her 3 PM to 11 PM sh that Resident #28 was sick and the nurses w to explain that she ch frequently that shift an to sleep which was no obtained vitals on the slept through getting 1 recalled that the resid #4 stated that during nurse supervisor if sh with Resident #28 and stated she was not av with the resident. The PM she left the hall to	nd the resident only wanted of usual for her and that she resident and the resident her vitals taken. The NA ent's vitals were "okay." NA the shift she asked the e knew what was wrong d the nurse supervisor vare anything was wrong e NA added that around 5 o help with the evening meal d when she came back the					
	notified of immediate provided an acceptab compliance on 03/24/ interventions were pu immediate jeopardy. F-224 Neglect/Failure identify status change 1. Resident #28 no Resident was transfer did not return to this fa hospital. The alleged a change in condition resident related to den	le credible allegation of 16. The following t into place to remove the to assess resident to longer resides in the facility. rred to hospital 2/2/16 and acility upon discharge from deficient practice included /overall status of the crease output and mental not immediately assessed					

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	TED: 04/13/2016 DRM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		345129	B. WING				C 03/24/2016
NAME OF P	ROVIDER OR SUPPLIER	·			STREET ADDRESS, CITY, STATE, ZIP CODE		
					1007 HOWARD STREET		
AUTUWIN	CARE OF MOCKSVILLE				MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 224	Continued From page	e 19	F	224	4		
	by this alleged deficie 3/23 all residents wer nursing staff to detern significant change in mental status. Any re significant change in utilizing the Change in which is a comprehen systems, medications functional status as w resident's Physician ((RP) notification. Lica in-serviced on the use assessment form and hour shift report as co and document reside 22 thru March 23 by t residents with cathete licensed nurses on M change in status utiliz Assessment of the re- and system review as MD/RP notification. C the patients with cath of the MD when decre status changes occur change in color consi mental status change 3. Licensed Nurses 2016 thru March 23rd scheduled shift to wo Nursing/designee reg failure to complete an care when a resident	sident including pain, lab, s well as documentation of Care plans were updated for eters to include notification eased output or any other including chills, pain, stency, and odor of urine, e.					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/13/2016 // APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345129	B. WING					C 24/2016
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				1007 HOWARD STREET	2		
				<u> </u>				
(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 BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
TAG F 224	Continued From page staff report a change Nursing assistants (N Director of Nursing M 23rd on what constitu significant change in a but not limited to the f change in color or cor mental status change pain and the need for the Licensed Nurse w in the resident's statu NAs who have not co required to complete scheduled shift to wor to work until they have 4. The facility will ut report as a communic status changes. The f changes that occur du communicate change this tool during shift to For verification both m record their initials be and information on the receiving and giving r	e 20 in resident condition. The A) were in-serviced by arch 22, 2016 thru March tes and how to identify a resident condition including, following: no urinary output, hisistency of the urine, s, nausea, vomiting, and immediate notification of then they identify a change s. Licensed nurses and mpleted in-service will be in-service prior to their next rk. They will not be allowed e completed the in-services. illize the 24 Hour shift to shift cation tool to document nurse will document any uring their shift and verbally s in status of residents from o shift report at shift change. nurses will be required to side each residents name e report as proof of eport of status changes.		224	D		TE	DATE
F 315 SS=J	2:30 PM when the fac additional training pro that proved they were	TER, PREVENT UTI,	F	315				4/1/16

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM A OMB NO. (PPROVED			
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	RVEY			
		345129	B. WING		C 03/24	/2016			
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•				
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028					
(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)	- 1	(X5) COMPLETION DATE			
F 315	Based on the residem assessment, the facili resident who enters the indwelling catheter is resident's clinical com- catheterization was need who is incontinent of the treatment and service infections and to rest function as possible. This REQUIREMENT by: Based on staff, physic and record review the resident when her cor Resident when her cor Resident when her cor Resident when her cor Resident when her cor she was admitted to the she was admitted to the septic shock and acut sampled residents (Re Immediate jeopardy bhe Resident #28 had no assessed for a chang jeopardy was remove facility implemented a compliance. The faci compliance at a lower (no actual harm with the minimal harm that is r complete employee a ensure monitoring systemic The findings included	t's comprehensive ty must ensure that a ne facility without an not catheterized unless the dition demonstrates that ecessary; and a resident bladder receives appropriate as to prevent urinary tract ore as much normal bladder is not met as evidenced ic an and family interviews e facility failed to assess a ndition changed. The urs with little to no urine pain, refused to eat before ergency Department where intensive Care Unit (ICU) for te renal failure for 1 of 3 esident #28). eggan on 01/31/16 when urine output and was not e in condition. Immediate d on 03/24/16 when the oredible allegation of lity remains out of r scope and severity level D the potential for more than not immediate jeopardy) to nd resident education and stems in place are effective.	F 31	 5 It is the policy of this facility that based the resident's assessment, the facility must assure care and services are provided to prevent urinary tract infecti for residents with catheters. 1. Resident #28 no longer resides in facility. 2. For other resident □s with the pote to be affected by this cited deficiency t following has been accomplished. On 3/22 & 3/23 all residents were observed Licensed Nursing staff to determine if they experienced a significant change their physical or mental status. Reside with catheters were assessed utilizing Nursing Change in Condition Assessmental status. Residents with an identified significant change in physical mental status had a nursing assessmental status had a n	the ential he d by in nts the hent al or ent g the hent				
	-	mitted to the facility on			ient				

Facility ID: 922953

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				יוחי ר		OMB NO	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	LETED
			A. BUILDIN	NG			2
		345129	B. WING _				, 24/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	03/	24/2010
					007 HOWARD STREET		
AUTUMN	CARE OF MOCKSVILLE				IOCKSVILLE, NC 27028		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D BE COMPLE	
F 315	Continued From page	e 22	F 3	315			
		ses that included Alzheimer's			notified for any identified Change in		
		nary tract infections, flaccid			Condition on March 22 & 23, 2016.		
		urine retention, anorexia,					
		roidism, hypertension,			3. Licensed Nurses were inserviced I	oy 🛛	
	-	d a sacral ulcer. The most			the Director of Nursing/Designee on		
		e Set (MDS) dated 01/12/16			March 22 thru April 1, 2016 regarding failure to complete a nursing assessme	nt	
		ar speech and able to make			and provide care when a resident has a		
	herself understood; s	•			change in status/condition including wh		
		ties of daily living but was			a CNA reports a change in resident's		
	able to feed herself w	vith setup from staff; and had			condition. The inservice included no		
		catheter. The MDS also			urinary output, changes in color,		
		received as needed pain			consistency or odor of urine, mental		
	medication and was r	not on Hospice.			status changes, nausea, vomiting, and		
	Resident #28 had a c	are plan for her urinary			pain. In-service of licensed nurses including use of the Nursing Change in		
		01/26/16 that specified the			Condition Assessment and the use of t		
		ed every shift and to provide			Twenty-four Hour report to identify		
		red. The care plan goal was			changes in status from shift to shift was	S	
	that the resident woul	ld not experience catheter			completed by Director of Nursing on		
	relates issues such a	s failure to drain.			March 22 thru April 1, 2016. New hired		
					licensed nurses will be inserviced durin		
	Resident #28 receive				orientation. Any licensed nurse who ha	as	
		diet with regular liquids.			not completed in-service will complete prior to next scheduled shift.		
	A review of Resident	#28's total daily fluid intake					
		urine output (measured in					
		ented by the nurse aides)			The C.N.A. staff were inserviced by the		
	revealed:				Director of Nursing/Designee on March	22	
		Urine out			thru April 1, 2016 on how to identify a		
	1/21/16 360ml	600ml			significant change in resident⊡s		
	1/22/16 600ml 1/23/16 360ml	400ml 325ml			status/condition and what constitutes a significant change in condition including		
	1/23/16 360ml	200ml			but not limited to the following: no urina	-	
	1/25/16 720ml	450ml			output, changes in color, consistency o	-	
	1/26/16 180ml	900ml			odor of urine, mental status changes,		
	1/27/16 300ml	300ml			nausea, vomiting, and pain and to notif	y	
	1/28/16 480ml	700ml			the Licensed Nurse immediately of any		
	1/29/16 560ml	1750ml			change they identify. New hired CNAs	will	

Event ID: C5C911

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		ND HUMAN SERVICES				F	ITED: 04/13/2016 ORM APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) [NO. 0938-0391 DATE SURVEY COMPLETED
		345129	B. WING				C 03/24/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				10	07 HOWARD STREET		
AUTUMN	CARE OF MOCKSVILLE			M	OCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315	1/30/16 840ml 1/31/16 720ml 2/01/16 440ml 2/02/16 0ml 0m The fluid intake docur documented by the n include water with me On 01/21/16 the nurs Resident #28 for a ro that the resident had made no changes to and ordered routine la On 01/25/16 the NP v Resident #28 for deci The NP assessed that was soft, non-tender increased the resider Alzheimer's, discontir a fortified nutritional s recommended monitor increased agitation at On 01/26/16 the nurs medical record that R catheter was patent at On 01/31/16 at 5 PM Nurse Supervisor spe urinary catheter was had not complained of or bladder pain; that the a change in the resider	400ml 0ml 50ml 1 mented was from meals only urse aides and did not edication pass. The practitioner (NP) saw utine visit. The NP noted a chronic urinary catheter, the resident's medications aboratory work. Was asked to review reased solid oral intake. at the resident's abdomen and without mass. The NP nt's medication for nued a salt restriction, added supplement and oring for weight loss, signs of nd decreased oral intake. The documented in the Resident #28's urinary and draining yellow urine. a nurse's entry made by the	F3	315	 be inserviced during orientation. The Nursing staff will utilize the Twenty-four Hour Report as a communication tool to document ch in status/condition from shift to shift will initial each resident on the Twe hour report to verify Changes in Resident s status/condition are communicated and followed up on shift. The Director of Nursing/Desig will review the Twenty-four hour Re- identify Resident changes in status/condition and validate asses and follow up including Physician notification. The Director of Nursing/Desigr complete audits 2x a week x 2 wee then weekly x 1 month utilizing the Twenty- four hour Report to validate identified changes in Residents status/condition are identified and follow-up including assessment and Physician notification is completed those residents with an identified cl in status/ condition. Results of audi be reviewed by the QA committee of months for trending and tracking ar on-going monitoring. 	and hty-four shift to nee port to sment sment hee will ks and e for hange ts will a 2	

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED 8 NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) [DATE SURVEY COMPLETED	
		345129	B. WING			C 03/24/2016		
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MOCKSVILLE				1007 HOWARD STREET MOCKSVILLE, NC 27028			
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 315	output revealed the R no urine output. No of the medical record on assessment had beer output or that the phy On 02/01/16 at 4 PM nurse supervisor spee "urinary catheter was had not complained of or bladder pain and th nurse aides." On 02/01/16 review of output revealed the R and only had 50ml of that an assessment h decreased urine outp been contacted. Further review of the received as needed p the physician: - On 02/02/16 at 1 complained of genera and was given Oxyco - On 02/02/16 at 3 complained of genera and was given Tylend - On 02/02/16 at 6 continued to complair specified) and was give Nurse #2. Review of the nurses revealed there was no assessment.	tesident went 24 hours with locumentation was made in a 01/31/16 that an a completed for no urine sician had been contacted. a nurse's entry made by the cified Resident #28's, intact and that the resident of leaking, dysuria, distention he bag was emptied by the f Resident #28's urine tesident #28 went 24 hours urine. No documentation ad been completed for the ut or that the physician had medical record revealed she hain medication ordered by :25 AM the resident dized pain (not specified) done by Nurse #2. :15 AM the resident dized pain (not specified)	F	315	5			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/13/2016 1 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345129	B. WING		_	(03//	C 24/2016
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE			007 HOWARD STREET	В		
(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 CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 315	the Director of Nursin, #28's urinary catheter On 02/02/16 at 5:00 F the nurse supervisor s Resident #28 was vis resident was not actin resident be sent to the Resident #28's blood temperature was 99.4 rate was 115 beats per respirations were 34. have 0 ml in Foley car The Emergency Medi report" dated 02/02/10 Resident #28 was sor 100.3 degrees Fahrer given 200ml of normal documented the resid urine in catheter bag much. On 02/02/16 Residen Emergency Departmen notes dated 02/02/16 presented with severed due to urinary tract inf attempted to get a uri documented that ther Resident #28 was als renal failure from the the ED, Resident #28 changed and the hosp "reddish pussy urine."	g (DON) specified Resident "was in place." PM a nurse's entry made by specified the family of iting and reported that the ag right and demanded the e Emergency Department. pressure was 95/54 and d degrees Fahrenheit, heart er minute and resting The resident was noted to theter bag. cal Services (EMS) "run 6 at 6:15 PM specified mnolent and had a fever of nheit. The Resident was al saline intravenously. EMS lent had "thick discolored" but did not specify how t #28 was transported to the ent (ED). Review of the ED specified the resident e sepsis and in septic shock fection (UTI). In the ED they ne specimen but e was not enough urine. o diagnosed with acute sepsis and dehydration. In 's urinary catheter was pital was able to obtain ' Resident #28 was sive Care Unit (ICU). charged from the hospital	F 315				

Facility ID: 922953

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/13/2016 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345129	B. WING			_		C 24/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				10	007 HOWARD STREET			
AUTUWIN	CARE OF MOCKSVILLE			М	IOCKSVILLE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	Continued From page	26	F	315				
		2 documented a late entry dent #28 was able to make						
		nurse aide (NA) reported						
	-	of pain all over and was						
		odone. The entry specified taken to be						
		Jrinary catheter noted with						
	cloudy urine approxim	nately 100cc (cubic						
	centimeters) output."							
		n of pain. Resident was aphoretic (sweating) and						
		was elevated. "Resident						
	appears in no distress	3."						
	On 3/21/16 at 1:10 PM	A a family member of						
		erviewed on the telephone						
		family visited twice daily.						
	-	xplained that on 02/02/16						
		<i>v</i> isited the resident and the usual self. She explained						
		very lethargic and did not						
	engage in conversation	on with the family as she						
	-	ly member added that she						
		rse and the nurse told her dication pass. The family						
		rse supervisor and asked						
	that the resident be tra	ansported to the ED. The						
	-	the hospitalization and						
	same.	ent's cognition was not the						
	On 03/21/16 at 4:00 F							
		ephone and stated that she						
	was assigned to work	hich was a double shift (16						
		urse explained that she did						
	not routinely work the	hall with Resident #28 and						
	was not overly familia	r with the resident. The						

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED	
						С	
		345129	B. WING		03/24/2016		
NAME OF PE	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD	•		
			1007 HOWARD STREET				
ΑυτυΜΝ 🤇	CARE OF MOCKSVILLE			OCKSVILLE, NC 27028			
				PROVIDER'S PLAN OF CC		0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 315	Continued From page	e 27	F 315				
		pht she was assigned to	1 010				
		r numerous complaints of					
		ed that she asked the nurse					
		ent's complaints of pain and					
		hat the resident "always"					
		nd that it was normal for her.					
	The nurse explained	that when a resident					
	complained of pain sl	he would administer pain					
	medication if ordered	, wait 30-60 minutes to					
		of the pain medication. She					
		was not resolved she would					
		. She stated that in the case					
		did not call the physician					
		feel anything was wrong with					
		e end of her shift (7 AM) the					
		e and 1 dose of Tylenol ared to be effective because					
		onger complaining of pain.					
		t Resident #28's urine output					
		the same shift and the					
		that the resident's intake					
	-	nurse explained that she					
		h the low urine output since					
		was poor and that during					
		ed less. She stated that she					
	visualized the cathete	er bag but could not recall					
	what the bag had in it	t or what the resident's urine					
	looked like. The nurs	se stated that she recalled a					
		something to her about the					
		it couldn't remember the					
		ated that low urine output					
	was considered less	-					
	,	8 hours or no urine output in					
	8 hours. The nurse of						
		t's abdomen or catheter by					
	cnecking placement a	and did not obtain vitals on					
1		e physician because the					

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			TE SURVEY
	CONTRECTION	IDENTIFICATION NOWIDER.	A. BUILDING	3		
						С
		345129	B. WING			3/24/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
ΔΠΤΠΜΝ	CARE OF MOCKSVILLE			1007 HOWARD STREET		
				MOCKSVILLE, NC 27028		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETIO DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY		DATE
F 315	Continued From page	e 28	F 31	5		
	Review of Resident #					
) record for January 2016				
	,	evealed the resident received				
		dication less than daily				
		he received 3 doses of "as				
	needed" pain medica					
	On 3/22/16 at 10:15 /	AM Nurse #4 was				
	interviewed and state	ed she was the nurse				
	assigned to Resident	: #28 on 02/02/16 from 7 AM				
		explained the resident slept				
	the majority of the shi	ift and was refusing all				
	intake and this was u	nusual for the resident. She				
		#28 had poor intake but				
	usually accepted som	ne of her meals. Nurse #4				
	reported that she did	•				
		dent #28 that included				
		r or assessing her abdomen				
		been very busy and the				
		ar to be in distress. Nurse				
	#4 stated that by the					
		nt drank a combined total of				
		luring the shift. Nurse #4				
	-	end of the shift nurse aide				
	-	at Resident #28's catheter				
		nurse stated that this was				
	-	cause the Resident had				
		and the physician would need the shift the nurse aide had				
		e resident and according to				
		ere "okay." The nurse				
		end of her shift when she				
		no urine output and she				
		along in report and expected				
		up by assessing the resident				
		nysician. Nurse #4 stated				
		he physician earlier in the				
		as "nothing to call about."				

Facility ID: 922953

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	DF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED		
			A. BUILDIN	G		С		
		345129	B. WING					
		545125				03/24/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE		
F 315	Continued From page	<u>></u> 20	F 3	15				
1 010		n the shift the poor urine	F 5	15				
		so stated that she had been						
		a "few times" during the						
		alized the catheter bag						
		e other side of the bed and						
		d Resident #28's catheter or						
	abdomen.							
	On 03/22/16 at 10:30							
		ephone and reported that						
		care for Resident #28 on						
	02/02/16 from 3 PM t							
	•	ft was very hectic because her shift she was notified						
		sultant would be following						
		pass. The nurse stated						
		n any concerns in report						
	-	nd therefore did not conduct						
	an initial round on her	r residents to check them.						
	Nurse #3 reported that	at it was her usual practice						
	to make a brief round	to "spot check" her						
		stated that she was not told						
		nt #28 had gone 8 hours with						
	•	se #3 proceeded to explain						
		ing her medication pass ent #28 arrived. She added						
		e nurse supervisor asked						
		Resident #28 because she						
		Nurse #3 stated she had to						
		ne medications already						
		could attend to Resident						
	#28. Nurse #3 estimation	ates she waited 5 to 10						
		nding to concern about the						
		tated that this was around						
		when she went into Resident						
		first time since her shift had						
	started that she had v	usualized the resident	1					
		at when she went into the						

Facility ID: 922953

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/13/2016 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345129	B. WING			_		C 24/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
				1	1007 HOWARD STREET			
AUTUMN	CARE OF MOCKSVILLE			N	MOCKSVILLE, NC 2702	28		
(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 CTIVE ACTION SHOULD B NCED TO THE APPROPRIA		(X5) COMPLETION DATE
]	DEFICIENCY)		
F 315	alert and her respons did not know how long that condition. The nu- how much urine was not have time to fully was insistent n calling The nurse aide assign 02/02/16 from 3 PM to employed at the facili On 03/22/16 at 1:00 F interviewed and repor 02/02/16 and did not	e was very slow. Nurse #3 g the resident had been in urse also was not aware of in the catheter bag and did assess because the family g 911. The to Resident #28 on to 11 PM was no longer ty unable to be interviewed. PM the nurse supervisor was red that she was working on recall any concerns being ut Resident #28. The nurse	F	315				
	resident 's family can that the resident was the resident sent to the reported the concern completing a medicat since Nurse #3 was b check on Resident #2 reported that the familer resident wouldn't spea supervisor called the resident was able to t She stated that she g and noted that it was supervisor added that became aware that the days without having mexplained that no urin a "flag" and the physic called. The nurse stat the resident had not b The nurse supervisor documenting and more	ne and expressed concern not acting right and wanted the ED. She added that she to Nurse #3 who was busy ion pass. And added that usy she went to the room to 8. The nurse supervisor ly was concerned that the ak but when the nurse resident's name, the urn her head and respond. lanced at the catheter bag empty. The nurse t after the incident she the resident had gone a few nuch urine output. She e output in 8 hours would be						

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CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES					FORM OMB NC	D: 04/13/2016 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION			SURVEY PLETED
		345129	B. WING	_		_		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				1007 HOWARD STREET MOCKSVILLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	She stated that the nu for measuring and do of urine in the cathete She went on to add th with the urinary output usual or change in ap output the nurse aide the nurse. The nurse nurse aides were awa accurate with their do On 03/22/16 at 1:38 F interviewed and state Resident #28 on 01/3 The NA reported that #28 did not have any the resident's cathete dry;" and that she was concern to the nurse nurse was). The NA a if the nurse assessed the concern. On 03/22/16 at 4:10 F (DON) was interviewe would expect nurse a no urine output to the follow-up with that con resident to determine be contacted. The DO assessment would ind to make sure it was p for signs of a change abdomen newness of concerns were identiff expected to call the p reported that she had 02/02/16 between 8 -	urse aides were responsible cumenting the total amount er bag into the computer. nat if a concern was noted it such as being less than opearance or not urine would report the concern to e supervisor stated that the are and educated to be oumentation. PM nurse aide (NA) #3 was d she was assigned to 1/16 from 11 PM to 7 AM. during the shift Resident urine output and reported r and tubing was "bone s "certain" she reported the (she couldn't recall who the added that she did not know the resident after reporting PM the Director of Nursing ed and reported that she ides to report concerns of nurse and for the nurse to ncern by assessing the if the physician needed to ON explained that an clude checking the catheter atent (able to flow) and look such as distended f pain. She added that if ied the nurse would be	F	315				

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CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MUI		E CONSTRUCTION		FORM	0: 04/13/2016 APPROVED 0: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	· ,				COMP	LETED
		345129	B. WING					
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				1007 HOWARD STREET MOCKSVILLE, NC 27028	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 315	look distended and th on conversation durin On 03/23/16 at 8:48 A interviewed on the tel a resident was having would be expected to unable to provide exp output then contact th stated that the need to would rely on nursing assessment with data resident's condition. On 3/23/16 at 2:13 Pf was interviewed on th that she had reviewed and 01/25/16 for routi resident's diet to enco The NP reported that or change in the reside visits. On 03/23/16 at 3:45 F and reported that on 0 her 3 PM to 11 PM sh that Resident #28 was sick and the nurses w to explain that she ch frequently that shift ar to sleep which was no obtained vitals on the slept through getting f recalled that the reside #4 stated that during f nurse supervisor if sh with Resident #28 and stated she was not aw	e resident was able to carry g the treatment.	F	315				

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	-	ID HUMAN SERVICES				FOR	M APPROVED D. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		345129	B. WING				C / 24/2016
NAME OF P	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUTUMN	CARE OF MOCKSVILLE				1007 HOWARD STREET MOCKSVILLE, NC 27028		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	PM she left the hall to in the dining room an resident had been tra Attempts were made Department physiciar reached. On 03/22/16 at 4:30 F notified of immediate provided an acceptate compliance on 03/24 following intervention remove the immediat F-315 Maintaining Ur 1. Resident #28 no Resident was transfe did not return to this f hospital. The alleged a change in condition resident related to de changes which were and identified and rep 2. All residents hav by the alleged deficie &23, 2016 all residen licensed staff to deter experienced a signific mental status. Any re significant change in by licensed nursing s status assessment with assessment of body s vital sign and functior documentation of Phy Responsible Party (R with a catheter have I	 a help with the evening meal d when she came back the nsported to the ED. to contact the Emergency in but he was unable to be PM the Administrator was jeopardy. The facility ble credible allegation of 16 at 2:30 PM. The swere put into place to e jeopardy. inary Catheter longer resides in the facility. rred to hospital 2/2/16 and acility upon discharge from deficient practice included /overall status of the crease output and mental not immediately assessed borted to the MD. e the potential to be affected nt practice. On March 22 ts were observed by mine if they had cant change in physical or sident observed with a status was further assessed taff using the Change in hich is a comprehensive systems, medication, labs, hal status as well as 	F	315			

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	S FOR MEDICARE &					OMB NO. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED		
	SUMEONUM		A. BUILDIN	NG				
			-			С		
		345129	B. WING		0	3/24/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
	CARE OF MOCKSVILLE			1007 HOWARD STREET				
AUTOWIN				MOCKSVILLE, NC 27028				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)		
PREFIX			PREFIX			COMPLETIO DATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY		0/112		
F 315	Continued From page	e 34	F 3	315				
		Nursing change of status						
	assessment which in							
		sident including pain, labs						
		essment and documentation						
		. The care plans for patients						
		been revised by the Licensed						
		2016 to include notification of						
		tput, change in temperature,						
		chills, pain, any change in						
		odor of urine, or mental						
	-	Nursing change of status						
		eted and included in the						
	electronic Medical Re							
	documentation of MD							
	3. Licensed Nurses	were in-serviced March 22,						
	2016 thru March 23th							
	scheduled shift to wo							
		assessment and provision						
		ho experience a significant						
		uding notification of the						
	resident 's MD and F	-						
		cant change in status.						
		e also in-serviced by the						
		n assessment of residents						
	with catheters includi	ng assessment of output						
		ation of MD and RP when						
	decreased output or o	other identified status						
		ling mental status changes,						
		sistency, color or odor of						
		e also in-serviced on neglect						
		omplete assessment when a						
		in status. Licensed nursing						
		on the use of the Change in						
		rm and the utilization of the						
		s communication tools to						
	-	resident status changes on						
	March 22-23 by the E	Director of Nursing. The						
	Nursing assistants (N							

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	2: 04/13/2016 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345129	B. WING		_	03/2	C 24/2016
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE			007 HOWARD STREET IOCKSVILLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	Director of Nursing M 23rd on what constitu significant change in the but not limited to the fi- change in color or com- mental status change pain and the need for the Licensed Nurse w in the resident 's stat in-serviced will be required in-service prior to the They will not be allow are completed. 4. Individual nurses deficient practice were of Nursing on March 2 change of status asse part of the electronic in notification of the MD identified. The identified by the Director of Nur constitutes a significa and on immediate not Nurse for any identified including no urinary of consistency, or odor of changes, nausea, vor they see as a change The facility will utilize report as a communic status changes. The ri- changes that occur du communicate change this tool during shift to For verification both m	arch 22, 2016 thru March tes and how to identify a resident condition including, following: no urinary output, hisistency of the urine, s, nausea, vomiting, and immediate notification of then they identify a change us. Staff who have not been juired to complete the beginning of their next shift. ed to work until in-services s identified in the alleged e in-serviced by the Director 22 on completion of the essment which becomes a medical record and includes and RP when a change is ed NA has been in-serviced sing on March 23 on what nt change in resident status tification to the Licensed ed changes in the resident utput, change in color, of urine, mental status miting, vital signs or anything in the patient. the 24 Hour shift to shift tation tool to document hurse will document any uring their shift and verbally s in status of residents from o shift report at shift change. nurses will be required to side each residents name	F 315				

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		ND HUMAN SERVICES			PRINTED: 04/13/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345129	B. WING		03/24/2016
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	CARE OF MOCKSVILLE			007 HOWARD STREET	
			N	NOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 315	Continued From page		F 315		
	Director of Nursing/D	report of status changes. resignee will monitor v of the 24 Hour report.			
	2:30 PM when the fac additional training pro that proved they were	was removed on 03/24/16 at cility provided evidence of ovided to the nursing staff e aware of the new system sing and reporting changes on.			
F 332 SS=D	RATES OF 5% OR M	ure that it is free of	F 332		4/1/16
	This REQUIREMENT by: Based on observatio interviews the facility medication error rate	s of five percent or greater. Γ is not met as evidenced ons, record reviews, and staff failed to ensure that the was 5% or below as out of 27 opportunities		It is the policy of this facility that reside will be free of any significant medicatio errors.	
	resulting in a medicat	tion error rate of 7.4% for 1 ed during medication pass		1. Resident #105 immediately receiv the correct dose of the two medications during the medication pass when the dosage error was identified. She originally received 20 mg of Prilosec ar	5
	03/11/16 with diagnos and gastroesophagea Minimum data set (M			 400 mg of gabapentin. The order was 1200 mg of gabapentin and 40 mg of Prilosec. She was given an additional mg of gabapentin and 20 mg of Prilose to equal correct dose. 2. Any Resident receiving medication the facility has the potential to be effect by this alleged deficient practice. The Licensed nurse who made the medication 	800 ec n in ted

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STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
AND PLAN U			A. BUILDING	A. BUILDING		
		345129	B. WING		C 03/24/2016	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN CARE OF MOCKSVILLE				007 HOWARD STREET MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC	
F 332	Continued From page	e 37	F 332			
	read gabapentin caps 1200 mg by mouth 3 Observation of medic 8:18 AM revealed Nu #105's medications w 400 mg one capsule. in a medication cup a #105. Interview with Nurse a confirmed that he had dose of gabapentin to stated that this was th with Resident #105 a no excuse but that was stated he did not notio of medication and that incorrect dose of medication 03/24/16 at 9:52 AM fairly new to the facilit that on February 2, 20 by a nurse with the correct medication pass and After the initial medication pharmacy, the license yearly medication pass training was provided stated that her expect give the correct medic	order dated 03/18/16 that sule 400 milligram (mg) give times a day for neuropathy. ation pass on 03/23/16 at rse #1 prepared Resident which included gabapentin The medication was placed and administered to Resident #1 on 03/23/16 at 9:38 AM d administered the incorrect o Resident #105. Nurse #1 he first time he had worked nd he was aware that was as the truth. Nurse #1 further ce the directions on the card at is why he administered the dication. ector of Nursing (DON) on revealed that Nurse #1 was ty. The DON further stated 016 Nurse #1 was observed onsultant pharmacy on no concerns were noted. ation pass done by the ed nursing staff received a as observation and additional as needed. The DON tation is that Nurse #1 would cation, correct dose, via the prince patient at all times.		 error will complete a medication in for Policies and Procedures for medication pass by the Director of Nursing /Designee and will have a Medication Pass observation comply the Pharmacy consultant by 4/13. The Licensed Nursing staff have a reserviced on March 23 - April 1, 2 the Policies and Procedures for Medication Pass by the Director of Nursing/Designee. Licensed Nursi also had a Medication Pass Observation completed by the Pharmacy Consultant/Director of Nursing/Reg QA nurse by 4/1/2016. New hired licensed nurses will complete inse and Medication Pass Observation orientation. 4. The Pharmacy consultant will complete at random a Medication Observations monthly x 2 months. Results of Medication Pass Obser will be submitted to Quality Assura Committee Monthly x 2 months for ongoing trending/tracking and more 	pleted 1/2016. ave been 2016 on f ses have rvation gional rvice during Pass vations ince	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/13/2016 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE COMF	SURVEY PLETED
		345129	B. WING				C / 24/2016
NAME OF P	ROVIDER OR SUPPLIER	L	I	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				1007 HOWARD STREET MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	 1b. Resident #105 wa 03/11/16 with diagnos and gastroesophagea Minimum data set (Mi available. Review of ti interviews indicated th cognitively intact. Review of Resident # revealed a physician read omeprazole cap one time a day for GE Observation of medica 8:18 AM revealed Nu #105 medications wh capsule delayed relea medication was place administered to Resident that per ead that he had dose of omeprazole to stated that this was the with Resident #105 an no excuse but that was that he read the dosa incorrectly. Interview with Directon 03/24/16 at 9:52 AM in fairly new to the facility that on February 2, 20 by a nurse with the cor- medication pass and After the initial medica pharmacy the license yearly medication pass 	as admitted to the facility on sees that included neuropathy al reflux disease (GERD). DS) information was not the medical record and staff that Resident #105 was 105's medical record order dated 03/18/16 that sule delayed release 40 mg ERD. ation pass on 03/23/16 at rse #1 prepared Resident ich included omeprazole ase 20 mg one capsule. The ed in a medication cup and dent #105. #1 on 03/23/16 at 9:38 AM d administered the incorrect o Resident #105. Nurse #1 he first time he had worked nd he was aware that was as the truth. Nurse #1 stated	F	332	2		

Facility ID: 922953

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING		<u>-039</u> ,
	345129		B. WING		C 03/24/2016	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1007 HOWARD STREET		
AUTUMN CARE OF MOCKSVILLE				MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	(X5) COMPLETION DATE
F 332	give the correct medi correct route to the co The DON also stated	tation is that Nurse #1 would cation, correct dose, via the orrect patient at all times. that she expected all ons to be followed to ensure	F 332	2		
F 371 SS=D	The facility must - (1) Procure food from considered satisfacto authorities; and	ERVE - SANITARY a sources approved or ry by Federal, State or local stribute and serve food	F 37		4/1/16	
	by: Based on observation facility failed to air dry storing them, and to do of lettuce, all of which spoiled. The findings included 1. On 3/21/16 at 9:35 observed stored on a on a wire storage rac stored face down. Most the interior of each bo was interviewed at th should be allowed to	 is not met as evidenced in and staff interview, the g 8 of 8 soup bowls before discard 1 apple and 3 heads in were visibly brown and i: A M eight small bowls were flat tray, which was placed k. All eight bowls were pisture was observed along powl. The Dietary Manager is time and stated the bowls air dry before they were the bowls and stated they 		 It is the facility policy to (1) procure from the sources approved or consist satisfactory by the federal, state and authorities and (2) store, prepare, distribute and serve food under sand conditions. Dinex bowels with water droph that were identified were not utilized food service on March 21, 2016 The were immediately returned to the commercial dishwasher by the Dieta manager and re-cleaned and proper stored for air drying on 3/21/16. The lettuce and apples that were identified were identified were identified were identified were identified were identified were interval to the commercial dishwasher by the Dieta manager and re-cleaned and proper stored for air drying on 3/21/16. The lettuce and apples that were identified were identifie	dered d local itary ets l for ey ary rly e ed	

Facility ID: 922953

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TATEMENT (OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
			A. BUILDING	COMPLETED		
		345129	B. WING		03/24/2016	
NAME OF P	ROVIDER OR SUPPLIER					
AUTUMN CARE OF MOCKSVILLE						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC	
F 371	Continued From page	e 40	F 371			
	would be rewashed a storing them.	nd allowed to dry before PM during interview the		 Dietary Manager. 2. No resident experienced nega outcomes as a result of this cited deficiency. Any resident has the po 		
	Dietary Manager stat	ed that all dishes should om to dry. Dishes should not		to be affected by this alleged deficie practice. No patients were affected bowls and the lettuce and apples we utilized for food service on March 2	ent as the ere not	
	holding pan filled with observed in the walk- top of the pan was ob	in cooler. The apple at the oserved to be brown and		 2016. 3. In-service training was conduct all Dietary Staff by the Dietary Mana and Regional Dietitian on March 21. 	ager , 2016	
		n on one side. The Dietary e pan and stated the apples		regarding storage of dishes and sto of fresh produce. This training will b completed for any newly hired dieta employees as part of orientation.	e ry	
	appeared to be wilted the bottom shelf of th	M a clear plastic bag of what I lettuce was observed on e walk-in cooler. The bag ared to be three heads of		 4. The Dietary Manager or design complete a QA tracking tool 3x per y 1 month and then randomly to assu compliance. Audit tracking tools we 	week x re	
	slimy. The bag was p front of a box of fresh Dietary Manager stat	ing brown and appeared laced on the wire rack in heads of lettuce. The ed the lettuce should have she did not think staff would		implemented on March 24, 2016. R of these audits will be reported to th Committee monthly by the Dietary Manager with follow-up corrective a taken as needed to assure complian	e QA ction	
	On 3/21/16 at 12:05 F Dietary Manger state	PM during interview the d that she expects staff to produce right away, and posible for this.				
F 520 SS=E	483.75(o)(1) QAA	ERS/MEET	F 520		4/1/16	
	-	in a quality assessment and consisting of the director of				

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 04/13/2016 DRM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345129	B. WING		C 03/24/2016		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
	AUTUMN CARE OF MOCKSVILLE				007 HOWARD STREET		
ACTORIN	AUTUMN CARE OF MOCKSVILLE			М	IOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE	
F 520	Continued From page 41 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as		F	520			
	by: Based on observation resident and staff inter Assessment and Ass maintain implementer those interventions the place in April 2015. T deficiency which was on the recertification/ current recertification/ deficiency was in the nutritional/therapeution of the facility during the show a pattern of the	T is not met as evidenced ans, record review and erviews the facility's Quality urance Committee failed to d procedures and monitor nat the committee put into his was for one recited originally cited in April 2015 complaint survey and on the /complaint survey. The area of c diet. The continued failure wo federal surveys of record facilities inability to sustain ssessment and Assurance			It is the policy to maintain a quality assessment and assurance commit consisting of the director of nursing, physician designated by the facility least three other members of the facility s staff. One way this facility achieves compliance is by conductin quarterly quality assurance committ meetings containing the administrat dept. managers, consultant pharma medical director and any other ident staff. The committee is guided by th administrator and audits are identified through review of facility practices, of measure indicators, facility identified	, a and at ng ee or, all cist, tified ie ed quality	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/13/2016 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345129	B. WING	³ 03/24/2016		C / 24/2016	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
AUTUMN	AUTUMN CARE OF MOCKSVILLE			10	007 HOWARD STREET		
				М	OCKSVILLE, NC 27028		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	e 42	F	520			
	dry 8 of 8 soup bowls discard 1 apple and 3 which were visibly bro During an interview of Administrator stated for Assurance Committee quarterly basis with the clinical indicators not continued to discuss had not monitored as plan of correction. He specific issues at each taking all problems re- during the current record	rred to F325 ic diet: Based on view, the facility failed to air before storing them, and to beads of lettuce, all of own and spoiled. In 02/12/16 at 4:55 PM the the Quality Assessment and e currently met on a neir meetings focusing on being met. He stated they previously cited issues but closely as they had for the e stated they focused on the meeting and would be elated to citations found certification survey to ssment and Assurance			 continuous audits and newly identified areas of concern. Dinex bowels with water droplets that were identified were not utilized for food service on March 21, 2016 They were immediately returned to the commercial dishwasher by the Dietary manager and re-cleaned and properly stored for air drying on 3/21/16. The lettuce and apple that were identified were identified were and apple that were identified were and the lettuce and apple were not util for food service on March 21, 2016. In-service training was conducted all Dietary Staff by the Dietary Manager and Regional Dietitian on March 21, 2 regarding storage of dishes and storage of fresh produce. This training will be completed for any newly hired dietary employees. Department Managers ar Medical Director were inserviced by the Administrator related to the QA process on 3/30/2016. The Dietary Manager or designed complete a QA tracking tool 3x per were implemented on March 24, 2016. Results of these audits will be reported the QA Committee monthly by the Die Manager with follow-up corrective actit taken as needed to assure compliance. The QA committee will mermonthly through next quarter to review. 	were be ice. s lized l for er 016 ge nd ne ss e will eek x d to tary on e. et	

Event ID: C5C911

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ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		IO. 0938-039 E SURVEY IPLETED
		345129			С	
		545129		STREET ADDRESS, CITY, STATE, ZIP CO		3/24/2016
NAME OF P	ROVIDER OR SUPPLIER			UDE		
AUTUMN CARE OF MOCKSVILLE				1007 HOWARD STREET MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 520	Continued From pag	e 43	F 52	findings from audits put in p annual survey and any othe concern identified. QA com review findings for any need corrective action and Admir monitor to ensure complian	er areas of mittee will d of further nistrator will	

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