PRINTED: 04/07/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345280	B. WING		03	/10/2017	
	ROVIDER OR SUPPLIER  CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 157 SS=D	consult with the resiductonsistent with his or representative(s) when the consistent with his or representative(s) when the consistent with the co	changes.  ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-  ving the resident which as the potential for requiring n;  ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or );  eatment significantly (that is, a n existing form of erse consequences, or to	F 15	7		4/7/17	
ADODATORY	(14)(i) of this section, all pertinent information is available and proving physician.  (iii) The facility must a resident and the resident when there is-			TITLE		(X6) DATE	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/03/2017

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

**Electronically Signed** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345280	B. WING		03/10/2017	
	ROVIDER OR SUPPLIER  CARE OF RAEFORD	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 157	Continued From pag		F 157			
	State law or regulative (e)(10) of this section (iv) The facility must update the address phone number of the This REQUIREMEN by:	dent rights under Federal or ons as specified in paragraph n.  record and periodically (mailing and email) and e resident representative(s).  T is not met as evidenced				
	interview the facility of a pressure ulcer for #179) reviewed for p	Based on record review, staff and physician nterview the facility failed to notify the physician of a pressure ulcer for 1 of 3 residents (Resident #179) reviewed for pressure ulcers which resulted n delayed assessment and treatment.		F157 Steps Taken in regards to those resider found to be affected:  MD was notified on 3/10/2017 of reside		
	with diagnoses whic Failure (CHF), Hype Artery Disease, Chro	d: admitted 2/28/17 to the facility h included Congested Heart rtension, Anemia, Coronary onic Obstructive Pulmonary d End Stage Renal Disease.		#179 □s wound.  Steps Taken in regard to those Resider having the potential to be affected:  An audit was conducted by DON and/o designee to determine if those resident with wounds had RP and MD documentation.	r	
	(MDS) dated 2/28/17 was moderately cog extensive assistance Resident #179 requi personal hygiene an The assessment als admitted with 2 unst the resident's sacrur	sion minimum data set 7 revealed that the resident nitively impaired. He required with transfers and toileting. red total assistance with d bathing. o revealed the resident was ageable pressure ulcers to m and to the buttocks.  AM Nurse #1 in the presence		Re-education for nursing staff on completion of PCNs for all new residen with wounds to be completed by DON and/or designee by 4/7/2017.  Re-education for nursing staff on notification of MD and RP on significan changes including admissions with wounds or newly acquired wounds by DON and/or designee to be completed 4/7/2017.	t	
	of the Director of Nu	rsing (DON), stated she did cian about the wound and did		Measures put in place to ensure the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345280	B. WING _	B. WING		03/	10/2017
	ROVIDER OR SUPPLIER  CARE OF RAEFORD			12	TREET ADDRESS, CITY, STATE, ZIP CODE 206 N FULTON STREET AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	expectation was for the wound treatments per for the nurses to use a make sure treatments completed.  A review of the physic 2/28/17 revealed Nurse notification of the press On 3/10/17 at 11:02 A he stated he was not wound upon admission wound upon admission 483.12(b)(1)-(3) PRO MISTREATMENT/NE §483.12 The resident abuse, neglect, misapproperty, and exploits subpart. This includes freedom from corpora seclusion and any phynot required to treat the 483.12(b) The facility implement written policity in the state of the sta	with the DON stated that her the nurses to complete or the physician's orders and their communication log to state that were missed were stan care notes (PCN) for se #1 failed to fill out the source ulcer.  AM interview with physician, made aware of the resident on.  HIBIT GLECT/MISAPPROPRIATN  That the right to be free from appropriation of resident thin as defined in this is but is not limited to all punishment, involuntary sysical or chemical restraint the resident's symptoms.  Insult develop and icies and procedures that:  Event abuse, neglect, and the and procedures to the sand procedure to		2224	deficient practice does not recur:  A new wound audit tool will be complete 5x week for 4 weeks ensuring all newly acquired or admitted wounds are complete with MD and RP notification to the DON and/or designee.  Monitoring effectiveness of corrective action:  New wound/admission audits will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back the Quality Assurance Committee for further action plan.	by o	4/7/17

		(X3) DATE SURVEY COMPLETED			
		345280	B. WING _		03/10/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N FULTON STREET  RAEFORD, NC 28376	,
(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 CORR ( (EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE COMPLETION
F 224	Continued From page	÷3	F 2	24	
	§483.95, This REQUIREMENT by: Based on observatio interviews and record provide assistance wiresident to soil hersel residents (Resident # initial treatment until 3 of 3 residents (Residents)	113, failed to obtain the B days after admission for 1 ent #179), and failed to anges per physician's ents (Resident #179)		F224 Steps Taken in regards to those found to be affected:  Resident #113 will be provided A incontinence care per plan of care per MD orders.  Steps taken in regard to those F	ADL and ure. changed
	1. Resident #113 was admitted to the facility on 01/31/14 with diagnoses that included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, contracture of hand, personal history of sudden cardiac arrest, generalized muscle weakness, major depressive disorder, anxiety disorder, diabetes type II with unspecified complications, lymphedema and dyspnea.  The review of the most recent Minimum Data Sheet (MDS) 12/30/16 identified that Resident #113 was cognitively intact. The MDS indicated the resident was totally dependent for bathing and one person physical assist during bathing and toileting, extensive assistance for bed mobility, transfer and locomotion on the unit and dressing. The resident required total dependence with			having the potential to be affected.  Re-education for all staff by DOI designee on call bell timeliness completed by 4/7/2017.  Re-education for all staff on abut by DON and/or designee to be oby 4/7/2017.  Re-education on Wound Policy Guidelines by DON and/or designee to be designed by 4/7/2017.  Re-education by American Medit Technologies (AMT) and DON and designee on wound documentate completed by 4/7/2017.  Measures put in place to ensure deficient practice does to not red	ed: N and/or will be use policy completed and gnee to be usel ical and/or tion the
	locomotion off the uni independent with all r assistance with set up	neals and required		A call light audit will be conducted	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		E SURVEY IPLETED
		345280	B. WING		03	3/10/2017
	ROVIDER OR SUPPLIER  CARE OF RAEFORD		1	STREET ADDRESS, CITY, STATE, ZIP CODE 206 N FULTON STREET RAEFORD, NC 28376	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 224	dated 02/12/17 stated able to verbalize her able to short staff resident reported that there was only of Assistant (CNA) on 1 hall. She stated that the been short for routine remember. She state 03/05/17 she had laid hours after pushing her with changing her to incontinence of uriccould have avoided thave but that she need she felt helpless and need for routine assist Staff interviewed on 0 Certified Nursing Ass Resident #113 require toileting, incontinent of stated they had been months on the hall do they had short staff a restorative aide work	e monthly nursing notes of that resident was alert and needs.  Int #113 on 03/06/17 at 3:17 hat she had often waited to after she pushed her call bell she explained on Sunday, is were able to get out of the ing within the facility. The she had become aware here Certified Nursing 00 hall and one CNA on 200 he weekend staffing had ally as long as she could do that on the morning of the inner bed at least two here call bell for staff to assist the wet linen and clothing due here. She stated that if she here accident that she would have ded help. Resident stated that no one cared about the stance and care.  103/09/17 at 10:15 AM. It is tant (CNA) #1 stated that here are and transfers.  117 at 3:07:42 PM. hursing assistant (RCNA) #1 working the past couple of being patient care, because the least 3 days a week and	F 224	and/or designee 5x week for 4 week ensure appropriate timeliness.  A treatment completion audit tool for wounds will be completed by DON designee 5x week for 4 weeks to extreatment completion by physician Monitoring effectiveness of correct action:  Call light audits and treatment compaudits will be brought by the DON designee to the Quality Assurance Committee for 3 months for review Any areas of continued concern with brought back to the Quality Assurance Committee for further action plan.	or and/or nsure order. ive pletion and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED			
		345280	B. WING _			03/10/2017
	ROVIDER OR SUPPLIER  CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N FULTON STREET  RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE DED TO THE APPROPRIATE SFICIENCY)	(X5) COMPLETION DATE
F 224	stated she has been months on the hall do are short staff at least work as a restorative.  Staff Interview 03/09/stated she worked 10/as a restorative aide the hall at least 3-4 do care because they has staff interview 3/9/17/she left at 7 pm on 3/CNAs to work the A has staff interview 3/9/17/there were 2 CNAs for and worked together.  Administrator interview PM. She stated it was bells were answered needs.  2. Review of facility Ulcer Guide." Read in nurse will be responsite treatment"  Resident #179 was a with diagnoses which Failure (CHF), Hyper Artery Disease, Chro	working the last couple of bing direct care because they it three days a week and her aid was undone.  In the thick of thick of the thick of the thick of thick of the thick o	F2	224	(FICIENCY)	
	On the admission wo 2/28/17 revealed the to the sacral crease a right buttocks. There the measurements of	End Stage Renal Disease. und assessment dated resident had an open area and a pinpoint area to the was no documentation of restaging of the wounds. sion minimum data set				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345280	B. WING _	<del></del>		03/10/2017	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 1206 N FULTON STREET RAEFORD, NC 28376	•		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 224	(MDS) dated 3/7/17 rivas moderately cogn extensive assistance Resident #179 require personal hygiene and also revealed the resident sacrum and to the buas A review of the residence revealed that an interestiveness of the wights of the physician for changes A review of the physician wound cleanser, pat of Ointment 250 unit/grawound bed, cover the and as needed.  On 3/8/17 at 9:38 AM observed receiving a the right buttocks. Do dressing was observed On 3/8/17 at 12:15PM not complete the dressing was observed on 3/8/17 at 12:15PM not complete the dressing change on 3 have time." Nurse #1 documented on the concerning not complete with physician's orders an communication log to were missed were coon 3/10/17 at 10:50 Among the physician's orders an communication log to were missed were coon 3/10/17 at 10:50 Among the physician's orders and communication log to were missed were coon 3/10/17 at 10:50 Among the physician's orders and communication log to were missed were coon 3/10/17 at 10:50 Among the physician's orders and communication log to were missed were coon 3/10/17 at 10:50 Among the physician's orders and communication log to were missed were coon 3/10/17 at 10:50 Among the property of the property of the property of the physician's orders and communication log to were missed were coon 3/10/17 at 10:50 Among the property of the physician's orders and communication log to were missed were coon 3/10/17 at 10:50 Among the property of the physician's orders and communication log to were missed were coon 3/10/17 at 10:50 Among the physician's orders and communication log to were	evealed that the resident itively impaired. He required with transfers and toileting. ed total assistance with I bathing. The assessment dent was admitted with 2 elucers to the resident's ttocks. Ent's care plan dated 2/28/17 evention was to assess the wound care and notify the sas needed. Etan treatment orders dated dent # 179 was to receive um and right buttocks with dry and to apply Santyl en (debriding agent) to the elevation with xeroform daily Resident #179 was treatment to the sacrum and uring the observation, the old ed to be dated 3/5/17. If Nurse #1 stated she did sing change on 3/6/17 and gone to dialysis. She did not complete the elevation log eting the dressing changes. If did not stated she had not communication log eting the dressing changes. If the Director of Nursing a expectation was for the ound treatments per the did for the nurses to use their make sure treatments that implete.	F 2	24			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345280	B. WING		03/10/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 224		about the admission but did	F 224		
F 241 SS=D	initiated. On 3/10/17 at 11:02 he was not made aw on admission.	e wound and no treatment  AM the physician stated that are of the resident's wound  Y AND RESPECT OF	F 241		4/7/17
	resident in a manner promotes maintenancher quality of life recoindividuality. The faci promote the rights of This REQUIREMENT by:  Based on observation interviews and record treat a resident in a contract.			F241 Steps Taken in regards to those resider found to be affected:	nts
	incontinent care for 1 (Resident #113) Findings included:	of 1 sampled residents.		Resident #113 will be provided ADL and incontinence care per plan of care.  Resident #179 dressing will be change	
	01/31/14 with diagno not limited to hemiple following cerebral info dominant side, contra history of sudden car muscle weakness, m anxiety disorder, dial complications, lymph			per MD orders.  Steps taken in regard to those Residen having the potential to be affected:  Re-education for all staff by DON and/o designee on call bell timeliness will be completed by 4/7/2017.  Re-education for all staff on abuse policiby DON and/or designee to be completed by 4/7/2017.	cy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345280	B. WING	B. WING			3/10/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD			R	AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 241	Continued From pa	age 8	F 2	241			
	#113 was cognitive	ely intact. The MDS indicated					
		stally dependent for bathing and			Measures put in place to ensure the		
	one person physical	al assist during bathing and			deficient practice does to not recur:		
	toileting, extensive	assistance for bed mobility,					
		fer and locomotion on the unit and dressing.			A call light audit will be conducted by I		
	The resident required total dependence with				and/or designee 5x week for 12 weeks	s to	
	locomotion off the unit. The resident was				ensure appropriate timeliness.		
	independent with all meals and required assistance with set up only.				Manitaring official companies		
					Monitoring effectiveness of corrective action:		
		rviewed on 03/06/17 at 3:17					
		stated that she had often had to			Call light audits and treatment comple		
	_	e needed after pushing her call ance. She stated that on the			audits will be brought by the DON and designee to the Quality Assurance	/or	
		7 she had laid in her bed at			Committee for 3 months for review.	nv	
	_	er pushing her call bell for staff			areas of continued concern will be	ury	
		hanging her wet linen and			brought back to the Quality Assurance	<u>;</u>	
		ontinence of urine. She stated			Committee for further action plan.		
	_	ive avoided the accident that			·		
	she would have bu	t that she needed help.					
		e felt helpless and that no one					
		ed for routine assistance and					
	care.						
	Resident #113 was	s interviewed on 03/09/17 at					
	2:55PM. The resid	ent stated on 03/05/17 the					
	certified CNAs wer	e not able to change her wet					
		for 2 hours. Resident also					
		hed that she could obtain the					
	_	assist herself with the care					
		e didn't have to lay in a wet bed					
	_	was cold and it made her feel					
	1	e. She stated that she had also the toilet in the bathroom for					
	_	aving pulled the call light cord					
		e stated that she has been					
		t has taken to get assistance					
		mbered looking at the time on					
		ablet. The resident stated that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345280	B. WING		03/10/	2017
	ROVIDER OR SUPPLIER  CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) OMPLETION DATE
F 241	Continued From pag she feels helpless wh to help her and every	nen there isn't enough staff	F 24	.1		
		e monthly nursing notes d that resident was alert and her needs.				
	that Resident #113 w transfers, toileting an resident did more up some assistance. Sta bed when not showe resident was schedu	sistant (CNA) #1 was /17 at 10:15 AM and stated /as a one person assist for d incontinent care. Stated per body bathing/care with ated that she is bathed in the red. CNA stated that the led for showers on Monday, ays and required one person				
	certified nursing assi- have been working the the hall doing patient	at 3:07:42pm- Restorative stant (RCNA)#1 stated they ne pass couple of months on care, because they are days a week and restorative ne.				
	stated she has been months on the hall do	at 3:09:15pm- RCNA #2 working the last couple of bing direct care because they at three days a week and her aid was undone.				
	10 am - 6 pm my dut goes undone, I work	Tat 3:11 pm- RCNA #2 I work ies as a restorative aide just the hall at least 3-4 days a t care because they are short				

PRINTED: 04/07/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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		345280	B. WING _			03/	10/2017
	ROVIDER OR SUPPLIER			12	REET ADDRESS, CITY, STATE, ZIP CODE 206 N FULTON STREET AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241 F 281 SS=D	assistant (CNA) #1 st 3/5/17 and there was 3-11 shift.  Staff interview 3/9/17 there were 2 CNA's for worked together on S  On 03/09/17 at 4:56 Finterviewed. She state expectation that call be assist residents as ne 483.21(b)(3)(i) SERV PROFESSIONAL STATE (b)(3) Comprehensive The services provided	at 3:12 pm- certified nursing ates she left at 7 pm on 2 CNA's to work the A hall at 3:29 pm- CNA#2 stated or A hall we just team up and unday 3/5/17  PM the Administrator was ed that it was her bells are to be answered to eded. ICES PROVIDED MEET ANDARDS  E Care Plans  d or arranged by the facility, mprehensive care plan,		241			4/7/17
	by: Based on record revi interviews, the facility treatment order for 1 #179) reviewed with p The findings included Resident #179 was awith diagnoses which Failure (CHF), Hypert Artery Disease, Chrol				F281  Steps Taken in regards to those resider found to be affected:  Resident #179 dressing will be change per MD orders.  Steps taken in regard to those Resident having the potential to be affected:  Re-education on Wound Care Policy are Guidelines by DON and/or designee to	d ts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345280	B. WING _			03/	/10/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ALITURAN	CARE OF BAFFORD			1:	206 N FULTON STREET			
AUTUWN	CARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 281	Continued From page	e 11	F 2	281				
		sion minimum data set evealed that the resident			completed by 4/7/2017.			
	extensive assistance Resident #179 require personal hygiene and	itively impaired. He required with transfers and toileting. ed total assistance with I bathing. The assessment			Re-education by American Medical Technologies (AMT) and DON and/or designee on wound documentation completed by 4/7/2017.			
		ident was admitted with 2 e ulcers to the resident's ttocks.			Measures put in place to ensure the deficient practice does to not recur:			
	Review of the resider revealed follow the fa	nt's care plan dated 2/28/17 cility skin protocol.			A treatment completion for wounds aud tool will be completed by DON and/or designee 5x week for 4 weeks to ensu			
		an treatment order dated atment to the sacrum and			treatment completion by physician order			
	the apply Santyl Ointi	ound cleanser, pat dry and ment 250 unit/gram to the h xeroform everyday and as			Monitoring effectiveness of corrective action:			
	needed. There was n	o reason given by the facility I three days before they got			The treatment completion wound audit tool will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review.			
	the right buttocks. Du	Resident #179 was treatment to the sacrum and ring the observation the old ed to be dated on 3/5/17.			areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	•		
	complete the dressing Resident #179 had go also stated she did no	urse #1 stated she did not g change on 3/6/17 because one to dialysis. Nurse #1 ot complete the dressing cause, "I did not have time."						
	(DON) stated that her nurses to complete w physician's orders an	M the Director of Nursing rexpectations were for the round treatments per the d for the nurses to use their make sure treatments that mplete.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345280	B. WING			03/10/2017	
	ROVIDER OR SUPPLIER  CARE OF RAEFORD			12	TREET ADDRESS, CITY, STATE, ZIP CODE 206 N FULTON STREET AEFORD, NC 28376		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282 SS=D	(b)(3) Comprehensive The services provided as outlined by the cormust-  (ii) Be provided by quaccordance with each care.  This REQUIREMENT by:  Based on record revi interviews, the facility services as outlined by Plan (CCP) for 2 of 2 reviewed care plan, for incontinent care for (Resident #113), and ordered treatment for days after admission (Resident #179) reviewing included:  1. Resident #113 woo1/31/14 with diagnor not limited to hemiple following cerebral infa dominant side, contra history of sudden carmuscle weakness, manxiety disorder, diab complications, lymphotomy in the review of the mosheet (MDS) on 12/3 #113 was cognitively	e Care Plans d or arranged by the facility, imprehensive care plan,  alified persons in in resident's written plan of  is not met as evidenced  iew, staff and resident failed to provide restorative by the Comprehensive Care 0 residents (Resident #113) failed to provide assistance for 1 of 1 sampled residents. failed to provide physician wound healing, until three for 1 of 3 residents failed to pressure ulcer.  as admitted to the facility on ses that included but were gia and hemiparesis farction affecting left facture of hand, personal diac arrest, generalized fajor depressive disorder, fietes type II with unspecified fiedema and dyspnea.  st recent Minimum Data for 16 identified that Resident fintact. The MDS indicated for bathing and	F	282	F282  Steps Taken in regards to those resider found to be affected:  Resident #113 will be provided ADL and incontinence care per plan of care.  Resident #113 is currently receiving Occupational Therapy for ROM service and splint re-evaluation.  Resident #179 dressing will be changed per MD orders.  Steps taken in regard to those Residen having the potential to be affected:  Re-education was provided to the restorative aides on 3/28/2017 by the SDC on providing restorative services to meet the plan of care.  Re-education for all staff by DON and/odesignee on call bell timeliness will be completed by 4/7/2017.	d s d ts	4/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345280	B. WING _			03/10/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD			R	AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETION DATE	
F 282	Continued From page	e 13	F 2	282			
	extensive assistance	for bed mobility, transfer e unit and dressing. The I dependence with it. The resident was neals and required			Re-education for all staff on abuse policy DON and/or designee to be comple by 4/7/2017.  Re-education on Wound Care Policy a Guidelines by DON and/or designee to apply the designee to the sample to the designee.	ted nd	
	2:55PM. The resident nursing assistants (C perform the restorativ mobility and independ facility had been so s	terviewed on 03/09/17 at a stated that the certified NA) were expected to be care needed to gain dence. She stated that the chort staffed that the completed as			completed by 4/7/2017.  Re-education by American Medical Technologies (AMT) and DON and/or designee on wound documentation completed by 4/7/2017.  Measures put in place to ensure the deficient practice does to not recur:		
	2 areas; first was the device; had splint to r to contracture. Goal s wear device as indica increased range of m with device and resid enhanced mobility. In enhanced ROM inclu	dated 12/29/16 focused on resident ability to tolerate a right upper extremity related stated that the resident will lated daily, resident will have otion (ROM) to extremity ent will be able to have terventions to obtain ded that skill was practiced as second area of focus was			A call light audit will be conducted by E and/or designee 5x week for 4 weeks to ensure appropriate timeliness.  A treatment completion for wounds audit tool will be completed by DON and/or designee 5x week for 4 weeks to ensure treatment completion by physician order.  Monitoring effectiveness of corrective	dit ure	
	the resident's capabil (reps) per joint to bila prevent further contra the resident would co with each session. In ability to perform reps 7 days/week, practice active ROM, encoura complete 10 reps to e fingers, elbow, should feet, never go beyond	ity to perform 10 repetitions teral lower extremities to actures. This goal stated that intinue to perform 10 reps terventions to increase s included skill practice 6 to e skill 15 minutes per day, ge resident to participate, each extremity below hands, der, neck, knees, legs and d point of resistance/never inging, observe resident for			action:  Call light audits and treatment complet audits will be brought by the DON and designee to the Quality Assurance Committee for 3 months for review. A areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	or .ny	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345280	B. WING _			03/	10/2017	
	ROVIDER OR SUPPLIER  CARE OF RAEFORD			120	REET ADDRESS, CITY, STATE, ZIP CODE D6 N FULTON STREET NEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 282	Continued From page		F 2	282				
	resident to assist with	y gestures, encourage the ROM, never force the I refer to OT and PT as						
	Certified Nursing Ass have been working th the hall doing patient	17 at 3:07 PM. Restorative istant (RCNA) #1 stated they e past couple of months on care, because they are lays a week and restorative e.						
	stated she has been months on the hall do	09/17 at 3:09 PM. RCNA #2 working the last couple of sing direct care because they three days a week and her aid was undone.						
	I work 10 AM to 6 PM aide just goes undone	09/17 at 3:11 PM. RCNA #2 I my duties as a restorative e, I work the hall at least 3-4 g direct care because they						
	Sheet (MDS) 12/30/1 #113 was cognitively the resident was total one person physical a toileting, extensive as transfer and locomoti	neals and required						
	PM, resident stated th	nt #113 on 03/06/17 at 3:17 nat she had often waited to after she pushed her call bell						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345280	B. WING		03/10	)/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N FULTON STREET  RAEFORD, NC 28376	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	no residents were able to short staffing within reported that she had was only one Certified on 100 hall and one of that the weekend staff routinely as long as a stated that on the molaid in her bed at least her call bell for staff to her wet linen and clot urine. She stated that the accident that she needed help. Resider and that no one cared assistance and care.  A record review of the dated 02/12/17 stated was able to verbalize Certified Nursing Assinterviewed on 03/09/that Resident #113 w transfers, toileting and resident did more upprome assistance. Stabed when not shower resident was schedul Wednesday and Frida assist.  Staff interview 3/9/17 certified nursing assist have been working the hall doing patient.	the stated that on 03/05/17, the to get out of the bed due of the facility. The resident of the become aware that there do Nursing Assistant (CNA) CNA on 200 hall. She stated fing had been short for the could remember. She raining of 03/05/17 she had to two hours after pushing to assist her with changing thing due to incontinence of the stated she felt helpless do about the need for routine that resident was alert and ther needs.  It stant (CNA) #1 was that resident was alert and ther needs.  It stant (CNA) #1 was that the ted that she is bathed in the ted. CNA stated that the ted for showers on Monday, and any and required one person assist contains and required one person that 3:07:42pm- Restorative that the pease couple of months on care, because they are lays a week and restorative	F 28:	2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345280	B. WING		03/10/2017
	ROVIDER OR SUPPLIER  CARE OF RAEFORD	,		STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N FULTON STREET  RAEFORD, NC 28376	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 282	Continued From pa	ge 16	F 28	2	
	stated she has beer months on the hall of	7 at 3:09:15pm- RCNA #2 n working the last couple of doing direct care because they st three days a week and her e aid was undone.			
	assistant (CNA) #1	7 at 3:12 pm- certified nursing states she left at 7 pm on is 2 CNA's to work the A hall			
		7 at 3:29 pm- CNA#2 stated for A hall we just team up and Sunday 3/5/17			
	PM. She stated that	strator on 03/09/17 at 4:56 it was her expectation that be followed as written.			
	Ulcer Guide." Read	ty protocol entitled, "Pressure in part, "9. The admitting sible for obtaining the initial			
	with diagnoses which Failure (CHF), Hype Artery Disease, Chr	admitted 2/28/17 to the facility the included Congested Heart ertension, Anemia, Coronary onic Obstructive Pulmonary			
	On the admission w 2/28/17 revealed the to the sacral crease	d End Stage Renal Disease. ound assessment dated e resident had an open area and a pinpoint area to the			
	the measurements of Review of the admis (MDS) dated 3/7/17	re was no documentation of or staging of the wounds. ssion minimum data set revealed that the resident			
		nitively impaired. He required e with transfers and toileting.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345280	B. WING	<del></del>	c	3/10/2017
	ROVIDER OR SUPPLIER  CARE OF RAEFORD		•	STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N FULTON STREET  RAEFORD, NC 28376		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 282	Continued From pag		F 28	32		
	personal hygiene an also revealed the resunstageable pressur sacrum and to the bit. A review of the resid revealed that an intereffectiveness of the physician for change A review of the physician for change on have time. The physician for complete were missed were con 3/10/17 at 10:50 Director of Nursing (called the physician for change of called the physician for the physician for called the physician for the physician for called the physician for the physician fo	ent's care plan dated 2/28/17 rvention was to assess the wound care and notify the s as needed. ician treatment orders dated ident # 179 was to receive rum and right buttocks with dry and to apply Santyl am (debriding agent) to the e wound with xeroform daily  If Resident #179 was a treatment to the sacrum and ruring the observation, the old red to be dated 3/5/17. If Nurse #1 stated she did ssing change on 3/6/17 179 had gone to dialysis. I she did not complete the 3/7/17 because, "I did not I stated she had not communication log pleting the dressing changes. If the Director of Nursing ar expectation was for the wound treatments per the and for the nurses to use their to make sure treatments that				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345280	B. WING		03/10/2017	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 206 N FULTON STREET RAEFORD, NC 28376	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 282 F 314 SS=D	On 3/10/17 at 11:02 A he was not made awa on admission. 483.25(b)(1) TREATA PREVENT/HEAL PRE  (b) Skin Integrity -  (1) Pressure ulcers. It comprehensive asses facility must ensure th  (i) A resident receives professional standard	MM the physician stated that are of the resident's wound  MENT/SVCS TO ESSURE SORES  Based on the sament of a resident, the eat- accare, consistent with s of practice, to prevent	F 282		4/7/17	
	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and  (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.  This REQUIREMENT is not met as evidenced by:  Based on record review, observation and staff interview the facility failed to obtain the initial treatment until 3 days after admission for 1 of 3 residents (Resident #179), and failed to complete dressing changes per physician's orders for 1 of 3 residents (Resident #179) reviewed for pressure ulcers.  The findings included:  Review of facility protocol entitled, "Pressure Ulcer Guide" Dated 7/2012, handed by the facility, Read in part, "9. The admitting nurse will be			F314  Steps Taken in regards to those reside found to be affected:  Resident #179 dressing will be change per order.  MD was notified on 3/10/2017 on resid #179 s wound.  Steps Taken in regard to those Resider having the potential to be affected:	d ent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245200	B. WING				
		345280	B. WING _	OTDEET ADDRESS SITV STATE 712 SI		3/10/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET			
				RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 314	Continued From pa	ge 19	F 3	14			
	1	aining the initial treatment"		An audit was conducted by	DON and/or		
	Tesponsible for obta	arming the initial treatment		designee to determine if the			
	Resident #179 was	admitted 2/28/17 to the facility		with wounds had RP and M			
		ch included Congested Heart		documentation.	5		
		ertension, Anemia, Coronary					
		ronic Obstructive Pulmonary		Re-education for nursing sta	aff on		
		nd End Stage Renal Disease.		completion of PCNs for all r			
	, ,	3		with wounds to be complete			
	On the admission w	ound assessment dated		and/or designee by 4/7/201	7.		
	2/28/17 revealed th	e resident had an open area					
		and a pinpoint area to the		Re-education for nursing sta			
		re was no documentation of		notification of MD and RP o	-		
	the measurements	or staging of the wounds.		changes including admissio			
	D			wounds or newly acquired v			
		ssion minimum data set		DON and/or designee to be	completed by		
		revealed that the resident		4/7/2017.			
		gnitively impaired. He required be with transfers and toileting.		Re-education for all staff on	ahuga paliay		
	1	ired total assistance with		by DON and/or designee to			
		nd bathing. The assessment		by 4/7/2017.	be completed		
	1 .	esident was admitted with 2		<i>Sy 11.1723111</i>			
		re ulcers to the resident's		Re-education on Wound Ca	are Policy and		
	sacrum and to the b			Guidelines by DON and/or of	•		
				completed by 4/7/2017.	· ·		
	A review of the resi	dent's care plan dated 2/28/17					
		ervention was to assess the		Re-education by American I			
		wound care and notify the		Technologies (AMT) and DO			
	physician for chang	es as needed.		designee on wound docume	entation		
				completed by 4/7/2017.			
		sician treatment orders dated			σ.		
	1	sident # 179 was to receive		Measures put in place to en			
		crum and right buttocks with		deficient practice does not r	ecur:		
		nt dry and to apply Santyl gram (debriding agent) to the		A new wound audit tool will	he completed		
		he wound with xeroform daily		A new wound audit tool will 5x week for 4 weeks ensuring			
	and as needed.	ne would with Actoloffit daily		acquired or admitted wound			
	and as needed.			complete with MD and RP r			
	On 3/8/17 at 9:38 A	M Resident #179 was		the DON and/or designee.			
		a treatment to the sacrum and		= 2 2			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345280	B. WING		03/10/2017	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 206 N FULTON STREET RAEFORD, NC 28376	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 314	the right buttocks. Dudressing was observed.  On 3/8/17 at 12:15PM not complete the dress because Resident #1' Nurse #1 also stated dressing change on 3 have time." Nurse #1 documented on the concerning not complete with the concerning not complete with the concerning not complete with the properties of the propertie	aring the observation, the old and to be dated 3/5/17.  If Nurse #1 stated she did sing change on 3/6/17 and gone to dialysis, she did not complete the 1/7/17 because, "I did not stated she had not communication log eting the dressing changes.  If the Director of Nursing expectation was for the cound treatments per the difference of the nurses to use their make sure treatments that implete.  If M Nurse #1 with the 1/ON) present stated she bout the admission but did a wound and no treatment  If the physician stated that are of the resident's wound  EASE/PREVENT OF MOTION  Ited range of motion reatment and services to the cound of the prevent further to the prevent further the cound of the counter the count	F 314	A call light audit will be conducted by E and/or designee 5x week for 4 weeks to ensure appropriate timeliness.  A treatment completion for wounds auditool will be completed by DON and/or designee 5x week for 4 weeks to ensure treatment completion by physician order.  Monitoring effectiveness of corrective action:  Call light audits and treatment complet audits will be brought by the DON and designee to the Quality Assurance Committee for 3 months for review. A areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	dit re er. ion /or	4/7/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	(X3) DATE SURVEY COMPLETED		
		345280	B. WING		03/10/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ALITLIMAL	CARE OF RAEFORD		'	1206 N FULTON STREET		
AUTUWN	CARE OF RAEFORD			RAEFORD, NC 28376		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 318	Continued From pag	ge 21	F 318			
	(3) A resident with li	mited mobility receives				
		s, equipment, and assistance				
		ve mobility with the maximum				
	·	dence unless a reduction in				
	mobility is demonstr					
		T is not met as evidenced				
	by:	on interviews and record		F318		
		on, interviews and record illed to provide Range of		F310		
		cises as care planned for 1 of		Steps Taken in regards to those reside	nts	
		#113) reviewed for ROM.		found to be affected:		
	Findings included:			Resident #113 is currently receiving Occupational Therapy for ROM service	s	
		admitted to the facility on oses that included but were		and splint re-evaluation.		
		egia and hemiparesis		Steps Taken in regard to those Resider	nts	
	-	farction affecting left		having the potential to be affected:		
		racture of hand, personal				
	history of sudden ca	rdiac arrest, generalized		A restorative program audit tool will be		
		najor depressive disorder,		completed by DON and/or designee to		
	_	betes type II with unspecified		determine appropriateness of programs	s in	
		hedema and dyspnea.		place and accuracy of orders and care plans.		
		ost recent Minimum Data				
		30/16 identified that Resident		Re-education was provided to the		
		y intact. The MDS indicated		restorative aides on 3/28/2017 by the		
		ally dependent for bathing and		SDC on providing restorative services t	0	
		assist during bathing,		meet the plan of care.		
		e for bed mobility, transfer		A minimum of one restorative aide will		
	resident required tot	he unit and dressing. The		work 6-7 x per week.		
	-	nit. The resident was		work 0-7 x per week.		
	independent with all			Measures put in place to ensure the		
	assistance with set	•		deficient practice does not recur:		
		interviewed on 03/09/17 at		A restorative audit tool will be complete	d 5	
		nt stated that the certified		x week for 4 weeks by DON and/or		
	nursing assistants ((	CNA) were expected to		designee to ensure residents are		

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345280	B. WING	B. WING		03/	10/2017
	ROVIDER OR SUPPLIER  CARE OF RAEFORD		•	12	TREET ADDRESS, CITY, STATE, ZIP CODE 206 N FULTON STREET AEFORD, NC 28376	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 318	perform the restorative mobility and independed facility had been so so restorative care had rordered. Resident state could obtain the strenwith the care needed.  The restorative nursing focused on 2 areas; for to tolerate a device; he extremity related to extremity related to extremity related to extremity related to extremity will have incompleted for the resident will have incompleted for the resident will have enhand to obtain enhanced Repracticed 6 to 7 days/focus was the resident repetitions (reps) per extremities to preventing goal stated that the reperform 10 reps with the increase ability to practice 6 to 7 days/minutes per day, active to participate, completed below hands, fingers, knees, legs and feet, resistance/never force observe resident for severbal, facial grimacine encourage resident to force the extremity rapt as needed.  Record review for nurstated that restorative stated that restorat	dence. She stated that the hort staffed that the not been completed as atted that she wished that she igth needed to assist herself and care plan dated 12/29/16 are two	F	318	receiving restorative services per order and care plan.  Monitoring effectiveness of corrective action:  Restorative audits will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concervill be brought back to the Quality Assurance Committee for further action plan.	e rn	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345280	B. WING _			3/10/2017	
	ROVIDER OR SUPPLIER  CARE OF RAEFORD		,	STREET ADDRESS, CITY, STATE, ZIP COD 1206 N FULTON STREET RAEFORD, NC 28376	E		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 318	been on 3 hours per of following were records  1. The number of making provided splin on 03/01/17, 03/07/13 and was not applicable Documentation that mapplication was viewed 03/08/17 and 03/09/103/03/17 and 03/04/11  2. Participation/cood 03/01/17, 03/07/17, 03/07/17, 03/07/17, 03/07/17, 03/09/17 and was not applicable on Level of assistance/todocumented on 03/01/03/09/17 and was not 03/04/17.  3. Transfer resident with contact guard as participation was docon 02/28/17, 03/03/17 of minutes spent train transfer was docume 02/28/17, 03/03/17 and 03/03/17 and 03/03/17 and 03/03/17 and 03/03/17 and 03/03/17 and 03/03/17, 03/07/17, 0	day for 6 days a week. The led:  ninutes documented as t assistance was 20 minutes 7, 03/08/17 and 03/09/17 le on 03/03/17 and 03/04/17. lesident tolerated splint ed on 03/01/17, 03/07/17, 7 and was not applicable on 7.  peration was documented on 3/08/17 and 03/09/17 and 03/03/17 and 03/04/17. lotal dependence was 1/17, 03/07/17, 03/08/17 and t applicable on 03/03/17 and t applicable on 03/03/17. The number sistance and activity lumented as not applicable on 1/10 of 1/10 o	F3	318			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345280	B. WING		03/10/2	017	
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF RAEFORD			•	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376	, 00.10.2011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE CO	(X5) MPLETION DATE	
F 318	was documented as 03/07/17, 03/08/17, on 03/03/17 and 03/ assistance/total dep completed on 03/01. 03/09/17 and not ap 03/04/17.  Monthly nurse's note #113 was alert and a she denied pain or completed as 103/04/17.	ty to tolerate and participate completed on 03/01/17, 03/09/17 and not applicable 04/17. The level of endence was documented as /17, 03/07/17, 03/08/17, plicable on 03/03/17 and e on 2/12/1 states resident able to verbalize her needs, discomfort and had voiced no	F 3	18			
	continued to have endextremities that corrollymphedema. ROM planned.  Resident #113 was 2:55PM. Resident strength to incresident to incresident to the strength to th	e also indicated that resident dema to bilateral lower elated with diagnosis of was ordered and care interviewed on 03/09/17 at tated that she wished that she ength needed to assist herself tated that she had not gained ase her independence tive care isn't performed as					
	Certified Nursing As have been working to the hall doing patient short staff at least 3 aide work was undo Staff interview on 03 stated she has been months on the hall of	8/09/17 at 3:09 PM. RCNA #2 n working the last couple of loing direct care because they st three days a week and her					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		E SURVEY PLETED
		345280	B. WING	<del></del>	03	/10/2017
	ROVIDER OR SUPPLIER  CARE OF RAEFORD		•	STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N FULTON STREET  RAEFORD, NC 28376	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 318	Continued From page	e 25	F 31	8		
F 353 SS=D	I work 10 AM to 6 PM aide just goes undonedays a week providin are short staff here.  Staff interview 03/09/states she left at 7 pm 2 CNAs to work the A Staff interview 03/09/stated there were 2 Cup and worked togeth Interviewed Administr PM. She stated that i restorative nursing cas written.  483.35(a)(1)-(4) SUF STAFF PER CARE PHER PHER PHER PHER PHER PHER PHER PH	ces e sufficient nursing staff with etencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care	F 35	33		4/7/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345280	B. WING		03/10/2017	
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF RAEFORD			•	STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N FULTON STREET  RAEFORD, NC 28376	1 00/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 353	sufficient numbers of personnel on a 24 nursing care to all re resident care plans:  (i) Except when waithis section, license (ii) Other nursing pelimited to nurse aide (a)(2) Except when this section, the facinurse to serve as a duty.  (a)(3) The facility monurses have the spests necessary to care identified through redescribed in the plant (a)(4) Providing care assessing, evaluating	ust provide services by of each of the following types 4-hour basis to provide esidents in accordance with  ved under paragraph (e) of d nurses; and ersonnel, including but not es.  waived under paragraph (e) of lity must designate a licensed charge nurse on each tour of  ust ensure that licensed ecific competencies and skill are for residents' needs, as esident assessments, and	F 38	·		
	This REQUIREMENty: Based on resident is record review of state to respond to reside incontinent care and dependent resident #113), the facility fair pressure ulcer as or	interview, staff interviews and ffing record, the facility failed ent's request for assistance for d for incontinent care for a for 1 of 1 resident (Resident ided to provide treatment to redered for 1 of 3 residents a facility failed to follow		F353  Steps Taken in regards to those resident found to be affected:  Resident #113 will be provided ADL a incontinence care per plan of care.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345280	B. WING _			03	3/10/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	7.10/2017
				12	206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD			R	AEFORD, NC 28376		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 353	Continued From page	e 27	F;	353			
		tment of pressure ulcer of 1			Resident #113 is currently receiving		
		ent #179) and the facility			Occupational Therapy for ROM service	es	
	1	M exercises as care planned			and splint re-evaluation.		
	for 1 of 1 resident (Re						
	,	,			Resident #179 dressing will be change	ed	
	The findings included			per MD orders.			
	1.a This tag was cros			MD was notified of resident #179□s			
		ns, resident interview, staff			wound on 3/10/2017.		
	interviews and record						
	treat a resident in a d			Steps Taken in regard to those Reside	nts		
	responding to her red			having the potential to be affected:			
	incontinent care for 1			<b>5</b> 1			
	(Resident #113).			An audit was conducted by DON and/o	or		
	,				designee to determine if those residen		
	b. This tag was cro	ssed reference to F224.			with wounds had RP and MD		
	Based on observation	ns, resident interview, staff			documentation.		
	interviews and record	d review, the facility failed to					
	provide assistance w	ith toileting causing the			Re-education for nursing staff on		
	resident to soil herse	If for 1 of 1 sample resident			completion of PCNs for all new resider	nts	
		facility failed to obtain the			with wounds to be completed by DON		
	I .	3 days after admission for 1			and/or designee by 4/7/2017.		
		ent #179), and failed to					
		nanges per physician's			Re-education for nursing staff on		
		dents (Resident #179)			notification of MD and RP on significar	nt	
	reviewed for pressure	e ulcers.			changes including admissions with		
					wounds or newly acquired wounds by		
	_	ssed reference to F281.			DON and/or designee to be completed	ру	
		ew, observation and staff			4/7/2017.		
		failed to follow physician			Do advection for all staff by DON ====1	or	
		of 3 residents reviewed			Re-education for all staff by DON and		
	(Res#179) with press				designee on call bell timeliness will be		
		essed reference to F314. ew, observation and staff			completed by 4/7/2017.		
		ailed to obtain the initial			Re-education for all staff on abuse pol	icv	
	_	s after admission for 1 of 3			by DON and/or designee to be comple	-	
	residents (Resident #	#179), and failed to complete			by 4/7/2017.	เธน	
	dressing changes pe	r physician's orders for 1 of			Re-education on Wound Care Policy a	nd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345280	B. WING		03	3/10/2017	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		710/2017	
				1206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD			RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 353	Based on observation review, the facility factor (ROM) exercitation (R	cossed reference to F318.  con, interviews and record ailed to provide Range of cises as care planned for 1 of t #113) reviewed for ROM.  Interview with the facility flucted. She stated she was all out we get the med aides or at are working on call states all out we get the med aids or its working; then I start calling (PRN) or part time staff to cur minimum on 7-3 Hall is 4 sistants (CNAs) and 2 nurses, 2 nurses, C Hall 3 CNAs and A and B Hall 2 nurses and 3 ave different staffing numbers  Interview was conducted with (DON) she stated she was on a Friday and every other ed "when people call out I f and calling the staff and so, we are in the process of people will come in."  7 at 3:07 pm with Restorative esistant, (RCNA) #1 stated thing the pass couple of doing patient care, because at least 3 days a week and	F 35	Guidelines by DON and/or design completed by 4/7/2017.  Re-education by American Medit Technologies (AMT) and DON and designee on wound documentatic completed by 4/7/2017.  Re-education was provided to the restorative aides on 3/28/2017 by SDC on providing restorative self meet the plan of care.  A minimum of one restorative aides work 6-7 times per week.  Measures put in place to ensure deficient practice does not recurred and/or designee 5x week for 4 wensure appropriate timeliness.  A treatment completion for wound tool will be completed by DON and designee 5x week for 4 weeks to treatment completion by physicial A new wound audit tool will be completed wounds are completed with MD and RP notifice the DON and/or designee.	cal nd/or on ey the vices to de will the d by DON eeks to ds audit nd/or ensure an order. completed newly exation by		
	"my work I can't do undone."	as a Restorative aide goes		Monitoring effectiveness of correaction:			
	Staff interview 3/9/1	7 at 3:09 pm with RCNA#2		Call light audits, treatment comp	letion		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345280	B. WING _			03/	/10/2017
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF RAEFORD				12	TREET ADDRESS, CITY, STATE, ZIP CODE 206 N FULTON STREET AEFORD, NC 28376	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	stated she had been months on the hall do are short staffed at le can't do my work as a Staff Interview 3/9/17 #2 I work 10 am - 6 p aide just goes undonedays a week providin are short staffed here. Staff interview 3/9/17 assistant (CNA) #1 st 3/5/17 and there were 3-11 shift. Staff interview 3/9/17 there were 2 NA's for and worked together. Staff Interview 3/9/17 "they stack the sched got help and we ain't. Staff interview 3/9/17 stated there were onl from 7 pm to 11pm.  A staff interview was 9:27 am with the facili (DON), she stated it is 1 had 2 nurses, 2 2 C 3/5/17.	working the last couple of bing direct care because they ast three days a week and I a Restorative Aide.  at 3:11 pm with Restorative m my duties as a restorative e, I work the hall at least 3-4 g direct care because they e.  at 3:12 pm nursing rates she left at 7 pm on e 2 CNA's to work the A hall  at 3:29 pm NA#2 stated A hall we just teamed up on Sunday 3/5/17  at 3:49 pm CNA #2 stated rule to make it look like we got no help".  at 3:49 pm with nurse #1 y 2 CNA's to cover A hall  conducted on 3/10/17 at	F	353	audits and new wound audit tool will be brought by the DON and/or designed the Quality Assurance Committee for months for review. Any areas of continued concern will be brought back the Quality Assurance Committee for further action plan.	0	
	DON both stated that outside staffing agend	facility does not use an					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION  NG	1, ,	(X3) DATE SURVEY COMPLETED		
		345280	B. WING _			03/10/2017	
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF RAEFORD			•	STREET ADDRESS, CITY, STATE, ZIP CODI 1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI  X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 353 F 371 SS=F	care plans were to be 483.60(i)(1)-(3) FOO STORE/PREPARE/S  (i)(1) - Procure food considered satisfactor authorities.  (i) This may include a from local producers and local laws or regulation of acilities from using a gardens, subject to a safe growing and food (iii) This provision do from consuming food (iiii) This provision do from consuming food (iiii) This provision d	it was her expectation that e followed as written. D PROCURE, SERVE - SANITARY  from sources approved or bry by federal, state or local  food items obtained directly subject to applicable State ulations.  es not prohibit or prevent broduce grown in facility sompliance with applicable ad-handling practices.  es not preclude residents als not procured by the facility.  e, distribute and serve food in fessional standards for food  egarding use and storage of dents by family and other fe and sanitary storage,	F3	353		4/7/17	
	record reviews, the f food food such as cr meat in the refrigeral clean and maintain the	ons, staff interviews and acility failed to store and label anberry juice, eggs, and for. The facility also failed to the ice maker machine in the pink substance on the inside		F371  Steps Taken in regards to thos found to be affected:  The cranberry juice was disca 3/6/2017.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345280	B. WING		03/10/2017	
	ROVIDER OR SUPPLIER  CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N FULTON STREET  RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 371	Continued From pag	ge 31	F 37	1		
	a) In reach in refrior of cranberry juice we contents gone and responsible in the same react cracked egg on a greggs on the tray. c) In another react staff drink bottle of found opened and ut d) In another react was found on a dript dated 03/01/17 (data refrigerator to thaw) 03/04/17. This was a The unlabeled and coracked egg, staff found the manual of the content of the content of the unlabeled and coracked egg, staff found the content of the content	gerator, one 64-ounce bottle as found opened with ¾ of not labeled. Inch in refrigerator, found a ay cardboard tray with other  The in refrigerator, a personal Mountain Dew 16 oz. was Inlabeled. In in refrigerator, a large ham proof brown tray with a label the ham was placed in and a discard date of found on 03/06/17.  Topened cranberry juice bottle, Illountain Dew bottle and out of the oved from the refrigerators to Kitchen Manager on		The cracked egg was discarded on 3/6/2017.  The personal drink was discarded on 3/6/2017.  The ham was discarded on 3/6/2017.  The ice machine was cleaned on 3/8/2017.  Steps Taken in regard to those Reside having the potential to be affected:  Dietary staff were educated on pasteurized eggs on 3/8/2017 by the dietary manager.  Dietary staff were educated on labelin open items in the refrigerator, storing personal items in the refrigerator, following discard dates on food items discarding cracked eggs by the Dietar Manager and completed on 3/24/2017.	ents  og  and ry 7.	
	11:30 AM. Stated th unlabeled drinks or including staff perso cracked egg was no inside of the tray bu discard the entire tra pasteurized. Stated	en Manager on 03/06/17 at at it is not acceptable to have bottles in the refrigerators and drinks. Stated that the it touching any other egg telt it was appropriate to ay. Stated that the eggs are that the label on the large dincorrectly but discarded it		the Administrator on 3/8/2017 on the strame to complete ice machine cleani and ice machine monthly check list.  Measures put in place to ensure the deficient practice does not recur:  Maintenance personnel will complete ice machine check list monthly and tu into the administrator indefinitely.	time ng the	
	2 Another observ	ation on 03/06/17 at 11:40 AM		Dietary manager and/or designee will		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345280	B. WING _			03/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ALITURAN	CARE OF BAFFORD			1206 N FULTON STREET		
AUTUWN	CARE OF RAEFORD			RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O  (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE THE APPROPRIAT	DATE
F 371	Continued From page	e 32	F3	371		
	the white flap inside of	substance in the corners of of ice maker. The pink slime of with the ice sliding down aker into the ice.		complete the dry storage week x 4 weeks and week	kly thereafter.	
	at 11:55 AM indicated contract with an outsi and that they were sumonths for inspection A receipt invoice #12 company was supplied			action:  The ice machine check lis by the Maintenance Direct designee to the Quality Ast Committee for 3 months for areas of continued concert brought back to the Quality.	ctor and/or ssurance for review. An rn will be ty Assurance	
	in kitchen was perfori icemaker machine wa	t cleaning of the Ice Machine med on 11/10/16. The as not cleaned within 3 date of the company visit.		The dry storage goods au brought by the Dietary Ma designee to the Quality As	idit will be anager and/or	
	comprised of expecta drinks with ice to resi- was removed from ar substance. He stated removed but he was	nager 03/08/17 at 12:00 PM titions of serving prepared dents for lunch when ice in ice maker with pink slimy that the ice should be unsure of the timeliness to drinks already on the trays al.		Committee for 3 months for areas of continued concert brought back to the Qualit Committee for further action	or review. Any rn will be ty Assurance	у
	Administrator stated to included cleaning pin maker in kitchen. She machines are to be comaintenance staff or stated that the machine and cleaned immedia prepared drinks were replaced with new drivesidents. Kitchen maprepared drinks need	k, slimy substance from ice e stated that the ice leaned once per month by more often if needed. She ne needed to be emptied itely. She stated that all the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DA	(X3) DATE SURVEY COMPLETED	
		345280	B. WING _			3/10/2017	
	ROVIDER OR SUPPLIER  CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP C 1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 371	Continued From pag for the lunch meal.	e 33	F3	71			