	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345129	B. WING			04/40/0047
NAME OF P	ROVIDER OR SUPPLIER	040120		STREET ADDRESS, CITY, STATE, ZIP C		04/13/2017
	KONDER OR SOFT EIER			1007 HOWARD STREET	ODL	
AUTUMN	CARE OF MOCKSVILLE	E		MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY		F 2	41		5/8/17
	resident in a manner promotes maintenan her quality of life reco individuality. The fac promote the rights of This REQUIREMENT by: Based on observation interviews the facility of 1 of 3 residents by remain in visibly soild for 34 minutes (Resident The findings included Resident #103 was a 12/22/16 with diagno speech, severe apha subarachnoid hemore Review of a care pla	the resident. T is not met as evidenced ons, record review, and staff failed to maintain the dignity allowing the resident to ed pants with a hole in them dent #103).		This plan of constitutes our compliance for deficiencies however, submission of the correction is not an admissi deficiency exists or that one correctly. This plan of corre- submitted to meet requirem established by state and fea- Resident Affected: Reside cleaned of incontinence and the time of notification by the nurse.	cited; plan of ion that a e was cited ection is ients deral law. ent was d changed at ie CNA and	
	#103 had self-care d effects from cerebral right hemiparesis, ap goal of the stated car would have ADLs me interventions of the c incontinent care as n nursing when resider Review of most rece set (MDS) dated 02/2 #103 was cognitively and was sometimes	eficit related to residual vascular accident including ohasia, and dysphagia. The re plan was Resident #103 et through next review. The are plan included: Provide necessary and report to		affected:       Social Services         Administrator interviewed o         alert and oriented residents         being treated with dignity at         Identified areas were correct         (No other areas of concern         identified).         The social worker observed         interviewable residents to e         were properly attired and ne         were observed.         Systemic Change:       Staff m         inserviced by the Director of	and n 5/8/2017 all related to nd respect. cted at the time were d all non nsure that they o dignity issues	

**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.

05/08/2017

			() (o)		OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING		04/13/2017
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
F 241	Continued From page	e 1	F 241		
	assistance of 2 staff r toileting and was alwa bladder. No behaviors MDS. Review of Resident # 04/10/17 through 04/ care. On 04/11/17 at 9:02 A interview with Reside #103 was sitting in his of his room he was du and brown sweat pan visibly wet between h approximately the siz pant leg. Resident # light be turned on and due to him being wet The call light was turn resident waited in his Resident #103 indica wet and did not like h them, it "made him fe started to cry. After v Resident #103's call I housekeeper knocked interrupting us. Resid that he needed some then shut the door. R cry and after addition summoned for help. N was not working prop that Resident #103 nd On 04/11/17 at 9:36 A	members for transfers and ays incontinent of bowel and s were identified on the 2103's medical record from 11/17 revealed no refusal of AM an observation and nt #103 was made. Resident s wheelchair in the doorway ressed in a light colored shirt its. The sweat pants were is legs and there was a hole e of quarter in the left upper 2103 requested that his call d his pants to be changed and having a hole in them. hed on at 9:02 AM, while room with the door closed. ted that he did not like being aving pants with a hole in el bad" and Resident #103 vaiting for staff to answer ight for 30 minutes the d on door and apologized for lent #103 indicated to her help. The housekeeper esident #103 continued to al 10 minutes Nurse #3 was Nurse #3 stated the call light verly and she was not aware eeded assistance.	Γ 24	<ul> <li>Dignity of residents with completion May 8, 2017.</li> <li>Three residents will be questioned observed related to dignity by Soc Worker weekly for three weeks ar monthly for three months. The Administrator or Director of Nursin audit these questionnaires/observ related to dignity. If any area of c are identified, this will be addressed that time. Continued areas of combe addressed in monthly QA mee further action plan. Random mon will occur and will be reported to t Quality Assurance Committee on ongoing basis until the issue has bresolved.</li> <li>Quality Assurance/Monitoring: Nucheck resident #103 three times a ensure cleanliness and proper att These audits will be performed by Director of Nursing.</li> </ul>	d or cial id then ig will ations oncern ed at iccrn will ting for itoring he an oeen

Facility ID: 922953

If continuation sheet Page 2 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/16/2017 / APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE	
		345129	B. WING				04/	13/2017
NAME OF P	ROVIDER OR SUPPLIER			s	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		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 241	that Resident #103 net his call light was not w had just finished brea morning round and w door when Nurse #3 n #103 needed to be ch Resident #103 had be and he would have be incontinent care. NA# changed Resident #1 rounded on her reside breakfast and was no was wet or needed as by Nurse #3. On 04/12/16 at 4:12 F of Nursing (DON) was stated that Resident # resident, he refused of the staff to touch him stated that Resident # demanded to be up a that on 04/11/17 she lip pants and the NA had but he refused. The D have seen Resident # she would have respon she or her staff did no required assistance, fi to treat residents with On 04/13/17 at 8:55 A was conducted. NA # for Resident #103 and staff because the staff what he was saying. I #103 got up on 3rd sh	d that she was not aware eeded assistance because working. NA #1 stated she kfast and had started her as actually in the room next hotified her that Resident hanged. NA #1 indicated that een up since before her shift een next on her round for #1 stated she had not 03 since coming on shift but ents immediately after t aware that Resident #103 asistance prior to being told PM an interview with Director is conducted. The DON #103 was a "different type of care a lot, and he refused for all night long." The DON #103 got very angry and t 6:00 AM. The DON stated had noticed the hole in his a attempted to redress him DON stated that if she would #103's call light on 04/11/17 ponded but it was not on so ot know that Resident #103 pout she did expect her staff	F	241				

Facility ID: 922953

If continuation sheet Page 3 of 40

	S FOR MEDICARE &					IO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	· · ·	TE SURVEY MPLETED		
		345129	B. WING		04/13/2017			
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 241 F 253 SS=E	restroom using the lif stated Resident #103 and bladder and did r defecated. NA #2 sta with Resident #103 a was able to understan On 04/13/17 at 9:21 / #3 was conducted. N #103 was very deman all. Nurse #3 stated th was able to figure out needs were, but it wa him if he was upset. I Resident #103 wante right then even if the residents. Nurse #3 stated the residents. Nurse #3 shim to calm down and right with him and he the staff usually did n Resident #103 on her Resident #103 on her Resident #103 gets u 6:00 AM in the mornin arrived at work. Nurse #103 did not refuse c care. Nurse #3 state care the NAs docume and she would docun medical record. 483.10(i)(2) HOUSEF SERVICES (i)(2) Housekeeping a	take Resident #103 to the t and 2 person assist. NA #2 was incontinent of bowel not know when he voided or ated she has had no issues is long as he was calm she nd him. AM an interview with Nurse urse #3 stated that Resident nding and had no patience at nat most of the time the staff t what Resident #103's is a lot harder to understand Nurse #3 stated when d something, he wanted it staff was assisting other tated that they usually asked d told him they would be was usually ok with that and ot have any problems with r shift. Nurse #3 stated that ip between 5:30 AM and ing and was up when she e #3 stated that Resident are and instead demanded d that if a resident refused ented in their electronic kiosk	F 241			5/11/17		

Facility ID: 922953

If continuation sheet Page 4 of 40

					OMB NO. 0938-03	
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345129	B. WING		04/13/2017	
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO	
F 253	Continued From page	e 4	F 25	3		
	Based on observatio facility failed to repair bathroom doors with laminate and wood in and 300 halls (reside #300, #303, #304, #3 repair smoke prevent splintered laminate a failed to repair a fire of splintered laminate a the 200 hall, failed to on the 400 hall with b laminate and wood of door and failed to rem around the base of to 3 of 13 rooms on the #304, #308 and #309 Findings included: 1. a. Observations or	ns and staff interviews the resident room and broken and splintered 8 of 40 rooms on the 200 nt room #206, #210, #216, 08 and #309), failed to tion doors with broken and nd wood on the 200 hall, door with broken and nd wood at the entrance of repair the shower/bath door broken and splintered in the lower edges of the nove brown stains from bilets and bathroom floors in 300 hall (resident room 9).		<ul> <li>Residents affected: The doors Rooms 206, 210, 216, 300, 303, 3 and 309 as well as the smoke pre- doors on 200 hall, the entrance to hall, and the shower bath door on are repaired by 5/11/2017 by the Maintenance Director.</li> <li>The bathroom floors in Rooms 30 and 309 have been repaired by 5</li> <li>Residents with the potential to be affected: All doors were checked broken/splintered laminate and w have been sanded by 5/11/2017.</li> <li>All resident bathroom floors were for need of repair/replacement of plan is in place to repair five bathr weekly until all bathrooms have b repaired.</li> </ul>	304, 308, evention 200 400 hall 4, 308, /11/2017. d for ood and audited tile. A rooms	
	was a long sliver of a $\frac{1}{2}$ - 2 inches in length lower edge of the bat broken and splintered edges of the resident Observations on 04/1 bathroom of resident was a long sliver of a $\frac{1}{2}$ - 2 inches in length lower edge of the bat broken and splintered edges of the resident Observations on 04/1 bathroom of resident was a long sliver of a $\frac{1}{2}$ - 2 inches in length	1/17 at 9:27 AM in the room #206 revealed there splinter approximately 1 and with a sharp point on the hroom door and there was d laminate and wood on the		Systemic changes: Staff has be inserviced on the proper usage of Work Order forms by the Adminis The Maintenance Director will che doors and bathroom floors throug facility two times per month to ens all doors and floors are in good re Any area identified will be correct that time. QA and Monitoring: The Admini will audit five facility doors and flo week for three weeks and then fiv and floors monthly. Any area idea will be corrected at that time. Rat monitoring will occur and will be r	f updated trator. eck all hout the sure that epair. ed at strator ors per ve doors ntified ndom	

Facility ID: 922953

If continuation sheet Page 5 of 40

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		345129	B. WING			04/	13/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET 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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 253	10	e 5 I laminate and wood on the	F	253	to the Quality Assurance Committee of	on an	
	edges of the resident			ongoing basis until the issue has been resolved.			
	bathroom of resident and splintered lamina edges of the bathroor						
	Observations on 04/1 bathroom of resident	1/17 at 10:58 AM in the room #210 revealed broken					
	edges of the bathroor	te and wood on the lower n door. 2/17 at 1:54 PM in the					
	bathroom of resident	room #210 revealed broken ite and wood on the lower					
	edges of the bathroor						
	revealed the door to r	c. Observations on 04/10/17 at 11:47 AM revealed the door to resident room #216 had					
	lower edges of the do						
	the door to resident re	1/17 at 10:59 AM revealed oom #216 had broken and nd wood on the lower edges					
	of the door.	2/17 at 1:57 PM revealed					
	the door to resident re	boom #216 had broken and nd wood on the lower edges					
		4/11/17 at 10:53 AM resident room #300 had I laminate on the lower					
	the door to resident re	2/17 at 2:04 PM revealed oom #300 had broken and					
	door.	n the lower edges of the					
		3/17 at 11:09 AM revealed oom #300 had broken and					

Facility ID: 922953

If continuation sheet Page 6 of 40

	-	ID HUMAN SERVICES				FORM	: 05/16/2017 APPROVED	
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE		
		345129	B. WING		_	04/*	13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	IATE, 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 253	splintered laminate or door. e. Observations on 04 revealed the door to r broken and splintered edges of the door and laminate and wood or bathroom door. Observations on 04/1 the door to resident ro splintered laminate or door and broken and wood on the lower ed Observations on 04/1 the door to resident ro splintered laminate or door and broken and wood on the lower ed f. Observations on 04/1 the door to resident ro splintered laminate or door. Observations on 04/1 the door to resident ro splintered laminate or door.	A/10/17 at 11:39 AM resident room #303 had d laminate on the lower d broken and splintered in the lower edges of the 11/17 at 10:54 AM revealed com #303 had broken and in the lower edges of the splintered laminate and lges of the bathroom door. 2/17 at 2:09 PM revealed com #303 had broken and in the lower edges of the splintered laminate and lges of the bathroom door. 2/17 at 11:40 AM revealed com #304 had broken and in the lower edges of the splintered laminate and lges of the bathroom door. 2/10/17 at 11:40 AM revealed com #304 had broken and in the lower edges of the 11/17 at 10:55 AM revealed com #304 had broken and in the lower edges of the 2/17 at 2:12 PM revealed com #304 had broken and in the lower edges of the 2/17 at 2:12 PM revealed com #304 had broken and in the lower edges of the 2/17 at 11:19 AM resident room #308 had d laminate on the lower d the bathroom door had d laminate and wood on the	F 253					

Facility ID: 922953

If continuation sheet Page 7 of 40

						<u>10. 0938-039</u>		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED		
		345129	B. WING _		0	4/13/2017		
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 TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE			
F 253	· · · · · · · · · · · · · · · · ·		F 2	53				
		1/17 at 10:57 AM revealed						
		bom #308 had broken and						
		n the lower edges of the m door had broken and						
		nd wood on the lower edges						
	of the door.							
	Observations on 04/1	2/17 at 2:17 PM revealed						
		oom #308 had broken and						
		n the lower edges of the						
		m door had broken and						
	of the door.	nd wood on the lower edges						
		4/10/17 at 11:44 AM in						
		evealed inside the bathroom						
		er corner there was a large						
	door.	plintered laminate on the						
		1/17 at 10:59 AM in resident						
		nside the bathroom door on						
	the right lower corner	there was a large area of						
	broken and splintered	l laminate on the door.						
		2/17 at 2:20 PM in resident						
		nside the bathroom door on						
		there was a large area of laminate on the door.						
	2. Observations on 04	4/10/17 at 12:05 PM						
	revealed the smoke p	prevention doors on the 200						
		plintered laminate on the						
	lower edges of the do							
		1/17 at 10:02 AM revealed						
		n doors on the 200 hall had I laminate on the lower						
	edges of the doors.							
	-	2/17 at 2:01 PM revealed						
		n doors on the 200 hall had						
	-	l laminate on the lower						
	edges of the doors.							

Facility ID: 922953

If continuation sheet Page 8 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/16/2017 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		345129	B. WING			_	04/	13/2017
NAME OF P	ROVIDER OR SUPPLIER			S	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		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B INCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From page	8	F	253	<b>,</b>			
	entrance to the 200 h splintered laminate or door. Observations on 04/1 the fire door on the rig the 200 hall had broke on the lower edges of Observations on 04/1 the fire door on the rig the 200 hall had broke on the lower edges of 4. Observations on 04 revealed the shower/1 had broken and splint edges of the door with on the edges of the door and splintered lamina door with deep gouge of the door. Observations on 04/1 the shower/bath door and splintered lamina door with deep gouge of the door. 5. a. Observations on bathroom of resident were dark brown stair base of the toilet and of the toilet. Observations on 04/1 bathroom of resident	on the right side of the all had broken and in the lower edges of the 1/17 at 2:26 PM revealed ght side of the entrance to en and splintered laminate if the door. 2/17 at 2:33 PM revealed ght side of the entrance to en and splintered laminate if the door. 4/10/17 at 12:15 PM bath door on the 400 hall tered laminate on the lower in deep gouges in the wood						

Facility ID: 922953

If continuation sheet Page 9 of 40

							O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		· · · ·	e survey Ipleted
		345129	B. WING			04/13/201	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, C	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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH (	VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 253			F	253			
	of the toilet.	on the floor around the base 2/17 at 2:19 PM in the					
	bathroom of resident room #304 revealed there were dark brown stains in the grout around the						
		on the floor around the base					
		4/10/17 at 11:19 AM in the room #308 revealed there					
		ns in the grout around the on the floor around the base					
	Observations on 04/ bathroom of resident	11/17 at 10:57 AM in the room #308 revealed there ns in the grout around the					
		on the floor around the base					
	bathroom of resident	2/17 at 2:17 PM in the room #308 revealed there					
		ns in the grout around the on the floor around the base					
	bathroom of resident	4/10/17 at 11:44 AM in the room #309 revealed there					
		ns in the grout around the on the floor around the base					
	bathroom of resident	11/17 at 10:59 AM in the room #309 revealed there					
	base of the toilet and of the toilet.	ns in the grout around the on the floor around the base					
	bathroom of resident	2/17 at 2:20 PM in the room #309 revealed there					
		ns in the grout around the on the floor around the base					

Facility ID: 922953

If continuation sheet Page 10 of 40

	S FOR MEDICARE &					O. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · · ·	E SURVEY IPLETED
		345129	B. WING		04	1/13/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MOCKSVILLE			1007 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 253	Continued From page 10		F 253	3		
	During an Intonview of	n 04/13/17 at 11:24 AM with				
	During an Interview on 04/13/17 at 11:24 AM with the Maintenance Director he explained he had an					
	assistant who helped him to complete repairs in					
		ned they did not have any				
	major renovations pla					
		lamage to walls in resident stated repairs were an				
		they utilized a work order				
		d the work order forms were				
		n his door and anyone could				
		nd leave it in the holder and				
		pair and document when the				
	repair was completed	nts and visitors could fill out				
	-	acked them to ensure				
		ed. He further stated he				
		lers to be completed for				
	anything that needed					
	-	d the work order system with				
		ring orientation and he had filled out the work order,				
		paired, when damage was				
		was located. He stated he				
		le rounds every day and				
		ine things they checked				
		ater temperatures or whether				
	the alarms worked or	exit doors.				
	During an environme	ntal tour with the				
	-	and Administrator on				
		I the Maintenance Director				
		completed work orders or				
		esident doors, bathroom				
	-	tion doors, fire doors or				
		He stated the grout around needed to be replaced and				
			1	1		1
	he would expect for h	ousekeeping staff to report				

Facility ID: 922953

If continuation sheet Page 11 of 40

					OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345129	B. WING		04/13/2017	
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO	
F 253	Continued From page	e 11	F 25	3		
	mopped and cleaned	bathrooms.				
	the Administrator he s to maintain a safe, co also stated it was his	n 04/13/17 at 11:47 AM with stated it was his expectation omfortable environment. He expectation for staff to use n to communicate repairs de to maintenance.				
F 281 SS=E	483.21(b)(3)(i) SERV PROFESSIONAL ST	ICES PROVIDED MEET ANDARDS	F 28	1	5/11/17	
	(b)(3) Comprehensive	e Care Plans				
		d or arranged by the facility, mprehensive care plan,				
	(i) Meet professional This REQUIREMENT by:	standards of quality. is not met as evidenced				
	Based on observation record reviews the far medication directly in dose packages and b	ns, staff interviews, and cility staff failed to dispense to a medicine cup from unit oottles for 3 of 5 residents ication pass (Resident #19, esident #60).		Resident Affected: On 4/12/2017 when the Director of Nursing was notified be surveyor of concerns from the previor day's med pass, Nurse #2 was suspensed and later terminated.	oy us ended	
	The findings included			Other residents with the potential to the affected: All staff nurses received education on the Five Rights of Med		
	Dose Preparation and dated 12/01/07 read	ocument titled "General d Medication Administration" in part, facility staff should tion when opening a bottle		Passes by the RN Nurse Supervisor completion of 5/8/2017. All nurses w checked off on the medication administration skills checklist by 5/11/2017 by the Director of Nursing RN Supervisors.	/ere	
	10/20/16 with diagnos	re-admitted to the facility on ses that included crease in the secretion of		Systemic Changes: Medication administration education and observation	ation	

Facility ID: 922953

	RS FOR MEDICARE &				OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING		04/13/2017
NAME OF F	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 281	the hormones produce Review of the most red data set (MDS) dated Resident #19 had mod daily decision making memory problems. Th Resident #19 required activities of daily living On 04/11/17 at 4:24 F of Nurse #2 preparing was made. Nurse #2 tablets out of a unit de left hand and then pla medication cup sitting cart. Nurse #2 was th bottle of tablets and p ungloved left hand and the medication cup sitting cart. Nurse #2 was th bottle of tablets and p ungloved left hand art the medication cup sitting cart. Nurse #2 was th bottle of tablets and p ungloved left hand art the medication cart. Nurs medication cart. Nurs medication cart and to the tablets in them art room and administere Nurse #2 returned to used the mouse to ele of the administration. hands or use hand sa administration of the f An interview with Nur 04/11/17 at 4:39 PM a worked at the facility stated that she "norm into her hand, I only u	eed by the pituitary gland). ecent quarterly minimum (01/22/17 revealed that odified independence with g and had long/short term he MDS revealed that d one person assist with g. PM a continuous observation g Resident #19's medication was observed to punch 2 ose card into her ungloved ace the tablets into a g on top of the medication ten observed to open a oour 1 tablet directly into her nd then placed that tablet into itting on top of the se #2 then locked her ook the medicine cup with nd entered Resident #19's ed the tablets to the resident. the medication cart and ectronically sign the record Nurse #2 did not wash her anitizer before or after the tablets. se #2 was conducted on and revealed that she had for 8 months. Nurse #2 nally pops the pills directly use gloves when doing eye nod sugars." Nurse #2 stated would lose the pill by directly	F 28	by Director of Nursing or Administra Nursing Staff will occur quarterly. In nurse will be observed to ensure the are following the five rights of medi administration. Random monitoring occur and will be reported to the Quart Assurance Committee on an ongoi basis until the issue has been reso	Each at they cation g will uality ng lved. 'he n and

Facility ID: 922953

If continuation sheet Page 13 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/16/2017 MAPPROVED
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	D. 0938-0391 SURVEY PLETED
		345129	B. WING _				04/	13/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				007 HOWARD STREET IOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 281	her to pop the pill into stated that the staff w or use hand sanitizer Nurse #2 stated "she in/out rooms and just then stated that "that washing or using han but I am just handing On 04/12/17 at 4:19 F Director of Nursing (D DON stated that the a "totally inappropriate." nursing staff was exp directly into the medic hands. The DON furth should have gloves on pills directly into her h remove the gloves an DON further stated th not visibly soiled then sanitizer between eac 2. Resident #55 was p 08/15/16 with diagnos obstructive pulmonary Review of the most re (MDS) dated 01/09/17 was cognitively intact assistance with activit On 04/11/17 at 4:13 F of Nurse #2 preparing was made. Nurse #2 tablets out of a unit do left hand and then pla medication cup sitting	<ul> <li>ber hand. Nurse #2 further vas expected to wash hands between each resident. got in the zone and ran forgets to do it. " Nurse #2 she should probably being d sanitizer between patients them a cup and I forget."</li> <li>PM an interview with the DON) was conducted. The actions of Nurse #2 were " The DON stated that the ected to place the pills cation cup and not in their her stated that Nurse #2 n if she was popping the nand and then she should be using hand and then she should had wash her hands. The net if the staff hands were they should be using hand ch resident.</li> <li>readmitted to the facility on ses that included chronic y disease.</li> <li>ecent minimum data set 7 revealed that Resident #55 and required one person ties of daily living.</li> <li>PM a continuous observation g Resident #55's medication was observed to punch 2 ose card into her ungloved</li> </ul>	F2	281				

Facility ID: 922953

If continuation sheet Page 14 of 40

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY IPLETED
		345129	B. WING		0	4/13/2017
NAME OF F	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP COD	E	
AUTUMN	CARE OF MOCKSVILLE			007 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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 281	ungloved left hand an into the medication cur- medication cart. Nurs medication cart and to the tablets in them an room and administered Nurse #2 returned to used the mouse to ele of the administration. hands or use hand sa administration of the f An interview with Nur 04/11/17 at 4:39 PM a worked at the facility stated that she "norm into her hand, I only u drops or checking blo she was scared she w popping the pill from f bottle to the medicine her to pop the pill into stated that the staff w or use hand sanitizer Nurse #2 stated "she in/out rooms and just then stated that "that washing or using han but I am just handing On 04/12/17 at 4:19 F Director of Nursing (D DON stated that the a "totally inappropriate."	bour 2 tablets directly into her ad then placed the tablets up sitting on top of the le #2 then locked her ook the medicine cup with ad entered Resident #55's ed the tablets to the resident. the medication cart and ectronically sign the record Nurse #2 did not wash her anitizer before or after the tablets. se #2 was conducted on and revealed that she had for 8 months. Nurse #2 hally pops the pills directly use gloves when doing eye bod sugars." Nurse #2 stated would lose the pill by directly the unit dose package or e cup and it was easier for o her hand. Nurse #2 further was expected to wash hands between each resident. got in the zone and ran forgets to do it. " Nurse #2 she should probably being d sanitizer between patients them a cup and I forget." PM an interview with the DON) was conducted. The actions of Nurse #2 were " The DON stated that the ected to place the pills	F 281			

Facility ID: 922953

If continuation sheet Page 15 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/16/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345129	B. WING			04/	13/2017
NAME OF P	ROVIDER OR SUPPLIER	-		S	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)	ЗE	(X5) COMPLETION DATE
F 281	remove the gloves an DON further stated the not visibly soiled then sanitizer between eace 3. Resident #60 was a 09/16/13 with diagnos hypertension, diabete embolism, anxiety, an Review of the Reside quarterly Minimum da 02/26/17 revealed that cognitively intact and assistance of 2 staff r and transfers. On 04/11/17 at 4:34 F of Nurse #2 preparing was made. Nurse #2 tablets out of a unit do left hand and then pla medication cup sitting cart. Nurse #2 was th bottle of tablets and p ungloved left hand an into the medication cu medication cart. Nurs medication cart and to the tablets in them an room and administer Nurse #2 returned to used the mouse to ele of the administration. hands or use hand sa administration of the to	and and then she should d wash her hands. The at if the staff hands were they should be using hand ch resident. admitted to the facility on ses that included is mellitus, chronic ad depression. Int #60's most recent that set (MDS) dated at Resident #60 was required extensive nembers for bed mobility PM a continuous observation g Resident #60's medication was observed to punch 4 obse card into her ungloved ace the tablets into a g on top of the medication en observed to open a bour 2 tablets directly into her ad then placed the tablets up sitting on top of the e #2 then locked her bok the medicine cup with ad entered Resident #60's ed the tablets to the resident. the medication cart and ectronically sign the record Nurse #2 did not wash her unitizer before or after the	F	281			

If continuation sheet Page 16 of 40

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COI	MPLETED
		345129	B. WING		0	4/13/2017
NAME OF P	ROVIDER OR SUPPLIER	L	STR	EET ADDRESS, CITY, STATE, ZIP COL		
AUTUMN	CARE OF MOCKSVILLE		1007 MO			
(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 ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 281	04/11/17 at 4:39 PM a worked at the facility stated that she "norm into her hand, I only u drops or checking blo she was scared she w popping the pill from t bottle to the medicine her to pop the pill into stated that the staff w or use hand sanitizer Nurse #2 stated "she in/out rooms and just then stated that "that washing or using han	and revealed that she had for 8 months. Nurse #2 ally pops the pills directly use gloves when doing eye od sugars." Nurse #2 stated would lose the pill by directly the unit dose package or e cup and it was easier for her hand. Nurse #2 further ras expected to wash hands between each resident. got in the zone and ran forgets to do it. " Nurse #2 she should probably being d sanitizer between patients	F 281			
F 282 SS=D	On 04/12/17 at 4:19 F Director of Nursing (E DON stated that the a "totally inappropriate." nursing staff was exp directly into the medic hands. The DON furth should have gloves o pills directly into her h remove the gloves an DON further stated th not visibly soiled then sanitizer between eac 483.21(b)(3)(ii) SERV PERSONS/PER CAR (b)(3) Comprehensive The services provided	VICES BY QUALIFIED RE PLAN	F 282			5/8/17

Facility ID: 922953

If continuation sheet Page 17 of 40

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. (X3) DATE S	URVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	COMPLE	ETED
		345129	B. WING		04/1:	3/2017
NAME OF PI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 282	Continued From page	e 17	F 28	2		
	(ii) Be provided by qu					
	This REQUIREMENT by:	is not met as evidenced				
	interviews the facility	ns, record reviews, and staff failed to implement care not applying a concave		Resident affected: The resident affected was assessed for continue of concave mattress and the care p		
	mattress as instructed residents (Resident #	d by the care plan for 1 of 3 7).		was updated to reflect that the cond mattress was not needed.	cave	
	The findings included	:		Other residents with potential to be affected: All residents on concave		
	-	hitted to the facility on ses that included repeated himer's disease, and others.		mattresses were reviewed by administrative nurses to ensure tha appropriate care plan interventions		
	Review of a care plar			in place.		
	01/26/17 and revised Resident #7 was at ris	on 03/08/17 read in part, sk for falls related to		Systemic Changes: Staff member were educated to review the Karde	x to	
	and short/long term m	veakness, history of falls, nemory deficits. The goal of vas Resident #7 would have		ensure resident interventions were place per plan of care.	in	
	no preventable injury	from falls through the next included concave mattress		Quality Assurance/Monitoring: Administrative nurses will review re requiring raised perimeter mattress weekly for three weeks and then m	es	
	Review of the most re Minimum Data Set (M revealed that Resider cognitively impaired a	IDS) dated 02/08/17		for three months to ensure mattres are in place and that care plans are place. Any areas identified will be corrected at that time. Random		
	assistance with bed n and toileting. The MD Resident #7 had a his	nobility, transfers, dressing, S further revealed that		monitoring will occur and will be rep to the Quality Assurance Committe ongoing basis until the issue has be resolved.	e on an	
		7's visual/bedside kardex Resident #7 had in place as bed.				

Facility ID: 922953

If continuation sheet Page 18 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/16/2017 / APPROVED ). 0938-0391	
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345129	B. WING			_	04/	13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, ST	ATE, 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	ıx	PROVIDER'S (EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 282	Continued From page	e 18	F	282	2				
		ent #7's bed on 04/10/17 standard mattress in place, was noted.							
		ent #7's bed on 04/11/17 at re was a standard mattress mattress was noted.							
		ent #7's bed on 04/12/17 at re was a standard mattress mattress was noted.							
	MDS Nurse was cond stated that the concav the care plan on 02/19 fall on 01/28/17. The Resident #7 fell on 01 emergency room and we discussed it and u 02/19/17 which was a mattress. The MDS n have devices like the needed they fill out a morning meeting and	urse stated that when they concave mattress that were							
	2:25 PM revealed the in place, no concave i	ent #7's bed on 04/12/17 at re was a standard mattress mattress was noted. ent #7's bed on 04/12/17 at							
	2:30 PM made with th	ne MD confirmed that as was a standard mattress							
		on 04/12/17 at 2:35 PM he morning meeting if the							

Facility ID: 922953

If continuation sheet Page 19 of 40

	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
		345129	B. WING		0	4/13/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	E	
AUTUMN	CARE OF MOCKSVILLE			007 HOWARD STREET IOCKSVILLE, 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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 282	team needed anything or removed they woul either he or his assist The MD reviewed his months and could not requesting a concave The MD did find a wo requesting Resident # to Oak Hall and he have requested. The MD statist list of resident with co- they did not use them Interview with Nurse # revealed that she tool times. Nurse #4 state Resident #7 on 01/28 sent to the emergency that Resident #7 was and tried to get up to fell. Since no one saw send the resident to the evaluation. Nurse #4 no injury and returned also stated that the kas nursing assistants (No the resident required each resident required each resident required moving to Oak hall. Interview with the Dire 04/12/17 at 3:35 PM r system was electronic each kardex each day	g repaired or devices added d fill out a work order and ant would take care of it. work orders for the last 4 t locate a work order mattress for Resident #7. rk order dated 03/08/17 #7 be moved from Pine Hall ad completed that as tated that he did not keep a oncave mattress because a very often. #4 on 04/12/17 at 3:23 PM k care of Resident #7 at d she was taking are of w/17 when she fell and was y room. Nurse #4 stated sitting up in her wheelchair help another resident and v her fall our protocol was to he emergency room for stated that Resident #7 had d to the facility. Nurse #4 ardex system was what the A) use to know what devices and how much assistance d. Nurse #4 stated that ncave mattress when she had not had one since	F 282			

Facility ID: 922953

If continuation sheet Page 20 of 40

	S FOR MEDICARE &		a			IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		345129	B. WING		0	4/13/2017
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 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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 282 F 323 SS=D	resident. The DON st the staff to follow the plan stated concave r should have had a co Interview with NA #2 she was taking care of time and to her knowl have a concave math fall interventions whe they can review them stated she had not re kardex yet but if she r 483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI (d) Accidents. The facility must ensu (1) The resident envir from accident hazard (2) Each resident reco and assistance device (n) - Bed Rails. The fa appropriate alternativ	ated that she does expect care plan and if the care mattress then Resident #7 incave mattress. on 04/13/17 revealed that of Resident #7 for the first ledge Resident #7 did not ress. NA #2 stated that their re listed in the computer and if they need to. NA #2 viewed Resident #7's needed to she could. c(3) FREE OF ACCIDENT SION/DEVICES ure that - ronment remains as free s as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use es prior to installing a side or	F 28			5/8/17
	must ensure correct i maintenance of bed r to the following eleme	ails, including but not limited ents. nt for risk of entrapment				
		and benefits of bed rails with nt representative and obtain				

If continuation sheet Page 21 of 40

F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	345129	B. WING		04/13/2017	
OVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ARE OF MOCKSVILLE					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO	
Continued From page	21	F 323			
appropriate for the res This REQUIREMENT by: Based on observation interviews, the facility securely attached to t (resident #14) The findings included: Resident #14 was adr with diagnoses of maj chronic pain, tremor, n sclerosis and dysphag #14's most recent cor assessment dated 03. #14 moderately impai making. The MDS als needed a one person mobility, locomotion o personal hygiene and On 04/10/17 at 10:55 made that resident's r loose, with significant rail would be tight aga resting. Leaving a sig mattress and the side attached to the bed fra to side, the side rail w frame but rather move mattress. The left sid good operating order,	sident's size and weight. is not met as evidenced ns, record review and staff failed to have a side rail he bed frame for 1 of 40 : mitted to the facility 03/12/09 jor depressive disorder, muscle weakness, multiple gia. Review of resident nprehensive Annual MDS /17/17 revealed resident ired for daily decision so revealed Resident #14 , physical assist with bed on/off unit, dressing, toileting, I bathing. AM an observation was right side rail to be very movement from where the ainst the bed to where it was gnificant gap between the a rail. The side rail was a me but when moved side vas not tight against the bed to be in , tight against the mattress		Resident Affected: The Director Maintenance tightened the side rail 4/12/2017. Residents with the potential to be affected: An audit of 100% of the I with side rails was completed on 4/12/2017 and no other areas were identified. System Changes: Staff education Administrator and Director of Nursi related to completion of work order timely notification of areas needing addressed was completed by 5/8/2 Quality Assurance/Monitoring: Residents with side rails on beds w audited weekly for three weeks and monthly times three months to ensu- side rails are attached and function properly. The Administrator will rev audits of these side rail reviews. R monitoring will occur and will be rep to the Quality Assurance Committe ongoing basis until the issue has be resolved.	l on beds e n by ng rs and to be 2017. vill be d then ure hing view candom ported be on an	
	F DEFICIENCIES CORRECTION COVIDER OR SUPPLIER CARE OF MOCKSVILLE SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I Continued From page (3) Ensure that the be appropriate for the res This REQUIREMENT by: Based on observatio interviews, the facility securely attached to the (resident #14) The findings included Resident #14 was add with diagnoses of mag chronic pain, tremor, sclerosis and dysphag #14's most recent cor assessment dated 03 #14 moderately impain making. The MDS als needed a one person mobility, locomotion of personal hygiene and On 04/10/17 at 10:55 made that resident's r loose, with significant rail would be tight aga resting. Leaving a sig mattress and the side attached to the bed fr to side, the side rail w frame but rather move mattress. The left sid good operating order,	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345129         COVIDER OR SUPPLIER         CARE OF MOCKSVILLE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 21         (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:         Based on observations, record review and staff interviews, the facility failed to have a side rail securely attached to the bed frame for 1 of 40	F DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A BUILDING         345129       B. WING         COVIDER OR SUPPLIER       345129         SARE OF MOCKSVILLE       ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 21       F 323         (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:       F 323         Based on observations, record review and staff interviews, the facility failed to have a side rail securely attached to the bed frame for 1 of 40 (resident #14)       F         The findings included:       Resident #14 was admitted to the facility 03/12/09 with diagnoses of major depressive disorder, chronic pain, tremor, muscle weakness, multiple sclerosis and dysphagia. Review of resident #14' moderately impaired for daily decision making. The MDS also revealed Resident #14 needed a one person, physical assist with bed mobility, locomotion on/off unit, dressing, toileting, personal hygiene and bathing.         On 04/10/17 at 10:55 AM an observation was made that resident's right side rail to be very loose, with significant movement from where the rail would be tight against the bed to where it was resting. Leaving a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was noted to be in good operating order, tight against the mattress	F GEFICIENCIES CORRECTION       (X1) FROVIDER/SUPPLIERCULA IDENTIFICATION NUMBER:       (X2) MULTIFICE CONSTRUCTION A BUILDING         345129       B. WING         STREET ADDRESS, CITY, STATE, ZIP CODE         OVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCECEDE OF VILL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREVIEW PREVIEW TAG       PROVIDER'S PLAN OF CORRECT (EECAL CORRECTIVE ACTION SHOU CROSS-REFERENCE TO THE APPRO DEFICIENCY MUST BE PERCECEDE OF VILL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREVIEW PREVIEW TAG       PREVIEW CORRECTIVE ACTION SHOU CROSS-REFERENCE TO THE APPRO DEFICIENCY         Continued From page 21       F 323         (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility 03/12/09 with diagnoses of major depressive disorder, chronic pain, tremor, muscle weakness, multiple sclerosis and dysphagia. Review of resident #14 moderately impaired for daily decision making. The MDS also revealed Resident #14 needed a one person, physical assits with bed mobility, loccomotion on/off unit, dressing, toileting, personal hygiene and bathing.       System Changes: Staff educatior Administrator and Director of Nursi related to completion of work order timely notification of areas needing addressed was completed by 5/2/2 Cuality Assurance/Monitoring: Residents with side rails on beds w audited weekly for three weeks and monitoring will occur and will be rej to the Cuality Assurance/Monitori	

If continuation sheet Page 22 of 40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MOCKSVILLE       B. WING       04/13/201*         (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 BE DEFICIENCY)       00/13/201*         F 323       Continued From page 22 Observation of resident's right side rail still very loose. It continued to leave a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was not tight against the bed frame but rather moved outward, away from the mattress. Observation of the bolts       F 323		TMENT OF HEALTH AN					PRINTED: 05/1 FORM APPF OMB NO. 0938	ROVED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         AUTUMN CARE OF MOCKSVILLE       1007 HOWARD STREET         MOCKSVILLE, NC 27028       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 CORRECTION (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (xx) (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (xx) (COMPL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 323       Continued From page 22 Observation of resident's right side rail still very loose. It continued to leave a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was not tight against the bed frame but rather moved outward, away from the mattress. Observation of the bolts       F 323	STATEMENT (	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,			(X3) DATE SURVE	
1007 HOWARD STREET MOCKSVILLE, NC 27028       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)     (xx COMPL DATE       F 323     Continued From page 22 Observation of resident's right side rail still very loose. It continued to leave a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was not tight against the bed frame but rather moved outward, away from the mattress. Observation of the bolts     F 323			345129	B. WING		_	04/13/20	17
AUTUMN CARE OF MOCKSVILLE         AUTUMN CARE OF MOCKSVILLE       MOCKSVILLE, NC 27028         MOCKSVILLE, NC 27028       (x4) ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPL DATE         F 323       Continued From page 22 Observation of resident's right side rail still very loose. It continued to leave a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was not tight against the bed frame but rather moved outward, away from the mattress. Observation of the bolts       F 323	NAME OF PI	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (xx COMPL DATE         F 323       Continued From page 22 Observation of resident's right side rail still very loose. It continued to leave a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was not tight against the bed frame but rather moved outward, away from the mattress. Observation of the bolts       F 323				1	007 HOWARD STREET			
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPL DATE         F 323       Continued From page 22 Observation of resident's right side rail still very loose. It continued to leave a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was not tight against the bed frame but rather moved outward, away from the mattress. Observation of the bolts       F 323	AUTUWIN	V CARE OF MOCKSVILLE		N	MOCKSVILLE, NC 2702	8		
Observation of resident's right side rail still very loose. It continued to leave a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was not tight against the bed frame but rather moved outward, away from the mattress. Observation of the bolts	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE	E COMP	K5) LETION ATE
Intal the diff the bed frame revealed the nuts to be loose which caused the right side rail         to remain loose.         04/12/17 8:36 AM observation of resident's side rail still very loose on right side.         04/11/17 3:43 PM an interview with resident #14.         He stated that he used the side rails to assist him in shifting and turning. He further stated he had noticed that the rails are loose but was unsure if he had reported them.         4/12/17 4:06 PM interview with Maintenance Director revealed resident's side rails were checked weekly. He stated that he and his helper physically checked "every bed" in the facility weekly.         04/12/17 4:47 PM during a follow up interview with Maintenance Director was asked to measure the gap provided due to resident #14's loose side rail on the right side of the bed. He measured resident #14's loose side rail on the right side of the bed. He measured resident #14's side rail movement and reported that the total movement from where the rail should be, to where the rail was as "2 3/4 inches". He stated that due and reported that the ot and occar for the type of side rail that was on resident #14's loose side rail he per bolited to the bed and was only able to be adjusted or tightened where the side rail and the	F 323	Observation of reside loose. It continued to between the mattress rail was attached to the moved side to side, the against the bed frame away from the mattress that held the rail to the nuts to be loose which to remain loose. 04/12/17 8:36 AM observal rail still very loose on 04/11/17 3:43 PM an He stated that he use in shifting and turning noticed that the rails a he had reported them 4/12/17 4:06 PM inter Director revealed resis checked weekly. He physically checked "e weekly. 04/12/17 4:47 PM dur with Maintenance Dire bed rails every Monda Maintenance director gap provided due to r on the right side of the resident #14's side ra that the total movements should be, to where the He stated that he did rail that was on reside bolted to the bed and	ent's right side rail still very o leave a significant gap s and the side rail. The side he bed frame but when he side rail was not tight e but rather moved outward, iss. Observation of the bolts e bed frame revealed the h caused the right side rail servation of resident's side right side. interview with resident #14. ed the side rails to assist him g. He further stated he had are loose but was unsure if h. rview with Maintenance ident's side rails were stated that he and his helper every bed" in the facility ring a follow up interview ector he stated he checked ay. On a walkthrough the twas asked to measure the resident #14's loose side rail e bed. He measured hil movement and reported ent from where the rail he rail was as "2 3/4 inches". not care for the type of side ent #14's bed as they were was only able to be	F 323				

Facility ID: 922953

If continuation sheet Page 23 of 40

DEPARTMENT OF HEALT CENTERS FOR MEDICAR							FORM	D: 05/16/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345129	B. WING			-	04/	13/2017
NAME OF PROVIDER OR SUPPLIEF	ł	•	•	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
AUTUMN CARE OF MOCKSV	IIF			1	007 HOWARD STREET			
				N	OCKSVILLE, NC 2702	3		
PREFIX (EACH DEFIC	IENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
the beds with this side rails that has be tightened up of unable to recall t rail was last insp 04/13/17 1:35 Ph revealed the Mai rails weekly. He out of rooms, the and adjust as ne staff to report to need to be tighten unable to tighten 483.45(d)(e)(1)-( FROM UNNECE 483.45(d) Unnece Each resident's of unnecessary dru drug when used- (1) In excessive therapy); or (2) For excessive (3) Without adeq (4) Without adeq (5) In the presen which indicate th discontinued; or (6) Any combinal	He s s typ d a k easily he la ecter A inten state y sh educe main ned ther 2) D SSA essa rug gs. dose dur uate ce o e do ions	tated that he did not check e of bed rail as often as the inob on the rail to allow it to y. He further stated he was ast time resident #14's side d. erview with Administrator ance Director checked side ed that since staff is in and ould be monitoring side rails d. He continued, he expected itenance for loose rails that to bed frame if staff were mselves. RUG REGIMEN IS FREE RY DRUGS ary Drugs-General. regimen must be free from An unnecessary drug is any e (including duplicate drug		323				5/8/17

If continuation sheet Page 24 of 40

		MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345129	B. WING		04/13/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 329	Continued From page	e 24	F 32	9	
	483.45(e) Psychotrop Based on a comprehe resident, the facility m	ensive assessment of a			
	drugs are not given the medication is necessary	ive not used psychotropic nese drugs unless the ary to treat a specific ed and documented in the			
	gradual dose reduction interventions, unless an effort to discontinu This REQUIREMENT by:	clinically contraindicated, in le these drugs; is not met as evidenced			
	interviews the facility order and discontinue	ns, record review and staff failed to follow a physician e a medication after 10 days <sup>5</sup> 5 residents sampled for tions (Resident #7).		Resident Affected: The nurse practitioner was notified on 4/12/20 licensed nurse and order was rece continue Lorazepam 0.5 mg every with no stop date.	ived to
	dementia, and depres	nitted to the facility on ses that included anxiety, ssion.		Residents with the potential to be affected: Physician orders for all n admissions from 4/14/2017 were re for accuracy. No other areas were identified.	eviewed
	02/01/17 read Loraze (mg) by mouth every	-		Systemic Changes: The first nurse enters orders, confirms and verifies medications. The next shift nurse medications and directions. The the check is conducted by the next shift	s checks hird

Facility ID: 922953

If continuation sheet Page 25 of 40

					OMB NO. 093	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
		345129	B. WING		04/13/20	17
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COM O THE APPROPRIATE	(X5) PLETIO DATE
F 329	Continued From page	e 25	F 32	29		
	hours as needed for u	0.5 mg by mouth every 8 up to 10 days. The MAR nt #7 had received Ativan 0.5		fourth check is complete administrative nurse to v medications and direction	erify that	
		ollowing days: 02/04/17, 2/12/17, 02/13/17, and		Quality Assurance/Monit	oring: An	
		nt comprehensive minimum I 02/08/17 revealed that		administrative nurse will resident's admission order three weeks and then on	ers weekly for	
	The MDS also reveal	erely cognitively impaired. ed that Resident #7 had ated in severity and no other		admission orders monthl months to ensure compli monitoring will occur and	ance. Random	
		iors were noted. The MDS further revealed to the Quality Assurance Committeesident #7 received 2 days of anti-anxiety ongoing basis until the issue has been been been been been been been bee				
	03/31/17 revealed the mouth every 8 hours The MAR revealed th Ativan 0.5 mg by mou	ated 03/01/17 through e following: Ativan 0.5 mg by as needed for up to 10 days. at Resident #7 had received uth on the following days: 3/13/17, 03/14/17, 03/16/17, nd 03/31/17.				
	Review of the MAR dated 04/01/17 through 04/30/17 revealed the following: Ativan 0.5 mg by mouth every 8 hours as needed for up to 10 days. The MAR revealed that Resident #7 had received Ativan 0.5 mg by mouth on the following days: 04/03/17 and 04/10/17.					
	PM revealed a well-g	ent #7 on 04/11/17 at 1:31 roomed resident sitting in room. Resident #7 was				
	AM revealed a well-g	ent #7 on 04/12/17 at 8:55 roomed resident sitting in room. Resident #7 was				

Facility ID: 922953

If continuation sheet Page 26 of 40

	S FOR MEDICARE &					O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		345129	B. WING		04	/13/2017
IAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
UTUMN	CARE OF MOCKSVILLE	1		1007 HOWARD STREET MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF 0 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 329	Continued From page	e 26	F 329			
smiling and calm as a member department braided her hair.		a member of the activity				
	04/12/17 at 3:45 PM had came back from The DON stated afte have been stopped c	rector of Nursing (DON) on revealed that Resident #7 the hospital with that order. r 10 days the order should or reevaluated. The DON d obtain a clarification order				
	revealed that he word did not necessarily re order in because he electronic medical re when he had an order certain amount of tim Ativan 0.5 mg by mo for up to 10 days the electronic system that would select the durat case it would have be further stated that if y duration of the medic which meant the order on the MAR until it w	at stated "duration" and you ation of the medication in this een 10 days. Nurse #1 you do not specify the cation it goes to "indefinitely" er would continue to appear as changed or discontinued.				
	mistake because he other reason why he duration in the electro Interview with the Nu 04/13/17 at 11:03 AM made aware of the e	he felt like this was just a did not recall the day or any would not have put the onic medical record. Irse Practitioner (NP) on A revealed that she had been rror with Resident #7 and re no adverse reactions from				

Facility ID: 922953

If continuation sheet Page 27 of 40

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/16/20 FORM APPROVI OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING		04/13/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•
	CARE OF MOCKSVILLE			1007 HOWARD STREET	
AUTUWIN	CARE OF MOCKSVILLE		1	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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETIO
F 332	Continued From page	e 27	F 332		
SS=D	RATES OF 5% OR M				
	(f) Medication Errors. that its-	. The facility must ensure			
	greater;	rates are not 5 percent or			
	by:	Γ is not met as evidenced			
	•	ons, record reviews, and staff		Resident Affected: On 4/12/207	17 when
	interviews the facility			the Director of Nursing was notif	ied by
	medication error rate	less than 5% as evidenced		surveyor of concerns from the p	revious
	by 2 errors out of 30	opportunities for 2 of 3		day's med pass, Nurse #2 was s	suspended
		#19 and Resident #55)		and later terminated.	
	-	lication pass. This resulted			
	in a facility medicatio	n error rate of 6.66%.		Other residents with the potentia	
				affected: All staff nurses recei	
	The findings included	1:		education on the Five Rights of	
				Passes by the RN Nurse Superv	
		re-admitted to the facility on		completion of 5/8/2017. All nurs	ses were
	10/20/16 with diagno			checked off on the medication	
	•••••	crease in the secretion of ced by the pituitary gland.)		administration skills checklist by 5/11/2017 by the Director of Nur RN Supervisors.	
	Review of a physicial	n order for Resident #19		, -	
	dated 10/20/16 read,			Systemic Changes: Medicatio	n
	milligrams (mg) by m	outh in the afternoon for		administration education and ob	servation
	hypopituitarism.			by Director of Nursing or Admini	
				Nursing Staff will occur quarterly	
		1/17 at 4:25 PM of Nurse #2		nurse will be observed to ensure	
		19's afternoon medication		are following the five rights of me	edication
		was observed pulling a card		administration.	
		the medication cart. The card			
		tion as Hydrocortisone 10		Quality Assurance/Monitoring	The
		punched 2 tablets (20 mg)		Quality Assurance/Monitoring: Administrator will ensure that the	The
		laced them in the medication dication dication cart. After preparing		medication administration educa	
		#19's medication Nurse #2		observations are completed qua	
		9's room and administered		licensed nurses. Random monito	

Facility ID: 922953

If continuation sheet Page 28 of 40

PRINTED: 05/16/2017

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIE	PLE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	· /	3	· · ·	MPLETED
		345129	B. WING		o	4/13/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 332	Continued From page	e 28	F 33	32		
the medication that included H mg 2 tablets.		cluded Hydrocortisone 10		occur and will be reported to Assurance Committee on a basis until the issue has bee	n ongoing	
04 ma an Nu sta ad do rig Int rev mo Re tal ov Nu ha sh on Int 04 ma sh	04/12/17 at 4:19 PM medication pass com and was not sure if th Nurse #2's medicatio stated she expected administered using th administration", the ri dose, to the right pati right route. Interview with Nurse revealed that she had months. Nurse #2 sta	e "5 rights of medication ght medication, the right ent, at the right time, via the #2 on 04/12/17 at 4:48 PM d worked at the facility for 8 ated she did not realize that				
	tablet in the afternoor oversight and nervou Nurse #2 stated that had completed a med	ceived 1 hydrocortisone n and it was "just an sness" that led to the error. facility management staff dication pass with her when e pharmacy had not done				
	04/13/17 at 11:03 AN made aware of the er	rse Practitioner (NP) on I revealed that she had been ror with Resident #19 and o adverse reactions from this				
		readmitted to the facility on sis that included chronic y disease.				
		n order for Resident #55 in part, Mucinex 1200 uth twice a day for 7 days				

Facility ID: 922953

If continuation sheet Page 29 of 40

	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/16/2017 / APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE	
		345129	B. WING			_	04/	13/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				007 HOWARD STREET IOCKSVILLE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 332	Observation on 04/11 preparing Resident #8 was made. Nurse #2 of medication out of th medication was Mucin #2 was observed to p tablet in a medication medication cart. After Resident #55's medic Resident #55's room medications that inclu- mouth. Interview with the Dire 04/12/17 at 4:19 PM r had medication pass hire and was not sure observed Nurse #2's DON stated she expe administration," the ri- dose, to the right path right route. Interview with Nurse # revealed that she had months. Nurse #2 sta Resident #55 receive was "just an oversigh to the error. Nurse #2 management staff has pass with her when sh pharmacy had not do Interview with the Nur 04/13/17 at 11:03 AM made aware of the er	(17 at 4:13 PM of Nurse #2 55's afternoon medication was observed to pull a box he medication cart. The hex 600 mg tablets. Nurse lace 1 Mucinex 600 mg cup on top of the preparing the rest of ation Nurse #2 entered and administered the ded Mucinex 600 mg by ector of Nursing (DON) on revealed that Nurse #2 she competency done upon her if the pharmacy had medication pass or not. The cted medication to be e "5 rights of medication ght medication, the right ent, at the right time, via the #2 on 04/12/17 at 4:48 PM worked at the facility for 8 ted she did not realize that d Mucinex 1200 mg and it and nervousness" that led stated that facility d completed a medication he was hired but the	F	332				

Facility ID: 922953

If continuation sheet Page 30 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/16/2017 M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345129	B. WING			04	/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 0-1	10/2011	
				10	007 HOWARD STREET			
AUTUMN	CARE OF MOCKSVILLE			М	OCKSVILLE, 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 463 SS=E	483.90(g)(2) RESIDE ROOMS/TOILET/BAT		F	463			5/8/17	
	(g) Resident Call Sys	tem						
	residents to call for st communication system	dequately equipped to allow aff assistance through a m which relays the call nber or to a centralized staff						
	by:	is not met as evidenced						
	interviews the facility system was functionir	ns, record reviews, and staff failed to ensure the call light ng properly for 3 resident , Room 204 W, and 216 D)			Residents affected: The call bell in room 204 was repaired on 4/13/2017 the call bell in room 216 was repaired 4/12/2017. While the call lights were	on		
	The findings included				being repaired, a manual call bell was placed in these rooms for the residen utilize until the call lights were fully functional.			
	the call light was push came on but the light on. The main panel a	(door) revealed that when ned the light in the room in the hallway did not come t the nurse's station did not cating Resident room 204 D			Residents with the potential to be affected: An audit of all resident roo was conducted by the Administrator a Maintenance Director on 4/12/2017 a all other call lights were functioning	nd		
	Interview with Nurse # confirmed that the cal the room and was not station. Nurse #3 stat was not working prop the resident in 204 D would take care of the right now.	#3 on 04/11/17 at 9:30 AM I light was not on outside t sounding at the nurse's ed because the call light erly she did not know that needed assistance but she e call light and the resident			properly. Systemic Changes: Staff members were educated by the Administrator of proper use of the Maintenance Work Order forms and proper procedure for alerting maintenance of issues related the call light system by 5/8/2017. Sta were also educated on placing tempo	n the d to ff rary		
	Observation and inter	view with the Maintenance			call bells at bedside if the call lights a	e		

Facility ID: 922953

If continuation sheet Page 31 of 40

		MEDICAID SERVICES	(X2) MULT		CONSTRUCTION	(X3) DATE	0.0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	PLETED
		345129	B. WING			04/	13/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MOCKSVILLE				007 HOWARD STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 463	Continued From page	e 31	F4	63			
	The Maintenance Dire	11/17 at 9:36 AM was made. ector entered Resident room			not properly functioning.		
	the call light. The MD and the call light in th The MD stated that th connections were old bathroom light did no would cause the call function properly. Afte bathroom switch the	and worn down and if the t get completely reset it light in the room not to			Quality Assurance/Monitoring: The Maintenance Director performs an au all call lights weekly for one month an then monthly times three months. Th audits will be reviewed by the Administrator. The results of these au will be reported to the Quality Assurar Committee. Continued areas of conc will be addressed by the QA Committee for further action plans as indicated.	d ese udits nce ern	
	2:35 PM revealed that types of call bell's with explained that room 2 pull system in the bat contacts were worn d call light in the room a	w with MD on 04/12/17 at the facility had 2-3 different hin the facility. The MD 204 D had the old style level hroom and the internal own and that caused the and in the hallway to not					
	of the issue and had of part and when the pa part. The MD stated hand it had arrived to to to repair it because of	e MD stated he was aware ordered the replacement rt came in, it was the wrong ne reordered the correct part he facility but he was unable f the different wiring system and the new part. The MD					
	in the facility so some was going to come ar The MD stated that e checked each call be they were all working assistant had comple	but the rest of the call lights cone from the parts company and help install the new part. ither he or his assistant Il every week to make sure properly, the MD stated his ted the call light check on					
	Nursing on 04/12/17	es were noted. ministrator and Director of at 4:06 PM revealed that that the call light system was					

If continuation sheet Page 32 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	05/16/2017 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345129	B. WING _				04/	13/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				007 HOWARD STREET IOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD BI CED TO THE APPROPRIA FFICIENCY)		(X5) COMPLETION DATE
F 463	not working properly. absolutely would have notified so he could have notified so he could have for assistance. The ac- expectation that all re calling for assistance. Interview with Mainter 04/12/17 at 4:57 PM r checked the call lights no issues with Room properly when he che there was a problem f issue or if he was una- let his supervisor know A follow up interview w at 9:21 AM with Nurse have had problems w call light not working p a outside company co in that room but to he had any issues with a 2. Observation of Res on 04/11/17 at 9:02 A call light was pushed turn on, the light in ha the main panel at the sound or light up indic Room 204 W had bee Observation and inter Director (MD) on 04/1 The MD confirmed tha call light was not work worked with the call light	The administrator stated he e wanted to have been ave notified the DON and ve gotten another way to call dministrator stated it was his esidents had a means of	F4	463				

Facility ID: 922953

If continuation sheet Page 33 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/16/2017 / APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE	
		345129	B. WING			_	04/	13/2017
NAME OF PF	ROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, ST	TATE, 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 PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 463	Continued From page	9 33	F	463	3			
	Resident room 204 W began working correct	/ and the call light than tly.						
	2:35 PM revealed that	w with MD on 04/12/17 at t his assistant had checked day and to his knowledge						
	there was no issues.	The MD stated that the as, when anyone discovered						
		ot working properly they						
		and placed it in the box on e or his assistant would take						
		ted he had no recent work						
		ninistrator and Director of at 4:06 PM revealed that						
	they were not aware to not working properly.	that the call light system was The administrator stated he e wanted to have been						
	-	ave notified the DON and						
		ve gotten another way to call diministrator stated it was his						
		sidents had a means of						
	04/12/17 at 4:57 PM r							
		s on 04/10/17 and there was 204 D the light was working						
		cked it. The MA stated if						
	there was a problem	then he would either fix the						
	issue or if he was una let his supervisor know	able to fix the issue he would w.						
		sident Room 216 D (door)						
		AM revealed that when the						
	÷ .	the light in room did not turn lway did not turn on, and the						
		se's station did not sound or						

Facility ID: 922953

If continuation sheet Page 34 of 40

							10.0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		ISTRUCTION	· · ·	TE SURVEY MPLETED	
		345129	B. WING			0	4/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
	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	ĸ	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 463	Continued From page	e 34	F4	163				
	light up indicating the D had been turned or	light in Resident Room 216 า.						
	Observation of Resident Room 216 D on 04/12/17 at 8:58 AM revealed that when the call light was pushed the light in room did not turn on,							
	main panel at the nur	y did not turn on, and the se's station did not sound or light in Resident Room 216 n.						
	Director (MD) on 04/1 that the call light in Re working. The MD con the call light in the roo	rview with the Maintenance I2/17 at 3:00 PM confirmed esident room 216 D was not firmed that when pushed, om did not come on, the light						
	panel at the nurse's s up indicating the call D had been turned or	come on, and the main station did not sound or light light in Resident Room 216 n. The MD stated his d the call lights on Monday						
		all if there was issue or not. lieved the box in the wall d have to replace it.						
	Nursing on 04/12/17 a they were not aware not working properly. absolutely would have	ninistrator and Director of at 4:06 PM revealed that that the call light system was The administrator stated he e wanted to have been ave notified the DON and						
	for assistance. The a	ve gotten another way to call dministrator stated it was his sidents had a means of						
	04/12/17 at 4:57 PM	nance Assistant (MA) on revealed that he had s on 04/10/17 and Resident						

Facility ID: 922953

If continuation sheet Page 35 of 40

	S FOR MEDICARE & I		()(0)		OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED	
		345129	B. WING		04/13/2017	
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
F 463	Room 216 D was not the call lights. The M/ MD which was his su slipped my mind." The discovered that the ca 216 D was not workin was checking the call was not something he supervisor the MD in had not filled out the v	e 35 working when he checked A stated he did not tell the pervisor because "it had e MA stated that actually he all bell in Resident Room g last Thursday when he lights. The MA stated that e could fix so he had told his passing. The MA stated he work order but had just told d maybe he had not heard	F 46	3		
F 490 SS=E	ADMINISTRATION/R 483.70 Administration A facility must be adm enables it to use its re efficiently to attain or practicable physical, r well-being of each res This REQUIREMENT by: Based on observation interviews the facility! utilize its resources efficiently utilize its resources of sustain plans of corred did not have a medicator or greater and resulter medication pass of a percent. The facility a communication occur administration to ensu	inistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. is not met as evidenced ms, record review and staff s administration failed to fectively to implement and ction to ensure the facility ation error rate of 5 percent d in observations during medication error rate of 6.66 also failed to ensure red from staff to ure the call light system was or 3 resident rooms (Rooms	F 49	Resident Affected: On 4/12/2017 whe the Director of Nursing was notified by surveyor of concerns from the previou day's med pass, Nurse #2 was suspen and later terminated. Other residents with the potential to be affected: All staff nurses received education on the Five Rights of Med Passes by the RN Nurse Supervisor v completion of 5/8/2017. All nurses we checked off on the medication administration skills checklist by 5/15/2017 by the Director of Nursing a	/ is nded e vith ere	

Event ID: RCN611

Facility ID: 922953

If continuation sheet Page 36 of 40

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	OMB NO. 0938-03 (X3) DATE SURVEY		
Interment of Dericiencies       (x) PROVIDENSOFFLIENCEIA         IDENTIFICATION NUMBER:       IDENTIFICATION NUMBER:         345129       NAME OF PROVIDER OR SUPPLIER					COMPLETED
		B. WING	04/13/2017		
		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
UTUMN	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 490	Continued From page	e 36	F 490		
F 520 SS=E	Continued From page 36 Cross refer to F 332: Assure facility had a medication error rate which were not 5 percent or greater: Based on observations, record reviews, and staff interviews the facility failed to maintain a medication error rate less than 5% as evidenced by 2 errors out of 30 opportunities for 2 of 3 residents (Resident #19 and Resident #55) observed during medication pass. This resulted in a facility medication error rate of 6.66%. F 332 was originally cited during the recertification survey of 03/24/16 for failure to ensure that the medication error rate was 5% or below as evidence by 2 errors out of 27 opportunities resulting in a medication error rate of 7.4% for 1 of 7 residents observed during medication pass (Resident # 105). Cross refer to F 463: Based on observations, record reviews, and staff interviews the facility failed to ensure the call light system was functioning properly for 3 resident rooms (Rooms 204 D, Room 204 W, and 216 D) on 1 of 3 resident halls. 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:		F 520	Systemic Changes: Medication administration education and observe by Director of Nursing or Administrat Nursing Staff will occur quarterly. Quality Assurance/Monitoring: Th Administrator will ensure that the medication administration education observations are completed quarter licensed nurses. Random monitorin occur and will be reported to the Qu Assurance Committee on an ongoin basis until the issue has been resolved	tive ne and ly for ng will ality g

Event ID: RCN611

Facility ID: 922953

If continuation sheet Page 37 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129		(X1) PROVIDER/SUPPLIER/CLIA			JLTIPLE CONSTRUCTION DING		SURVEY LETED
		345129	B. WING			04/13/2017	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				007 HOWARD STREET IOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page 37 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and		F	520			
	(g)(2) The quality ass committee must :	essment and assurance					
	(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and						
	(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;						
	Secretary may not rec records of such comm such disclosure is rela	mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this					
		and correct quality					
	interviews the facilitie Assurance Committee implemented procedu interventions that the April of 2016. This wa which was originally of	ns, record reviews and staff s Quality Assessment and e failed to maintain irres and monitor these committee put into place in is for one recited deficiency cited in March of 2016 on a or and subsequently recited in			Resident Affected: On 4/12/2017 when the Director of Nursing was notified by surveyor of concerns from the previous day's med pass, Nurse #2 was suspend and later terminated. Other residents with the potential to be affected: All staff nurses received	ded	

Facility ID: 922953

If continuation sheet Page 38 of 40

PRINTED: 05/16/2017

	TERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039 (X3) DATE SURVEY		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345129		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING					
		B. WING		0	04/13/2017			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•			
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)			ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE		
F 520			F 52	-				
	The deficiency was in facility did not have a percent or greater. T facility during two fed	urrent recertification survey. the area to assure the medication error rate of 5 he continued failure of the eral surveys of record show tes inability to sustain an irrance Program.		education on the Five Right Passes by the RN Nurse Su completion of 5/8/2017. All checked off on the medicati administration skills checklis 5/11/2017 by the Director of RN Supervisors.	upervisor with nurses were on st by			
	Findings included: This tag is cross referred to:			Systemic Changes: Medi administration education an by Director of Nursing or Ad	d observation Iministrative			
	error rates of 5 percer observations, record	did not have medication nt or greater: Based on reviews, and staff interviews aintain a medication error		Nursing Staff will occur qua nurse will be observed to er are following the five rights administration.	nsure that they			
	rate less than 5% as	evidenced by 2 errors out of of 3 residents (Resident 5) observed during s resulted in a facility		Quality Assurance/Monitorin Administrator will ensure that medication administration e observations are completed licensed nurses.	at the ducation and			
	facility was cited for fa medication error rate evidence by 2 errors resulting in a medicat	tion survey of 03/24/16 the ailure to ensure that the was 5% or below as out of 27 opportunities ion error rate of 7.4% for 1 ed during medication pass		In addition, the results of the checklists will be reviewed of monthly QA meeting to dete nursing needs further educa frequent oversight to ensure error rate of less than 5%. monitoring will occur and wi to the Quality Assurance Co	during the ermine if ation or more a medication Random III be reported			
	the Administrator and explained the Quality Committee used plan a certain period of tim deficiencies. The Adu done training for nurs medication administra	ministrator stated they had		ongoing basis until the issue resolved.				

Facility ID: 922953

If continuation sheet Page 39 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/16/2017 APPROVED ). 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
345129		B. WING			_	04/13/2017			
NAME OF PROVIDER OR SUPPLIER			•		STREET ADDRESS, CITY, ST	TATE, 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 LSC IDENTIFYING INFORMATION)	ID PREF TAG	≡IX	PROVIDER'S (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 520	he was not sure why medications to achiev but more work would Director of Nursing st nursing staff had faile	staff had failed to administer ve a rate less than 5 percent have to be done. The ated she did not know why d to achieve a medication 5 percent but it would be	F	520					

Event ID: RCN611

Facility ID: 922953

If continuation sheet Page 40 of 40