	-	ID HUMAN SERVICES			FOR	MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>′</i>		СОМ	E SURVEY PLETED
		345280	B. WING			C / /21/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
		vas conducted from 6/15/17 nediate Jeopardy was				
	CFR 483.12 at tag F2 CFR 483.25 at tag F3	157 at a scope and severity J 224 at a scope and severity J 309 at a scope and severity J 323 at a scope and severity J				
	The tags F224, F 309 Substandard Quality), and F 323 constituted of Care.				
		began on 4/14/17 and was An extended survey was				
F 157 SS=J	483.10(g)(14) NOTIF (INJURY/DECLINE/R		F 15	7		7/17/17
	(g)(14) Notification of	Changes.				
	consult with the resid	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-				
		ving the resident which as the potential for requiring n;				
	mental, or psychosoc deterioration in health	n, mental, or psychosocial reatening conditions or				
	(C) A need to alter tre a need to discontinue	eatment significantly (that is, an existing form of				
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					07/13/2017

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

PRINTED: 07/21/2017

	-	D HUMAN SERVICES					FORM): 07/21/2017 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	LETED
		345280	B. WING					C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE,	ZIP CODE		
				12	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 157	 commence a new form (D) A decision to transport resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the resident and th	erse consequences, or to m of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment IO(e)(6); or ent rights under Federal or ns as specified in paragraph	F	157	DEFI	CIENCY)		
	update the address (r phone number of the This REQUIREMENT by: Based on record revi facility failed to consu regarding a change ir # 1) of two sampled re multiple falls. The res subdural hematoma, multiple body parts, a when she was transfe	a condition for one (Resident esidents who experienced ident was found to have a extensive bruising to nd gastrointestinal bleeding			Preparation and submis required by state an POC does not constitu purposes of general lia malpractice or any oth Corrective action taken found to have been aff 1a. Resident #1 no lon facility.	d federal law. Th tte an admission ability, profession er court proceed n for the resident fected:	nis for al ing. s	

Facility ID: 922954

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ С 345280 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1206 N FULTON STREET** AUTUMN CARE OF RAEFORD RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 157 Continued From page 2 F 157 staff failed to notify the physician that Resident # 1b. Resident #2's MD and Responsible 1 was acting differently after sustaining falls and a Party were notified on 4/14/17 and a head bruise to her head while taking aspirin. On to toe assessment was completed at that 6/10/17 the resident refused two meals and care time. Resident #2 was seen by the Nurse before the staff contacted the physician to obtain Practitioner 4/19/17 and ordered a CT of new orders. Interview with the facility physician chest without contrast. Right shoulder revealed the staff had not communicated the X-Ray and a CBC, and each order was extent of bruising the resident had on her body or completed. The MD was contacted on the change in her condition. The immediate June 18, 2017 and an order was obtained jeopardy was removed on 6/17/17 when the at that time for Tylenol 325 MG as needed. facility provided an acceptable credible allegation of compliance. The findings included: Corrective action taken for those residents having the potential to have been Record review revealed Resident # 1 resided at affected: the facility from 4/18/17 until 6/10/17. According 2a. An assessment was conducted on to the medical record the resident had the 6/17/17/for current residents that had falls following diagnoses: advanced Parkinson's since June 1st. disease, frontotemporal dementia with pseudo 2b. As of June 1st fall incidents have been audited to include head to toe bulbar affect, chronic atrial fibrillation, iron deficiency anemia, hyperglycemia, hypertension, assessments, neurological checks, pain alopecia totalis (loss of hair), healed fracture of assessment and intervention as warranted RP notification and MD the right humerus, history of falls; chronic kidney disease, scoliosis, and hypothyroidism. notification. 2c. A review of the 24 hour report and Review of physician orders revealed the resident changes in condition will be discussed was admitted on 4/18/17 with an order for Aspirin and reviewed in clinical meeting. 325 milligrams (mg) daily for Atrial Fibrillation. (Aspirin can be used as an anti-coagulant.) Measures that will be put into place or systemic changes made to ensure that Record review revealed the physician assessed the deficient practice will not occur: the resident on 4/21/17 and noted that there was 3a. Re-education on notification of no bruising or abnormal bleeding as of the responsible party and Physician will be completed by July 17th, 2017 to licensed physician's assessment date, and the resident's nurses. This will include SBAR/change in last hemoglobin was noted by the physician to be 9.8 (Normal range 12-16). condition. 3b. Newly hired nurses will be educated Review of the resident's Minimum Data Set on notification of responsible party and (MDS) assessment, dated 4/25/17, revealed the Physician by DON/designee.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 922954

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PRINTED: 07/21/2017

		(X1) PROVIDER/SUPPLIER/CLIA	· /	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345280	B. WING		C 06/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/21/2017
				206 N FULTON STREET	
AUTUMN	CARE OF RAEFORD		I	RAEFORD, NC 28376	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET
F 157	Continued From page	3 3	E 157		
	resident was cognitive extensive assistance bed mobility, transfers hygiene, and bathing; assistance for ambula also coded the reside fractures within the la facility admission. Review of the resider revealed the staff iden risk for falls. The facil was that she not sust interventions added of devices as needed; a evaluate for unsteady safety measures; mai proper nonskid foot w treat as ordered. On 4 wheelchair brakes" w interventions. On 4/20 provide rest periods F "assist with transfers to the care plan interv and assist resident to PM" was added to the Review of the nursing 1 sustained a fall on 4 2 documented at this out of bed while gettir landed on her buttock bed. On 4/24/17 at 7: documented that the right flank but had no	ely impaired; needed from one staff member for s, dressing, toileting, ; and needed limited ation. This MDS assessment ont as having no falls or st 6 months prior to her ht's care plan, dated 4/18/17, ntified Resident # 1 was at ity's goal for the resident ain injury due to a fall. Listed on 4/18/17 were: ambulation ssess cognitive status, y gait, instruct on appropriate intain a safe environment, year; therapy to evaluate and 4/25/17 "anti rollback as added to the care plan 6/17 "assess for fatigue and PRN (as needed)" and and ambulation" was added yentions. On 6/9/17 "offer bed between 7 PM to 8 e care plan interventions. g notes revealed Resident # 4/24/17 at 6:00 AM. Nurse # time that Resident # 1 slid ng into her wheelchair, and ss with her back against the 18 AM, Nurse # 2 resident had a bruise to her	F 157	 3c. Based on DON/designee revents, failure of any employee with notification requirements wadditional education and couns Monitoring: 4a. The 24 hour report will be reidentify changes in condition and review 5x/week in clinical meetidensure ongoing compliance with notification policy for 12 weeks. 4b. An audit of changes in combe completed in clinical meeting ongoing compliance of Physicia responsible party notification requirements. 4c. Audits will be reviewed by the A committee monthly for 3 mont	to comply ill receive eling. eviewed to d SBAR ng to n dition will g to ensure in and he QA and

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	00,	21/2011
				12	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	fall of 4/24/17, Resider further falls until the d through 6/9/17, the re- falling three times with Record review reveals (Tuesday) at 5:42 PM Resident # 1 was obs her buttocks next to h the physician was ma On 6/8/17 (Thursday documented Resider The nurse noted Resi edge of her wheelcha onto the floor landing noted the resident wa her skin tone was nor documentation of brui indicated the physicia fall. Nurse # 1 was intervia and 6/16/17 at 9:46 A resident had fallen on incident had been log 6/10/17. The nurse por nursing notes which v (Saturday) at 5:12 PM Saturday entry, which occurred on 6/9/17 (F The entry read, "Write Resident observed wi and her right elbow re Resident had old brui right temporal area. R	ent # 1 did not sustain any ate of 6/6/17. From 6/6/17 sident was documented as nin these four days. ed a nursing note on 6/6/17 by Nurse # 3 noting erved sitting on the floor on er bed. The note indicated de aware of the fall.) at 7:55 PM Nurse # 2 t # 1 sustained another fall. dent # 1 was "sitting on the ir and slid out of the chair on her buttocks." Nurse # 2 s cooperative, pleasant, and mal. There was no ising or injury. The note n was made aware of the ewed on 6/15/17 at 2:00 PM M. Nurse # 1 stated the 6/9/17 (Friday) but the ged as occurring on binted to an entry in the vas dated 6/10/17 1. Nurse # 1 stated this documented a fall, riday) at 3:43 PM.	F	157				

Facility ID: 922954

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	S FOR MEDICARE &			E CONSTRUCTION		D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		SURVEY PLETED
			A. BUILDING			С
		345280	B. WING			/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		21/2017
				1206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD			RAEFORD, NC 28376		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETIO
F 157	Continued From page	e 5	F 15	7		
		ontact RP (name of RP) to	1 10			
		d fall." The note was signed				
	by Nurse # 1.					
		# 1 on 6/15/17 at 2 PM and				
		evealed she had been the				
	· ·	he fall on 6/9/17 at 3:43 PM.				
		# 4 had been in attendance				
		he TV room, but was caring				
		at the time and had not seen				
	Resident # 1 fall. Inte					
		ecked Resident # 1 in the TV e her back to her room and				
		ly at the time of the incident.				
		resident had some yellow				
		and a purple bruise to the				
		he time of her assessment.				
	Nurse # 1 stated the	resident continuously wore				
	either a wig or bonne	t secondary to her hair loss.				
		ne time of the incident the				
		under her bonnet, and she				
		ent's bonnet off to assess				
		se # 1 stated she felt the				
		ave let her remove the				
		ated she did let the physician d a bruise to her temple, but				
		change in the resident in				
		ange in condition to him. This				
	interview also reveale	-				
		cian about whether the				
	aspirin dosage should	d be evaluated.				
	Nurse # 2 was intervi	ewed on 6/16/17 at 9:16 AM.				
		staffing sheets, Nurse # 2				
		care for Resident # 1 from				
	-	riday) until 7:00 AM on				
	6/10/17 (Saturday). I	he nurse stated it often got				
	hectic on the unit whe	he nurse stated it often got ere Resident # 1 resided and together. According to				

Facility ID: 922954

If continuation sheet Page 6 of 100

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT		STRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	OMPLETED
							С
		345280	B. WING		<u>-</u> -		06/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP COD	DE	
	CARE OF RAEFORD				N FULTON STREET		
				RAEF	FORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 157	Continued From page	e 6	F 1	157			
		t she might have called and					
	told Resident # 1's re						
		her head, but she could not					
	recall the reason she	•					
	•	2, she recalled the assistant DON) talking to her the					
		/17 about Resident # 1, and					
		Resident # 1 was acting					
		vondering if she might have					
	-	on. Nurse # 2 did not recall					
		ent's physician regarding					
	this.						
	Interview with the AD	ON on 6/16/17 at 3:55 PM					
		ponsible for following up on					
	falls and accidents. T	he ADON stated she had					
		# 1 on the morning of					
		ise the resident had fallen on					
		ne ADON stated she had not esident # 1's temple on the					
		1/17. The ADON stated on					
		/17 she went to check on the					
		oted she had a bruise to her					
	temple which she had						
	-	N on Friday evening of					
		esident reach one time into					
		reaching for something that er pupils seemed to be small.					
		e did not have a pen light in					
		urological check, but she					
	had spoken to Nurse	# 1 and it was her					
		urse # 1 was going to follow					
		According to the ADON she physician directly about her					
	observations.	- priysician uneoliy about nel					
	NA # 2 was interview	ed on 6/16/17 at 11:10 AM.					
		d cared for Resident # 1 on					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_	(06/:	; 21/2017
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	CARE OF RAEFORD			1206 N FULTON STREET			
AUTUWIN	CARE OF RAEFORD			RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	NA # 2 stated Resident the air that were not the "hallucinating." NA # 2 Resident # 2 and she but was not exactly su There was no docume noting NA # 2's obser had been notified. NA # 3 was interviewe NA # 3 stated she arright 6/9/17 (Friday) and st residents from 7:00 P with NA # 3 revealed room when she arrive repeatedly stand up, a she tried to redirect the 3 stated the resident was medications from the Interview with Nurse # revealed she had been dayshift on 6/10/17 (S she had not received reported to duty that F bruised or injured. Nuk know the resident had NAs (NA # 6 and NA a reported they had fou giving her care. Nurse went to assess the re- have bruises on her b The nurse stated the and she immediately her supervisor.	nt # 2 reached for things in here; as if she were 2 stated this was different for had told a nurse about it, ure which nurse it was. entation in the nursing notes vations or that the physician ed on 6/17/17 at 10:45 AM. ived to work at 7:00 PM on ayed in the TV room with M to 9:00 PM. Interview Resident # 1 was in the TV ed at work, kept trying to and elbowed NA # 3 when he resident to sit down. NA # would scream, became nt to open her mouth for nurse. # 3 on 6/15/17 at 12:25 PM en on duty during the Saturday). Nurse # 3 stated anything in report when she Resident # 1 had been rse # 3 stated she did not d been hurt until two dayshift	F 15				

		MEDICAID SERVICES				IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING	G		
		345280	B. WING		C	
		345280				6/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE)E	
	CARE OF RAEFORD			1206 N FULTON STREET		
				RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIOI DATE
F 157	Continued From page	2 8	F 15	57		
1 107				57		
		revealed she had routinely 1, and the resident was				
		tive with care. NA # 6 stated				
		rday), she had last cared for				
	her on 6/6/17 (Tuesd					
	,	Resident # 1 was assigned				
		A # 6) had assisted with her.				
	NA # 6 stated Reside	nt # 1 would not eat nor				
	drink for breakfast or	lunch, and she refused care				
		NA # 6 stated after lunch				
		Resident # 1 to let them				
		and when they pulled back				
		ng to provide care there				
		ses on her arms, breast,				
		s. NA # 6 stated the bruising				
		verywhere." NA # 6 stated				
		the nurse. NA # 6 stated the present when she had last				
		1 on 6/6/17 (Tuesday).				
	NA # 7 was interview	ed on 6/16/17 at 12 noon.				
	Interview with NA # 7	revealed she had not				
	-	en she reported to duty on				
		s anything wrong with				
		stated Resident # 1 would				
		lunch and refused morning				
		ne nurse also tried to assist				
	,	e resident refused. NA # 7				
		e and NA # 6 went together when they pulled back the				
		ses on both arms, both hips,				
		er arm, on the side of her				
	-	and on her right head.				
	-	revealed she had not seen				
		d earlier because the				
		et and when they were				
		nnet tipped backward which				
	· •					
	revealed the bruising	. NA # 7 stated the head				

Facility ID: 922954

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
				1:	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD			R	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	9	F	157				
	Review of the record regarding the bruising NA # 7 and Nurse # 3	that was found by NA # 6,						
	6/10/17 at 5:38 PM "r Called (responsible p return call)." This was nursing notes regardi	rd Nurse # 1 noted on new order noted-CT of hand. arty) and left message to the only notation in the ng any communication with an since the resident had ay) at 3:43 PM.						
	revealed Nurse # 3 ha 6/10/17 and told her F "everywhere." Nurse a understanding that the bruising and not a cha # 1 stated she called if the resident had bee she told the physician he therefore wanted h hospital. The nurse cl CT of the head and no been indicated in the was arranged for Res	e main concern was the ange in mental status. Nurse the physician and he asked en falling. Nurse # 1 stated the resident had fallen, and her sent for a CT scan at the arified the order was for a ot of the hand which had notes. The nurse stated it ident # 1 to go to the epartment via way of a						
	6/15/17 at 5:25 PM re her at home and the r the change in Reside DON stated she had j at the facility and ther resident much better stated Nurse # 1 was	N (Director of Nursing) on evealed Nurse # 3 had called main concern seemed to be nt # 1's mental status. The ust recently been employed efore Nurse # 1 knew the than she did. The DON planning to go in to work, d Nurse # 1 communicate						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/21/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345280	B. WING			06/2	C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		S ⁻	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
			12	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD		R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 157	the bruising was not of would have gone to the called. A review of the reside administration record received her prescribe of Aspirin daily from 6 There was no indicati staff had consulted w the Aspirin should be began falling. Review of 6/10/17 EF the resident's bruising physician noted the re- right parietal area of h right elbow, the right l left flank. He further m with a Hemoglobin lev physician documente GI (gastrointestinal bl was grossly guaiac pe CT scan of the reside revealed she had a fr hematoma measuring thickness. An interview with the on 6/17/17 at 7:00 PM reason for the resider her repeated falls. Ac staff had notified him on 6/9/17, but they had other changes in her (6/9/17), the extent of with him regarding the	the DON stated the extent of conveyed to her or she the facility when she was ent's June 2017 medication (MAR) revealed she had ed dosage of 325 milligrams 6/6/17 through 6/10/17. on in the record the facility ith the physician regarding if held when the resident R medical records revealed g was extensive. The ER esident had bruising on the her head; the right flank, the hip, the right knee, and the toted she had critical anemia vel of 5.9 which the d was "likely secondary to a eed)." The resident's stool positive for blood in the ER. A nt's head on 6/10/17	F 157				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/21/2017 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			(06//	; 21/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
			1	206 N FULTON STREET			
	CARE OF RAEFORD		1	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
TAG F 157	Continued From page at the dosage of 325 i residents, and Reside with the dosage. Review of the residen she passed away on a death certificate the p cause of death as "su "complications of a fa On 6/29/17 at 4:52 PN informed of the immer provided a credible al 6/18/17. The allegation Credible Allegation of Resident # 1 has diag limited to Lewy Body disease, Pseudo Bulk Upon admission, she for falls. Subsequent a fall risk as to prever sustained three separ and 6/9/17 which resu areas of her body. Th unwitnessed in the da 3:45 pm. Resident #1 knee with the other fo arm was on a chair ar wheelchair. Resident by the Unit Manager a dayroom and a head	e 11 milligrams daily for ent # 1 had been admitted t's death certificate revealed 5/14/17 at 6:30 PM. On the hysician had listed the bdural hematoma" and ll." <i>A</i> , the administrator was diate jeopardy. The facility legation of compliance on on of compliance indicated: Compliance mosis including but not Dementia, Parkinson's ar, anemia, and A-fib. was determined to be a risk y, she was care planned for at injuries. Resident #1 ate falls on 6/6/17, 6/8/17 ilted in bruising to multiple	F 157	Di		TE	DATE
	spoke with the Unit M observation. The Uni area where the bruise #1's forehead, but did	resident's forehead and anager regarding the t Manager observed the was located on resident not complete a head to toe ise to the forehead was not					

Facility ID: 922954

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	S FOR MEDICARE &					IO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		BENTIFICATION NUMBER.	A. BUILDING				
					С		
		345280	B. WING		0	6/21/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	CARE OF RAEFORD			1206 N FULTON STREET			
	CARE OF RAEFORD			RAEFORD, NC 28376			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
F 157	Continued From page	e 12	F 15	7			
		by the UM and the extent					
		ned due to the UM not					
		m resident #1's head. The					
		at resident #1 didn't let UM					
		. The Unit Manager failed to					
		be assessment immediately					
		tion of the bruise to the					
		UM notified the attending					
		he fall and bruise to head.					
		e bruise to resident #1's					
		d neuro checks at that time.					
		tarted following the MD					
		tinue based on the facility's					
	policy. On 6/10/17, r	-					
		refused to get out of bed or					
		offered by staff. She refused					
		away. Thru encouragement,					
		sist resident with ADL care					
		her body. At this time she					
		aking. The nurse was					
		ed the DON at 3:25 pm					
		of meals, refusal of care					
		An order was obtained to					
	send resident #1 to h						
	Resident was transpo						
	wheelchair at 5:15pm						
	transferred to hospita	al and admitted with subdural					
		eed. Resident later expired					
		e failed to complete a					
		assessment at time of fall					
	per policy. The nurse	e also failed to contact the					
		to Resident #1. Resident					
	#2 sustained a bruise	e to right armpit that was					
	identified on 4/14/17.	The RP and MD were					
		however, the nurses failed					
		the bruise for any changes.					
	In addition, the nurse	s also failed to advise the					
	1		1			1	
	MD of changes to res	sident's #2 area to right					

Facility ID: 922954

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_	(06/2	C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
			1	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD		F	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	on 4/19/17 and ordered chest and X-Ray to rig results later revealed osteopenic bones. For the resident affect All residents who sus 2017 were assessed use of an audit tool to head to toe assessme regarding changes in assessment audit incl medical record to ens in place to include con changes to meet the or affected residents. A record was conducted appropriate interventiis subsequent to each far education was provide Plan to identify other in the deficient practice Other residents who a practice will be identiff that will be conducted have had falls since J be reviewed by Direct persons for compliance education will be prov another resident that failure to conduct ass policy. Resident #2 s to the right armpit. T Party were both notified documentation to incl assessments which we	ed CT without contrast to the ght shoulder in which the a hematoma with ted: ted: ted: ted: ted: ted: ted: ted:	F 157				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/21/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345280	B. WING		C 06/21/2017
NAME OF P	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, 2	
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE IENCY)
F 157	resident was seen by that time a CT of che shoulder X-Ray and a results of the tests re hematoma. It was of the medical record the assessment was con medical record reflect lower spine and there X-rays to address the The compression frac- to admission to the fa admission evaluation observed resident #2 ADL care. MD notifie medication ordered fa Action Taken to Fix th Re-education to all n 6/17/17. All Nursing nurses and CNAs we either via phone or in following: Fall Manag Handling of residents to Toe Assessments, procedure, and Neur Procedure. All CNAs regarding reporting a nurse through the us Tool." All employees phone will receive wr to work. The Neurological che on 6/17/17 to all licer address the frequence follows: Every 15 mi 30 minutes for 4 hour hours, then every 4 h	w the Nurse Practitioner. At est without contrast, Right a CBC were ordered. The evealed an intermuscular determined from review of hat no head to toe ducted for the resident. The ests compound fracture to the e have been no follow up e affected area of the spine. ctures were sustained prior acility and are noted on a by MD. Staff have calling out in pain during ed on 6/18/17 to have pain or resident #2.	F	157	

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	S FOR MEDICARE &	WEDICAID SERVICES				D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · ·	SURVEY
			A. BUILDING			с
		345280	B. WING		06/21/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		21/2011
				1206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD			RAEFORD, NC 28376		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 157	Continued From pag	e 15	F 15	7		
1 107						
		ig staff on 6/17/17 to include esses to include assessment				
	for pain.					
		J removal on 6/17/17.				
		on was verified on 6/21/17 at				
		no longer worked at the				
		be reached by phone for				
		of current resident records lls, injury and staff action.				
		or of Nursing was interviewed				
		M. She provided the Fall				
	Management Protoc	-				
	Neurological Check	policy inservice details. On				
		M through 5:42 PM, random				
		as Nursing Assistants				
		nt #1 following the falls, were				
		steps of the "Stop and				
		cation, assessment and bers interviewed were able to				
		eceived regarding falls,				
		cy regarding neurological				
		otification, neglect and how to				
		in condition. The facility was				
		ence that they had completed				
		ents and inserviced all staff				
		sidents in the facility were				
		were no concerns. The				
F 224	483.12(b)(1)-(3) PR	was removed on 6/17/17.	F 224	4		7/17/17
SS=J		EGLECT/MISAPPROPRIATN	F 224	*		// / / / / / /
	8483 12 The residen	t has the right to be free from				
		t has the right to be free from ppropriation of resident				
	-	ation as defined in this				
		es but is not limited to				
		al punishment, involuntary				

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE). 0938-039 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	i	COMP	LETED
			5.44946			C
		345280	B. WING			21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION DATE
F 224	Continued From page	e 16	F 22	4		
	not required to treat t	he resident's symptoms.				
	483.12(b) The facility implement written pol	must develop and licies and procedures that:				
		event abuse, neglect, and nts and misappropriation of				
	(b)(2) Establish polici investigate any such	es and procedures to allegations, and				
	§483.95,	as required at paragraph				
	by:					
	-	n, record review, staff		Preparation and submission	of this POC	
	interviews, family inte	1 3		is required by state and fede		
		sidents # 1 and Resident #		POC does not constitute an		
		who had sustained injuries		purposes of general liability,	•	
		to assess the residents and		malpractice or any other cou	rt proceeding.	
	provide care. The fac Resident # 1, commu			Corrective Action taken for the	ne residents	
	physician the residen	-		found to have been affected		
		services when the resident		1a. Residents #1 no resides		
		e a head injury and a change		1b. Resident #2's MD and F	-	
		sustaining three falls within		Party were notified on 4/14/1	7 and a head	
	-	ecision was made to send		to toe assessment was comp		
		edical treatment, the facility		time. Resident #2 was seen	-	
	The resident was fou	gency medical services.		Practitionaer4/19/17/ and ore the chest without contrast, R		
		nematoma, and critical lab		X-Ray and a CBC, each orde		
	work when transferre			completed. The MD was con		
	resident expired four	days following her facility		June 18, 2017 and an order	was obtained	
		y failed to assess Resident #		at that time for Tylenol 325 N	IG as	
	-	ication of a painful armpit		needed.		
		was identified to have an nematoma six days after the		Corrective action taken for th	nose residente	
	armpit bruise was ide	-				

Facility ID: 922954

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ULINILIN	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938	<u>3-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
					С	
		345280	B. WING		06/21/201	17
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
				1206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD			RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMP THE APPROPRIATE DA	K5) LETIC ATE
F 224	Continued From page	e 17	F 22			
1 22 1			F 22			
		pain. The facility also failed nt and management of		affected: 2a. An assessment audit	was conducted	
		he experienced while		on 6/17/17 for current resi		
	· ·	sistance from staff. The		falls since June 1st.		
	•	ed to be in pain during		2b. As of June 21st fall in	cidents have	
	transfers.			been audited to include he		
	liansiers.			assessments, neurologica		
	Immediate jeonardy I	began on 4/14/17 when		assessment and intervent		
		as cognitively impaired and		warranted, RP notification		
		ance for her care, was		notification.		
		ainful armpit bruise. The		2c. A review of the 24 ho	ir report and	
		as the resident and on		changes in condition will b		
	-	was noted to also have a		and reviewed in clinical m		
		On 4/20/17 a computerized			coung.	
		realed the resident had an		Measures that will be put	nto place or	
		oma to her chest muscle for		systemic changes made to	-	
		ceived anything for pain.		the deficient practice will r		
		o neglected at a level of IJ.		3a. Re-education on Abu		
		staff identified Resident # 1,		policy and procedure, fall	•	
		falls within four days, had a		(including Safe Handling of		
		nd they failed to assess the		regarding transfers, Head		
		nd worsening injury in order		assessments,) Neurologic		
		municate to the physician the		and Procedure, Pain Man	-	
	resident's medical sta			Protocol and Stop and Wa		
	identification of the h			completed by DON/desigr		
	knowledgeable the re			nurses and CNAs by 7/17		
		the air, refused fluids,		3b. New employees will b		
		efused care. Nurses did not		Abuse/Neglect policy and		
		nad extensive bruising on		Management (including S		
	-	body until the afternoon of		residents regarding transf		
	-	nt was transported out for		Assessments,)Abuse/Neg		
		n- emergent transport. The		procedure, Neurological C		
		was removed on 6/18/17.		Procedure, Pain Manager	-	
		n out of compliance at a		and Stop and Watch Tool		
	-	evel D (no actual harm with		DON/designee.		
		an minimal harm that is not		-		
	immediate jeopardy)			Monitoring:		
		lement the new procedures		4a. A review of each incid	lent and the 24	
	to assure residents a	re assessed and not		hour report will be discuss	ed and	

Facility ID: 922954

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			()(0)			NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	ATE SURVEY
						С
		345280	B. WING		(06/21/2017
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
	CARE OF RAEFORD			1206 N FULTON STREET		
				RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page	e 18	F 22	4		
	neglected.			reviewed 5x/week in clinical r	meeting to	
	The findings included	:		ensure ongoing compliance v	with policy for	
	1 The facility's neurol	ogical checks policy, last		12 weeks.4b. A fall audit will be complete	ated by	
		06, was reviewed. According		DON/designee for each fall for	•	
		ical checks were to be		4c. Audits will be reviewed b		
	completed if a resider	•		A committee monthly for 3 m	onths.	
		na. The frequency of the ne as follows: every 15				
		every 30 minutes for four				
	hours; every hour for	4 hours; every 4 hours for				
	16 hours; and every 8	3 hours for 48 hours.				
	Record review reveal	ed Resident # 1 resided at				
		17 until 6/10/17. According				
	to the medical record					
	• •	advanced Parkinson's				
	bulbar affect, chronic	ral dementia with pseudo atrial fibrillation iron				
		/perglycemia, hypertension,				
		of hair), healed fracture of				
		story of falls; chronic kidney				
	disease, scoliosis, an	a nypotnyrolaism.				
	Record review reveal	ed the physician assessed				
		17 and noted that there was				
	no bruising or abnorn	•				
		d her last hgb (hemoglobin) sician to be 9.8. (Normal				
		sician noted in his 4/21/17				
		e let me know about any				
	changes in behavior f					
	exacerbation of today	1 3 135UCS.				
	Review of the resider	nt's MDS (Minimum Data				
		ed 4/25/17, revealed the				
	resident was cognitive					
	bed mobility, transfer	from one staff member for				

Facility ID: 922954

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345280	B. WING				C / 21/2017
NAME OF P	ROVIDER OR SUPPLIER		- I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
AUTUMN	CARE OF RAEFORD				1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	hygiene, and bathing; assistance for ambula also coded the reside fractures within the la facility admission. From 6/6/17 through documented as falling four days. Record review reveal on 6/6/17 (Tuesday) a noting Resident # 1 w floor on her buttocks noted the resident wa none were noted. Nurse # 3 was intervie PM. Nurse # 3 stated # 1 and found no brui 6/6/17. A nursing progress no (Wednesday) at 4:25 documentation at this responsive and coope notation made that th bruises or injuries. Nurse # 3 was intervie PM. Interview with Nu- resident had no bruise A nursing progress no at 4:25 AM revealed a head to toe assessme found to be pleasant is was signed by Nurse	and needed limited ation. This MDS assessment int as having no falls or st 6 months prior to her 6/9/17, the resident was g three times within these ed a nursing progress note at 5:42 PM by Nurse # 3 vas observed sitting on the next to her bed. The nurse is assessed for injuries and ewed on 6/15/17 at 12:25 d she had checked Resident sing or injury after her fall on ote dated 6/7/17 AM by Nurse # 3 contained time that the resident was erative, and there was no e resident had sustained ewed on 6/15/17 at 12:25 urse # 3 revealed the es on her assessment. ote dated 6/8/17 (Thursday) a nurse had completed a ent, and the resident was and cooperative. The note	F	224			

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PRINTED: 07/21/2017

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/21/2017 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE COMP	SURVEY PLETED
		345280	B. WING			_		C 21/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page bruising or injuries.	20	F	224				
	Review of a "Bi Week at 12:30 PM revealed current skin issues.	ly Skin Check" dated 6/8/17 Resident # 1 had no						
	(RP) on 6/16/17 at 10 visited Resident # 1 o afternoon and stayed	with her until 7 PM. The RP Resident # 1 had bruises on						
	documented Residem The nurse noted Resi edge of her wheelcha onto the floor landing resident was coopera tone was normal. The	te dated 6/8/17 at 7:55 PM t # 1 sustained another fall. dent # 1 was "sitting on the ir and slid out of the chair on her buttocks." The tive, pleasant, and her skin note was signed by Nurse cumentation of bruising or						
	Nurse # 2 stated Resi room when she susta (Thursday) at 7:55 PM with Nurse # 2, she has to her room, lifted her of bruising, and could	ewed on 6/16/17 at 9:15 AM. ident # 1 had been in the TV ined the fall on 6/8/17 <i>I</i> . According to the interview ad taken the resident back clothes, found no evidence not recall any injury noted led on 6/9/17 (Friday) at 7						
	assessment of Reside entered on 6/9/17 (Fri 2. Nurse # 2 noted the	gress note which noted an ent # 1's condition was iday) at 3:25 AM by Nurse # e resident was pleasant and skin tone was normal. There n of bruising or injury.						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_		C 21/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	21	F 224	Ĺ			
	2 on 6/9/17 at 6:56 Al	ote was entered by Nurse # M noting the resident had a t elbow. There was no the note.					
	AM. Nurse # 2 could r observed from her as during her shift from 7 6/9/17. She did not re hematoma on Friday	(6/9/17) morning before she the resident's arm being ted to work on Friday					
	record on 6/9/17 (Frid 1. Nurses # 1 docume order was received to and that the resident's was notified. There w	ote was entered into the lay) at 2:56 PM by Nurse # ented at this time that an o x-ray Resident # 1's elbow is RP (Responsible Party) as no documentation of sident's condition or of the e.					
	completed on 6/9/17 of "indication" for the x-r The X-ray report note swelling" but no defini	revealed a mobile x-ray was of the resident's elbow. The ay was noted to be "pain." d there was "mild soft tissue ite bony abnormalities. The ally signed by the radiologist					
	According to the nurshematoma to her arm and no other injury. T	ewed on 6/15/17 at 2:00 PM. e the resident had a on the morning of 6/9/17 he nurse stated this had to the physician and an x-ray					

Facility ID: 922954

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP	SURVEY LETED
		345280	B. WING		-		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		-
			1	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD		F	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	22	F 224				
		progress note of 6/9/17 here were no other nursing ess notes for 6/9/17.					
	2:00 PM that the follow the progress notes for incident that occurred entry read, "Writer cal observed with her righ right elbow resting on assessed for injuries; had old bruising to he temporal area. Reside pain. MD in facility, no Writer attempted to co inform of unwitnessed Interview with Nurse a revealed she had bee	ent had no complaints of otified of unwitnessed fall. ontact RP (name of RP) to I fall." # 1 on 6/16/17 at 9:46 AM in the nurse to respond to					
	# 1 revealed she had TV room, but did not t and look at her entire incident. Nurse # 1 si yellow bruising on her the right temple area assessment. Nurse # continuously wore eith secondary to her hair the time of the incider under her bonnet, and resident's bonnet off t Nurse # 1 stated she have let her remove to she did let the physici bruise to her temple.	1 stated the resident her a wig or bonnet loss. Nurse # 1 stated at ht the bruise did not extend					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/21/2017 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			06/:	C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE	•	
A			12	06 N FULTON STREET			
AUTUMIN	CARE OF RAEFORD		R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 224	6/9/17 (Friday), and s a change in Resident she had started a new sheet for the resident checks up until 6:45 F copy of the neurologic The last neuro check record was 6:45 PM. was blank, and Nurse records to show the n completed per the fac Nurse # 1 did not kno not continue the checc NA # 4 was interviewe NA # 4 stated she had Resident # 1 fell on 66 not recall helping with Friday evening nor an On 6/10/17 there was neurological check an 1's physical status for nursing progress note on 6/10/17 at 12:25 A at this time that the re were normal. There w of any of the bruising identified earlier by Ne was extending. Nurse # 2 was intervie According to facility st had been assigned to 7 PM on 6/9/17 (Frida (Saturday). Nurse # 2 she came to work on Resident # 1's right el	he stated she had not noted # 1. According to Nurse # 1 prological assessment flow and completed neuro PM. The nurse provided the cal assessment flow sheet. documented on the flow The rest of the flow sheet # 1 could not find any other euro checks had been cility's protocol schedule. w why the next nurse did ks per schedule. ed on 6/16/17 at 3:40 PM. d been present when /9/17. NA # 4 stated she did the Resident for the rest of my bruises.	F 224				

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUI T	IPLE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	NG	· · /	IPLETED
						С
		345280	B. WING		0	6/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET		
				RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 224	Continued From page	e 24	F 2	224		
		neurological checks on the				
		ave documented them.				
	-	2, she recalled the ADON				
		nursing) talking to her the				
		/17 about Resident # 1, and				
		Resident # 1 was acting ering if she might have a				
	-	. The nurse did not recall				
		ent was acting differently.				
	-					
		ON on 6/16/17 at 3:55 PM				
		ponsible for following up on				
		he ADON stated she had # 1 on the morning of				
		use the resident had fallen on				
		ne ADON stated she had not				
	noticed a bruise to R	esident # 1's temple on the				
		9/17. The ADON stated on				
		/17 she went to check on the				
	-	oted she had a bruise to her				
	temple which she had	D not seen earlier. DN on Friday evening of				
		esident reach one time into				
		reaching for something that				
		er pupils seemed to be small.				
	The ADON stated she	e did not have a pen light in				
		urological check, but she				
	had spoken to Nurse					
	understanding that N up with the physician	urse # 1 was going to follow				
		ed on 6/16/17 at 11:10 AM. d cared for Resident # 1 on				
		rom 3 PM until 7 PM. NA # 2				
	-	eached for things in the air				
		is if she was "hallucinating."				
		is different for Resident # 2				
		urse about it, but was not				
	avaatly auro which a	urse it was. NA # 2 stated the				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FC	ED: 07/21/2017 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		345280	B. WING			C 06/21/2017
NAME OF P	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIF		
			120	6 N FULTON STREET		
AUTUMN	CARE OF RAEFORD		RA	EFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 224	resident always had s but she had a cap on 6/9/17 and she did no head. NA # 3 was interviewed NA # 3 stated she arri 6/9/17 (Friday) and st residents from 7 PM t 3 revealed Resident # when she arrived at w repeatedly stand up, a she tried to redirect th 3 stated the resident w angry, and did not wa nurse to give medicat not assisted her to be done so. NA # 5 was interview Interview with NA # 5 Resident # 1 slept Fri which began at 11 PM Resident # 1 normally and therefore she loo awaken her and was Interview with Nurse # revealed she had bee dayshift on 6/10/17 (S Nurse # 3 she had no she reported to duty t bruised or injured whi do neurological check not know the resident dayshift NAs (NA # 6 and reported they had giving her care. Nurse	ed on 6/17/17 at 10:45 AM. ived to work at 7 PM on ayed in the TV room with o 9 PM. Interview with NA # 4 1 was in the TV room vork, kept trying to and elbowed NA # 3 when he resident to sit down. NA # would scream, became nt to open her mouth for the ions. NA # 3 stated she had d and thought NA # 2 had ed on 6/15/17 at 11:30 PM. revealed she recalled day night during her shift 1 on 6/9/17. NA # 5 stated v did everything for herself ked in on her, but did not not aware of bruises. # 3 on 6/15/17 at 12:25 PM	F 224			

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	· · ·	E SURVEY IPLETED
		345280	B. WING		0	C 6/21/2017
NAME OF P	ROVIDER OR SUPPLIER		S [_]	IREET ADDRESS, CITY, STATE, ZIP COD		0/21/2017
AUTUMN	CARE OF RAEFORD			206 N FULTON STREET AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 224	have bruises on her b The nurse stated the and she immediately her supervisor. NA # 6 was interview Interview with NA # 6 cared for Resident # usually very cooperat prior to 6/10/17, she f 6/6/17. NA # 6 stated Resident # 1 was ass (NA # 6) had assisted Resident # 1 would n or lunch, and she refut them. NA # 6 stated the resident lunch and after lunch they finally let them assist her wi pulled back her cover care there were dark breast, back, thighs, a bruising seemed "like stated they immediate stated the bruising ha she had last cared for (Tuesday). NA # 7 was interview Interview with NA # 7 received a report whe 6/10/17 that there wa Resident # 1. NA # 7 not eat breakfast nor	back, legs, hip, and head. bruises were red in color called Nurse # 1, who was ed on 6/15/17 at 4:35 PM. revealed she had routinely 1, and the resident was tive with care. NA # 6 stated had last cared for her on on Saturday of 6/10/17, signed to NA # 7 and she d with her. NA # 6 stated ot eat nor drink for breakfast used care by swinging at the nurse also tried to feed d she refused. NA # 6 stated y convinced Resident # 1 to th care, and when they rs and clothing to provide purple bruises on her arms, and legs. NA # 6 stated the e it was everywhere." NA # 6 ely got the nurse. NA # 6 ely got the nurse. NA # 6 ad not been present when r Resident # 1 on 6/6/17 ed on 6/16/17 at 12 noon. revealed she had not en she reported to duty on s anything wrong with stated Resident # 1 would lunch and refused morning he nurse also tried to assist	F 224			

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	OF DEFICIENCIES	MEDICAID SERVICES			INSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	OMPLETED
						с	
		345280	B. WING				06/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODI		
A T MANI	CARE OF RAEFORD			1206	N FULTON STREET		
	CARE OF RAEFORD			RAE	FORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 224	Continued From page	o 27	Í F.	224			
1 227		er arm, on the side of her		224			
		and on her right head.					
	-	revealed she had not seen					
		d earlier because the					
		et and when they were					
		nnet tipped backward which					
	-	. NA # 7 stated the head					
	bruise was about the	size of her hand.					
	Interview with Nurse	# 1 on 6/16/17 at 9:46 AM					
		ad called her at home on					
	6/10/17 and told her	Resident # 1 had bruises					
	"everywhere." Nurse	# 1 stated it was her					
	-	e main concern was the					
	-	ange in mental status. Nurse					
		the physician and he asked en falling. Nurse # 1 stated					
		the resident had fallen, and					
	he therefore wanted l						
		graphy) scan at the hospital.					
		as arranged for Resident # 1					
		out- patient department via					
		ncy transport service.					
		1 she had not thought					
		ion necessitated emergency gency room. The nurse also					
		erstanding the hospital					
		patient department was					
		ernoons. Therefore Nurse #					
	1 stated she contacte						
	transport service to ta						
		e did not know how the					
	resident ended up in	the emergency room.					
	Interview with the DC	N (Director of Nursing) on					
		evealed Nurse # 3 had called					
		main concern seemed to be					
		nt # 1's mental status. The					

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	was planning to go in had Nurse # 1 common The DON stated the e not conveyed to her of the facility when she w DON the resident left by non-emergency transform A review of the reside (medication administr had received her press milligrams of Aspirin of 6/10/17. The MAR was on 6/15/17 at 5:30 PM the ADON the MAR s the Aspirin was held. Review of 6/10/17 Em medical records revea was extensive. The E resident had bruising her head; the right fla hip, the right knee, an noted she had critical level of 5.9 which the "likely secondary to a The resident's stool w for blood in the ER. <i>A</i> head on 6/10/17 reve frontoparietal subdura mm (millimeters) in the An interview with the on 6/16/17 at 3 PM an revealed the most like extensive bruising wa According to the physi	he DON stated Nurse # 1 to work, and therefore she unicate with the physician. extent of the bruising was or she would have gone to was called. According to the the facility around 5:15 PM ansport. ant's June 2017 MAR ation record) revealed she scribed dosage of 325 daily from 6/6/17 through as reviewed with the ADON A and it was confirmed with howed no documentation hergency Room (ER) aled the resident's bruising R physician noted the on the right parietal area of nk, the right elbow, the right d the left flank. He further anemia with a Hemoglobin physician documented was GI (gastrointestinal bleed)." vas grossly guaiac positive A CT scan of the resident's aled she had a al hematoma measuring 5 ickness. resident's facility physician nd again on 6/17/17 at 7 PM ely reason for the resident's	F 224				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 07/21/2017 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_	(06/:	C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Friday (6/9/17), the ex- consulted with him reg According to the phys status in conjunction of require an immediate Emergency Room. Review of the resident she passed away on a death certificate the p cause of death as "su "complications of a fail 2. Resident # 2 was a 7/11/16 and had diagr dementia, osteoporos gastro-esophageal reg glaucoma, mood diso osteopenia, a history fractures affecting 12 ranged in severity from history of sternal fract review revealed the re and her last weight, d 68.5 pounds. Review of the resident Data Set) assessment the resident had a BIN mental status) score of not answer any quest assessment. The resi needing extensive ass dressing, toileting, and totally dependent on s resident's annual MDS	f any other changes on ktent of the bruising, or garding the Aspirin dosage . ician any change in mental with a head injury would evaluation at the t's death certificate revealed 6/14/17 at 6:30 PM. On the hysician had listed the bdural hematoma" and II." admitted to the facility on noses of failure to thrive, is, anemia, hypertension, flux disease, anxiety, rder, vitamin D deficiency, of multilevel compression of the vertebra which m mild to severe; and a ure with deformity. Record esident was 97 years of age ocumented on 6/3/17, was t's quarterly MDS (Minimum t, dated 2/23/17, revealed MS (brief interview for of "0." This indicated she did ions correctly on the dent was assessed as sistance with transfers, d hygiene. The resident was staff for her bathing. The	F 224				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		345280	B. WING			C 06/21/2017		
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		-	
AUTUMN	CARE OF RAEFORD				1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 224	Continued From page	30	F	224	4			
	updated on 5/26/17, be resistive to care an plan also noted the re- altered skin integrity. some of the listed car included: skin assess needed, and to notify needed. According to required a "total lift fo A problem was also o plan which identified for pain. Staff were direct assess the resident for Review of the record progress note by Nur- 8:56 AM noting that th her right arm pit which centimeters (cm.) Thi 10:48 AM on 4/14/17 the area was bluish/rea arm and inner upper a director of nursing) was communication note was resident complained the was touched. Review of Resident # revealed no document any pain medication of documented Residen	ments quarterly and as MD of changes in skin as the care plan the resident r transfers." In the resident's current care the resident had chronic ted on the care plan to or pain. revealed a dayshift nursing se # 5 on 4/14/17 (Friday) at he resident had a bruise to h measured 8 X 5 s same nurse noted at the following information: ed and was under her right arm, the ADON (assistant as notified, a physician was completed, and that the hat the area hurt when it 2's April 2017 MAR tation Resident # 2 received						
		ailable for interview during rview with the ADON on						

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PRINTED: 07/21/2017

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
					с	
		345280	B. WING		0	6/21/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224	e e i i i i i e e i e e e e e e e e e e	e 31	F 22	4		
	6/17/17 at 1:06 PM.					
	(Friday) at 10:48 AM the bruise existed, an or the resident's phys progress notes until 4					
	Review of the NP's (Nurse Practitioner's) 4/19/17 note revealed the resident had a chest bruise in addition to the right axilla (armpit) bruise. The NP ordered a CT (computerized tomography) of the chest and blood work.	ident had a chest bruise in xilla (armpit) bruise. The NP iterized tomography) of the				
	Thursday after the bri Friday 4/14/17. The fi had a "large area of h pectoralis major muse 6 cm (centimeter) mo intramuscular hemato the extent of the resio fractures. The CT rep diffuse osteopenia; pu two of the compression compression fracture five of the compression documented as mode	7 which corresponded to uise had been found on indings revealed the resident high density within the right cle measuring 8.5 X 4.1 X 4. ust likely representing oma." The CT also showed dent's compression bort noted the resident had rior cement augmentation of on fractures; three of the s were documented as mild; on fractures were				
	(4/20/17) showing the completed a Bi-week	which the CT was done e hematoma, Nurse # 6 ly check of the resident's e # 6 documented the				

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		MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	E SURVEY
			A. BUILDING		C	
		345280	B. WING			
	ROVIDER OR SUPPLIER	545200		STREET ADDRESS, CITY, STATE, ZIP CODE	00	6/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			1206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD			RAEFORD, NC 28376		
	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	PECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETIO DATE
F 224	Continued From pag	e 32	F 22	4		
		ent skin issues. There was		·		
		e bruising in the nurse				
	progress notes for 4/					
	Interview with Nurse	# 6 on 6/17/17 at 3:15 PM				
		t included bruising on				
		7 skin assessment check				
		sessing for and documenting sores and not bruises.				
		soles and not bruises.				
	Review of Resident #	≠ 2's May 2017 MAR				
	revealed the resident	t received nothing for pain				
	during the month of N	May.				
	-	t director of nursing) was				
		17 at 1:06 PM. During the				
		reviewed Resident # 2's				
		the ADON, on a scheduled				
		omputer system prompts the In assessment after a bruise				
	-	to a resident's computerized				
		twenty four hours up until a				
		riod post injury. The ADON				
		mplications related to the				
		the assessments would be				
		2 hour period. In reviewing				
		N stated Resident # 2's first				
		following the identification of had not been completed by				
		the ADON the other				
	-	t been done because the				
	first 24 hour assessm	nent had been missed and				
		ceive the prompting. The				
		why the first 24 hour post				
		ad been missed. Interview				
		aled Resident # 2 had always al lift for transfer since her				
		with the ADON and a review				

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IND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 345280 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUTUMN CARE OF RAEFORD ID (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID F 224 Continued From page 33 bruising revealed some of the staff members had not been transferring and repositioning the resident correctly and the facility had concluded this potentially could have led to the resident's injury. Review of in-service materials following the incident revealed staff were to "have her lean forward with her upper body" in order that they "guide her hips back" in the wheelchair." Resident # 2 was observed to appear extremely thin and frail. Her bones were very prominent. The NAs worked to try to position the mechanical lift sling back beneath the resident in order that they complete the transfer, and it was observed that the resident was not cooperative. The resident was observed to complain of pain as they worked to get the sling beneath her and transfer her into the bed, and she was not cooperative in leaning forward so that they could place the sling beneath her and transfer her into the bed, and she was not cooperative in leaning forward so that they could place the sling beneath her so that they work hor have to move the resident as they worked to have to move the resident as they worked to have to move the resident as	COMPLETED C 06/21/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUTUMN CARE OF RAEFORD 1206 N FULTON STREET RAEFORD, NC 28376 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF COD (EACH ORRECTIVE ACTION CROSS-REFERENCED TO THE/ DEFICIENCY) F 224 Continued From page 33 bruising revealed some of the staff members had not been transferring and repositioning the resident correctly and the facility had concluded this potentially could have led to the resident's injury. Review of in-service materials following the incident revealed staff were to "have her lean forward with her upper body" in order that they "guide her hips back" in the wheelchair." F 224 Resident # 2 was observed on 6/15/17 at 3:55 PM as nursing assistant (NA) # 6 and NA # 9 transferred the resident from her wheelchair to bed using a mechanical lift in order to provide care. The resident mas observed to appear extremely thin and frail. Her bones were very prominent. The NAs worked to try to position the mechanical lift sling back beneath the resident in order that they complete the transfer, and it was observed that the resident was not cooperative in leaning forward so that they could place the sling beneath her. NA # 6 stated the NA, who had gotten the resident her so	06/21/2017
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NA, who had gotten the resident out of bed earlier, should have left the sling beneath her so	
earlier, should have left the sling beneath her so	
that they did not have to move the resident as	
much to get it positioned correctly. Upon	
completing the care the NAs again transferred	
the resident back from the bed to the wheelchair,	
and the resident complained once again she was hurting. According to these evening shift NAs the	
resident complained of pain anytime they	
transferred her. The NAs were asked if the nurse	
knew the resident hurt, and responded that the	
nurses did because the nurses heard her scream	
when she was transferred.	
Interview with the ADON on 6/17/17 at 3 PM	

Facility ID: 922954

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED
		345280	B. WING		C 06/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 224	revealed the facility u assessments. One as	sed two different pain ssessment was intended for	F 2	224	
	voice their pain level facility also had a pair cognitively impaired,	ognitively alert and could on a scale of 1-10. The n assessment for the which required staff to sidents expressed pain in			
	other ways such as s A review of Resident the ADON revealed s been identified on 4/2	triking out or pushing away. # 2's pain assessments with ince the hematoma had 20/17 the nurses had not			
	They had used a num According to the ADC	nitively impaired resident. heric evaluation of her pain. NN the nurses should have			
	impaired residents. T would need to tell the	assessment for cognitively The ADON stated the NAs nurses about how the care so they could address			
	for pain thus far in the was confirmed with N AM. The nurse stated	had not received anything e month of June 2017. This lurse # 4 on 6/17/17 at 10:25 I the resident did not have lered for pain, but she could			
	6/17/17. NA # 8 was i 6/17/17. According to say she hurt sometim	to care for Resident # 2 on interviewed at 10:30 AM on o NA # 8, Resident # 2 would les, but then would say she ore she concluded that the d not in pain.			
	informed of the imme	M, the administrator was diate jeopardy. The facility llegation of compliance on			

Facility ID: 922954

If continuation sheet Page 35 of 100

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		· · ·	TE SURVEY MPLETED
	CONTRECTION		A. BUILDING			
			D MINO			С
		345280	B. WING			6/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
	CARE OF RAEFORD			1206 N FULTON STREET		
	CARE OF RAEFORD			RAEFORD, NC 28376		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO
F 224	Continued From page	e 35	F 22	14		
	-	on of compliance indicated:				
	F 224 Neglect	en or compliance indicated.				
	Credible Allegation of	f Compliance				
		gnosis including but not				
	-	Dementia, Parkinson's				
		par, anemia, and A-fib.				
		was determined to be a risk				
		ly, she was care planned for				
		nt injuries. Resident #1				
		rate falls on 6/6/17, 6/8/17				
	-	ulted in bruising to multiple				
	areas of her body. The					
		ayroom at approximately				
		1 was noted to be on one				
		oot flat on the floor. Her right				
		nd her left arm was on her				
		t was assessed by the Unit				
		d to a chair in the dayroom.				
		a bruise to resident's				
		with the Unit Manager				
	-	ation. The Unit Manager				
		here the bruise was located,				
		UM remove her night cap.				
		led to complete a head to				
	toe assessment imme					
	observation of the bru					
		ed the attending physician				
	regarding the fall and					
		s at that time. Neuro checks				
		g the MD order, but did not				
	continue based on the					
		efused breakfast. She also				
	refused to get out of I	bed or allow personal care				
		refused lunch, pushing staff				
		gement, staff were able to				
		DL care and noted bruises				
	on her body. At this t	time she was alert but not				
	speaking. The nurse					
	opeaning. The name					

Event ID: C5BS11

Facility ID: 922954

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_	(06/2	C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD		F	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	bruising. An order wa #1 to hospital for head transported to hospital Resident was later tra and admitted with sub bleed. Resident later nurse failed to comple assessment at time o extent of resident #1's by the nurse. The act The nurse also failed to a resident # 2's area to found to be a hemato For the resident affect On 6/17/17 all reside since June 1, 2017 w toe by the DON and A audit included a revie ensure that all measu contacting the MD of current needs of the a of the medical record to review appropriate assessments subsequ findings, staff educatio Plan to identify other the deficient practice Other residents who a practice will be identif that will be conducted have had falls since J be reviewed by Direct persons for compliant	sal of care and multiple as obtained to send resident d CT. Resident was al via wheelchair at 5:15pm. Ansferred to another hospital odural hematoma and GI expired at hospital. The ete a thorough head to toe f fall per policy and the s bruising was not assessed ual bruising to resident #1. to contact the MD to advice dent #1. In addition, the advise the MD of changes to right armpit which was later ma. ted: Ints who sustained a fall ere assessed from head to ADON. The assessment w of the medical record to res were in place to include any changes to meet the affected residents. A review was conducted by the DON interventions and uent to each fall. Based on on was provided by DON. residents who are at risk for are at risk for deficient ied by an assessment audit I for all current residents that une 1st. Assessments will tor of Nursing or delegated	F 224				

Facility ID: 922954

If continuation sheet Page 37 of 100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	· · ·	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		345280	B. WING		0	C 5/21/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD		0/21/2017
AUTUMN	CARE OF RAEFORD			206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 224	another resident that failure to conduct ass policy. Resident #2 a 4/14/17 to the right an Responsible Party we No further documenta when the resident wa Practitioner. At that t contrast, Right should ordered. Upon review the surveyor it was de toe assessment was The nurse failed to as resident # 2's conditional armpit. Action Taken to Fix th Re-education to all nu 6/17/17. All Nursing nurses and CNAs we either via phone or in following: Fall Manag Handling of residents to Toe Assessments, procedure, and Neuro Procedure. All nursin that Emergency Medi contacted for any res assessed and found to CNAs have received reporting any change through the use of a ' employees who recei receive written mater	had been affected by the sessments according to sustained a bruise on rmpit. The MD and ere both notified on that date. ation was noted until 4/19/17 as seen by the Nurse ime a CT of chest without der X-Ray and a CBC were w of the medical record by etermined that no head to conducted for the resident. assess for any change in on to include the area on the Problem urses and CNAs began on staff to include licensed re educated on 6/17/17 person regarding the ement, which includes Safe regarding transfers, Head Abuse/Neglect policy and pological Check Policy and pological Check Policy and pological Check Policy and pological Services (911) will be ident that has been to need emergency care. All education regarding in condition to nurse 'Stop and Watch Tool." All ved education via phone will ial upon returning to work. '7 to have pain medication	F 224			

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COMF	SURVEY PLETED
		345280	B. WING			C / 21/2017
NAME OF PF	ROVIDER OR SUPPLIER	L	s	TREET ADDRESS, CITY, STATE, ZIP CO		
	CARE OF RAEFORD			206 N FULTON STREET		
				RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page 6:04 PM. Nurse #1 n	e 38 o longer worked at the	F 224			
F 309 SS=J	interview. A sample of were reviewed for fall The Assistant Director on 6/21/17 at 5:07 PM Management Protoco Neurological Check p 6/21/17 from 2:02 PM nursing staff as well a involved with Resider able to articulate the Watch Tool" for notific reporting. Staff memb describe education re assessment, the polic checks, physician not respond to changes i able to provide evider an audit of the reside on 6/17/17. Other resi observed and there w immediate jeopardy w 483.24, 483.25(k)(I) F FOR HIGHEST WELL 483.24 Quality of life Quality of life is a fun- applies to all care and residents. Each reside facility must provide t services to attain or m practicable physical, well-being, consisten	a bolicy inservice details. On I through 5:42 PM, random as Nursing Assistants as Nursing Assistants at #1 following the falls, were steps of the "Stop and cation, assessment and bers interviewed were able to aceived regarding falls, cy regarding neurological cification, neglect and how to an condition. The facility was nee that they had completed ants and inserviced all staff idents in the facility were vere no concerns. The vas removed on 6/18/17. PROVIDE CARE/SERVICES L BEING damental principle that d services provided to facility lent must receive and the he necessary care and maintain the highest mental, and psychosocial t with the resident's assent and plan of care.	F 309			7/17/17

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	OF DEFICIENCIES	MEDICAID SERVICES	(Y2) MUUT	PLE CONSTRUCTION		10. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · ·	MPLETED
			A. BUILDIN	<u> </u>		С
		345280	B. WING			6/21/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		0/21/2017
	KOWDER OR SOLT EIER			1206 N FULTON STREET	-	
AUTUMN	CARE OF RAEFORD			RAEFORD, NC 28376		
				•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From page	<u>- 39</u>	F 3	na		
		nt and care provided to	10			
		ed on the comprehensive				
	•	dent, the facility must ensure				
		e treatment and care in				
		essional standards of				
	· ·	nensive person-centered				
		sidents' choices, including				
	but not limited to the	following:				
	(k) Pain Managemen	t				
		ure that pain management is				
		who require such services,				
	consistent with professional standards of practice,					
		erson-centered care plan,				
	and the residents' go	als and preferences.				
	(I) Dialysis. The facil	-				
		e dialysis receive such				
		with professional standards				
		rehensive person-centered				
	care plan, and the re-	sidents' goals and				
	preferences.	is not met as evidenced				
	by:	is not met as evidenced				
		n, record review, staff		Corrective action taken for the	e Residents	
	interviews, family inte			found to have been affected:		
		sidents # 1 and Resident #		1a. Residents #1 no longer re	sides at the	
	-	who had sustained injuries		facility.		
		ssess the residents and		2a. Resident #2's RP and ME) were	
	provide care. The fac	ility failed to assess		notified on 4/14/17. The Nurs	e	
		ate emergency medical		Practitioner examined residen		
		sident was identified to have		4/19/17. A CT scan without c		
		hange in mental status after		the chest and X-Ray to right s		
	-	within four days. The		completed on 4/19/17 and Ph	ysician was	
		have extensive bruising, a		notified of results.		
		and critical lab work when		Address have same stine a fi	will be	
		spital. The resident expired		Address how corrective action accomplished for those reside		
	LIGUL GAYS TO DOWING NO	er facility discharge. The		 accomplished for mose reside 	IIIS HAVING	

Facility ID: 922954

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
DIEANOI	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	<u> </u>		
		0.45000				С
		345280	B. WING		0	6/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET		
	1			RAEFORD, NC 28376		1
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From pag	e 40	F 30	9		
		nful armpit bruise. The		deficient practice will not occur	•	
		ed to have an intramuscular		3a. Re-education on Fall Man		
	chest hematoma six	days after the armpit bruise		(including Safe handling of res	-	
		ich she received nothing for		regarding transfers, head to to		
	pain. The facility also	o failed to provide		assessments), abuse/neglect p		
		nagement of Resident # 2's		procedure, neurological check		
		d while receiving transfer		procedure, stop and watch too		
		and the resident was		management protocol will be c	•	
	observed in pain.			by DON/designee to licensed r		
	Increadiate Lassandu	heren 4/44/47 when feeility		CNAs by 7/17/17. Nursing sta		
		began 4/14/17 when facility ent # 2, who was cognitively		re-educated by DON/designee emergency medical services (§		
		d staff's assistance for care,		contacted for any resident that		
		to her armpit. The staff failed		assessed and found to need en		
	to assess the resider			care by 7/17/2017.	Jeney	
	resident was identifie	ed to have a bruise also on				
	her chest. On 4/20/1	7 the resident was identified		3b. New employees will be ed		
	to have an intramuso	cular chest hematoma for		Fall Management, which incluc	les safe	
		ceived anything for pain. For		handling of residents regarding		
		lity also failed to provide care		head to toe assessments, abus	•	
		nmediate jeopardy level. On		policy and procedure, neurolog		
		entified Resident # 1, who		policy and procedure, stop and		
		within four days, had a nd they failed to assess the		and pain management protoco staff will be educated that eme	-	
		nd worsening injury. Nurses		medical services (911) will be o	• •	
		esident had extensive		for any resident that has been		
		areas of her body until the		and found to need emergency		
	afternoon of 6/10/17.	-				
	transported out for m	edical care by a non-		Indicate how the facility plans t	o monitor	
		The immediate jeopardy		its performance to make sure t	he	
		8/17 when the facility		solutions are sustained:		
		ble credible allegation of				
	compliance. The faci			4a. A fall audit will be complete	-	
		be and severity level D (no		DON/designee for any fall for 1		
		ential for more than minimal ediate jeopardy) to allow the		4b. Audits will be reviewed by A committee monthly for 3 mor		
		d fully implement the new		4c. Each incident and the 24 h		
		e residents are assessed and		will be discussed and reviewed		
	receive care.			clinical meeting to ensure ongo		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP	SURVEY LETED
		345280	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
				1	206 N FULTON STREET		
AUTUMIN	CARE OF RAEFORD			F	RAEFORD, NC 28376		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page The findings included		F	309	compliance with policy for 12 weeks.		
	1. The facility's neuro revised in August 200 to the policy neurolog completed if a resider sustaining head traun checks were to be do minutes for 2 hours; et hours; every hour for 16 hours; and every & Record review reveal the facility from 4/18/ ¹ to the medical record following diagnoses: a disease, frontotempoi bulbar affect, chronic deficiency anemia, hy alopecia totalis (loss of the right humerus, his disease, scoliosis, an Record review reveal Resident # 1 on 4/21/ no bruising or abnorn assessment date, and (Hgb) was noted by th (Normal range 12-16) 4/21/17 progress note about any changes in exacerbation of today Review of the resider assessment, dated 4/ was cognitively impai assistance from one s mobility, transfers, drop	logical checks policy, last 16, was reviewed. According ical checks were to be ht was suspected of ha. The frequency of the ne as follows: every 15 every 30 minutes for four 4 hours; every 4 hours for 8 hours for 48 hours. ed Resident # 1 resided at 17 until 6/10/17. According the resident had the advanced Parkinson's ral dementia with pseudo atrial fibrillation, iron yperglycemia, hypertension, of hair), healed fracture of story of falls; chronic kidney d hypothyroidism. ed the physician assessed 17 and noted that there was hal bleeding as of his d her last (hemoglobin) he physician to be 9.8. The physician noted in his a, "Please let me know behavior that indicated an 's issues. ht's minimum data set (MDS) 25/17, revealed the resident red; needed extensive					

Facility ID: 922954

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PRINTED: 07/21/2017

	-	D HUMAN SERVICES					FORM	D: 07/21/2017	
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION		(X3) DATE COMP	LETED	
		345280	B. WING			-		C 21/2017	
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		-	
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET					
				R	RAEFORD, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	the resident as having the last 6 months prio From 6/6/17 through 6	e 42 S assessment also coded g no falls or fractures within r to her facility admission. 6/9/17, the resident was g three times within these	F	309					
	on 6/6/17 (Tuesday) a noting Resident # 1 w floor on her buttocks i	ed a nursing progress note at 5:42 PM by Nurse # 3 ras observed sitting on the next to her bed. The nurse s assessed for injuries and							
	(Wednesday) at 4:25 documented at this tir responsive and coope	AM by Nurse # 3							
	PM. Nurse # 3 stated # 1 after her fall on 6/ or injury. Interview wit	ewed on 6/15/17 at 12:25 I she had checked Resident 6/17 and found no bruising th Nurse # 3 revealed the es on her assessment on							
	at 4:25 AM revealed a head to toe assessme								
	Review of a "Bi Week at 12:30 PM revealed	ly Skin Check" dated 6/8/17 Resident # 1 had no							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
AUTUMN	CARE OF RAEFORD			206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page current skin issues.		F 309				
	documented Resident The nurse noted Resi edge of her wheelcha onto the floor landing resident was coopera tone was normal. The	ote dated 6/8/17 at 7:55 PM t # 1 sustained another fall. dent # 1 was "sitting on the ir and slid out of the chair on her buttocks." The tive, pleasant, and her skin note was signed by Nurse cumentation of bruising or					
	Nurse # 2 stated Resi room when she susta 7:55 PM. According to 2, she had taken the r lifted her clothes, four and could not recall a	ewed on 6/16/17 at 9:15 AM. ident # 1 had been in the TV ined the fall on 6/8/17 at to the interview with Nurse # resident back to her room, and no evidence of bruising, ny injury noted on her shift 7 (Friday) at 7:00 AM.					
	assessment of Reside entered on 6/9/17 at 3 # 2 noted the resident	skin tone was normal. There					
	2 on 6/9/17 at 6:56 AM	ote was entered by Nurse # M noting the resident had a t elbow. There was no the note.					
	Nurse # 2 could not re observed from her as during her shift from 7 AM on 6/9/17. She did	ewed on 6/16/17 at 9:16 AM. ecall any injury she had sessments of Resident #1 7:00 PM on 6/8/17 until 7:00 d not recall observing the (6/9/17) morning before she					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
AUTUMN	CARE OF RAEFORD			206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	left work, but recalled puffy when she report (6/9/17) evening for h A nursing progress no record on 6/9/17 at 2: # 1 documented at thi received to x-ray Res the resident's RP (Re notified. There was no assessment of the res hematoma in this note Review of the record completed on 6/9/17 of "indication" for the x-r The X-ray report note swelling" but no defin report was electronica on 6/9/17 at 9:11 PM. Nurse # 1 was intervite According to the nurs hematoma to her arm and no other injury. T been communicated to was done. Following the nursing 2:56 PM there were n the progress notes da It was confirmed with 2:00 PM that the follo the progress notes for incident that occurred entry read, "Writer ca observed with her right	the resident's arm being ted to work on Friday er next shift. ote was entered into the 56 PM by Nurse # 1. Nurses is time that an order was ident # 1's elbow and that sponsible Party) was o documentation of sident's condition or of the e. revealed a mobile x-ray was of the resident's elbow. The ay was noted to be "pain." d there was "mild soft tissue ite bony abnormalities. The ally signed by the radiologist ewed on 6/15/17 at 2:00 PM. e the resident had a o on the morning of 6/9/17 he nurse stated this had to the physician and an x-ray progress note of 6/9/17 at io other nursing notations in	F 309				

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OLITILI	STOR MEDICARE &	MEDICAID SERVICES				D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY PLETED
	JORNEOHUN	DENTITION NUMBER.	A. BUILDIN	G		
		0.45000				С
		345280	B. WING			/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
	CARE OF RAEFORD			1206 N FULTON STREET		
				RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 309	Continued From page	245	F 3	00		
1 303				09		
	-	no injuries noted. Resident				
	had old bruising to he	er arms and the right ent had no complaints of				
		otified of unwitnessed fall.				
		ontact (responsible party) to				
		d fall." The entry was signed				
	by Nurse # 1.					
	Intonviow with Nurses	# 1 on 6/16/17 at 9:46 AM				
		en the nurse to respond to				
		:43 PM. Interview with Nurse				
		checked Resident # 1 in the				
		take her back to her room				
		body at the time of the				
		tated the resident had some				
	yellow bruising on he	r arms and a purple bruise to				
	the right temple area					
		1 stated the resident				
	continuously wore eit					
	,	loss. Nurse # 1 stated at				
		nt the bruise did not extend				
		d she did not take the				
		to assess her head further. felt the resident would not				
		the bonnet to assess for				
		ted she did let the physician				
		d a bruise to her temple.				
		# 1 revealed she left the				
	facility around 7:00 P	M on 6/9/17 (Friday), and				
	she stated she had n	-				
		ing to Nurse # 1 she had				
	•	l assessment flow sheet for				
		pleted neuro checks up until				
		provided the copy of the				
		nent flow sheet. The last				
		nted on the flow record was				
		the flow sheet was blank, not find any other records to				
	auu in $SE = 1 COUIO$					

Facility ID: 922954

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CENTER	S FOR MEDICARE & I					FORM OMB NC): 07/21/2017 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION			SURVEY LETED
		345280	B. WING				21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	know why the next nu checks per schedule. Nursing Assistant (NA 6/16/17 at 3:40 PM. N present when Resider stated she did not rec for the rest of Friday e On 6/10/17 there was neurological check an 1's physical status for nursing progress note on 6/10/17 at 12:25 A at this time that the re were normal. There w of any of the bruising identified earlier by Ne was extending. Nurse # 2 was intervia According to facility st had been assigned to 7:00 PM on 6/9/17 un (Saturday). Nurse # 2 she came to work on Resident # 1's right el she did not recall othe if she had done any n resident, she would h According to Nurse # (assistant director of r Friday evening of 6/9/ they discussed that R differently and wonde urinary tract infection.	A) # 4 was interviewed on A) # 4 was interviewed on AA # 4 stated she had been IA # 4 stated she had been IA # 1 fell on 6/9/17. NA # 4 all helping with the resident evening nor any bruises.	F 30	9			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345280	B. WING				C 21/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
AUTUMN	CARE OF RAEFORD				1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RECTIVE ACTION SHOULD BE CON RENCED TO THE APPROPRIATE		
F 309	Interview with the ass (ADON) on 6/16/17 a responsible for follow accidents. The ADON Resident # 1 on the m the resident had faller stated she had not no 1's temple on the Frid ADON stated on Frida went to check on the she had a bruise to he seen earlier. Accord evening of 6/9/17 she time into the air as if s something that was n seemed to be small. not have a pen light in neurological check, b # 1 and it was her und was going to follow up NA # 2 stated she had the Friday of 6/9/17 fr NA # 2 stated Reside the air that were not t "hallucinating." NA # 2 Resident # 2 and she but was not exactly si 2 stated the resident a her arms, but she had evening of 6/9/17 and on her head. NA # 3 was interviewed NA #	istant director of nursing t 3:55 PM revealed she was ing up on falls and I stated she had checked on horning of 6/9/17 because in on 6/8/17. The ADON triced a bruise to Resident # lay morning of 6/9/17. The ay evening of 6/9/17. The ay evening of 6/9/17 she resident again, and noted er temple which she had not ing to the ADON, on Friday e saw the resident reach one she was reaching for ot there, and her pupils The ADON stated she did in her pocket to do a ut she had spoken to Nurse derstanding that Nurse # 1 o with the physician. ed on 6/16/17 at 11:10 AM. d cared for Resident # 1 on om 3:00 PM until 7:00 PM. int # 2 reached for things in	F	309				

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PRINTED: 07/21/2017

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	stand up, and elbower redirect the resident to the resident would sci did not want to open f give medications. NA assisted her to bed an so. NA # 5 was interviewed Interview with NA # 5 Resident # 1 slept Fri which began at 11:00 stated Resident # 1 n herself and therefore not awaken her and w Interview with Nurse # revealed she had bee dayshift (7:00 AM to 7 According to Nurse # report when she repor 1 had been bruised of alerted her to do neur stated she did not kno hurt until two dayshift came to her and repor on her while giving her immediately went to a found her to have bru and head. The nurse in color and she imme who was her supervise NA # 6 was interviewed Interview with NA # 6 cared for Resident # 1	ept trying to repeatedly d NA # 3 when she tried to o sit down. NA # 3 stated ream, became angry, and her mouth for the nurse to # 3 stated she had not nd thought NA # 2 had done ed on 6/15/17 at 11:30 PM. revealed she recalled day night during her shift PM on 6/9/17. NA # 5 ormally did everything for she looked in on her, but did vas not aware of bruises. # 3 on 6/15/17 at 12:25 PM en on duty during the 7:00 PM) on 6/10/17. 3 she had not received a rted to duty that Resident # r injured which would have rological checks. Nurse # 3 ow the resident had been NAs (NA # 6 and NA # 7) rted they had found bruises er care. Nurse # 3 stated she assess the resident and ises on her back, legs, hip, stated the bruises were red ediately called Nurse # 1,	F 30				

Facility ID: 922954

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HUMAN SERVICES				FORM	07/21/2017 APPROVED
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY LETED
345280	B. WING _				C 21/2017
		STREET ADDRESS	S, CITY, STATE, ZIP CODE		
		1206 N FULTON	STREET		
		RAEFORD, NC	28376		
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	CH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
 An Saturday of 6/10/17, ned to NA # 7 and she with her. NA # 6 stated eat nor drink for breakfast ed care by swinging at e nurse also tried to feed she refused. NA # 6 stated convinced Resident # 1 to care, and when they and clothing to provide urple bruises on her arms, di legs. NA # 6 stated the was everywhere." NA # 6 yot the nurse. NA # 6 not been present when Resident # 1 on 6/6/17. A on 6/16/17 at 12:00 noon. evealed she had not she reported to duty on anything wrong with ated Resident # 1 would nch and refused morning nurse also tried to assist esident refused. NA # 7 and NA # 6 went together then they pulled back the se on both arms, both hips, arm, on the side of her d on her right head. Evealed she had not seen earlier because the and when they were net tipped backward which NA # 7 stated the head ze of her hand. 	F3	09			
	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280 EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) (9) In Saturday of 6/10/17, ned to NA # 7 and she vith her. NA # 6 stated eat nor drink for breakfast ed care by swinging at e nurse also tried to feed she refused. NA # 6 stated convinced Resident # 1 to care, and when they and clothing to provide urple bruises on her arms, d legs. NA # 6 stated the was everywhere." NA # 6 rot been present when Resident # 1 on 6/6/17. (on 6/16/17 at 12:00 noon. evealed she had not she reported to duty on anything wrong with ated Resident # 1 would nch and refused morning nurse also tried to assist esident refused. NA # 7 nd NA # 6 went together en they pulled back the es on both arms, both hips, arm, on the side of her d on her right head. evealed she had not seen earlier because the and when they were to tipped backward which VA # 7 stated the head ze of her hand.	EDICAID SERVICES (1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 345280 B. WING	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTIO A. BUILDING 345280 B. WING 345280 B. WING CEMENT OF DEFICIENCIES INUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) ID PREFIX TAG CROSS 19 n Saturday of 6/10/17, ned to NA # 7 and she <i>vith her.</i> NA # 6 stated eat nor drink for breakfast ed care by swinging at e nurse also tried to feed she refused. NA # 6 stated convinced Resident # 1 to care, and when they and clothing to provide imple bruises on her arms, d legs. NA # 6 stated the was everywhere." NA # 6 / got the nurse. NA # 7 no fo/16/17 at 12:00 noon. evealed she had not she reported to duty on anything wrong with ated Resident # 1 would nch and refused morning nurse also tried to assist asident refused. NA # 7 nd NA # 6 went together en they pulled back the es on both arms, both hips, arm, on the side of her d on her right head. evealed she had not seen earlier because the and when they were et tipped backward which IA # 7 stated the head ze of her hand.	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345280 B. WING Staturday of PLUE ID PREIN TAG DENTIFICATION NUMBER: ID VICTOR DEFICIENCIES AND DEFICIENCIES AND DEFICIENCIES IDENTIFING INFORMATION) ID PREIN TAG DENTIFING INFORMATION) ID PREIN TAG PROVIDER'S PLAN OF CORRECTIO CROSS-REFERENCED TO THE APPROPI DEFICIENCY) 19 F 309 n Sturday of 6/10/17, ned to NA # 7 at she thin her. NA # 6 stated eat nor drink for breakfast ed care by swinging at en rurse also tried to feed she refused. NA # 6 stated theory or vice urge and when they and clothing to provide inple bruises on her arms, d legs. NA # 6 stated the was everywhere." NA # 6 rot been present when Resident # 1 to care, and when they and clothing to provide inple bruises on her arms, d legs. NA # 6 stated the was everywhere." NA # 6 rot been present when Resident # 1 on 6/6/17. 10 n6/16/17 at 12:00 noon. vealed she had not she reported to duty on anything wrong with ated Resident # 1 would net Am # 6 went together en they pulled back the is on both arms, both hips, arm, on the side of her d on her right head. vealed she had not seen earlier because the and when they were et tipped backward which IA # 7 stated the head ze of her hand. 1 on 6/16/17 at 9:46 AM	HUMAN SERVICES FOOMB NC EDICAID SERVICES OMB NC (a) PROVIDERSUPPLERCLIA IDENTIFICATION NUMBER: (x) MULTIPLE CONSTRUCTION A BUILDING (x) DATE 345280 B. WING (a) DATE 345280 B. WING (b) FULTON STREET RAFFORD, NC 28376 EMENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFICATION NUMBER: ID PRETIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY) 19 n Saturday of 6/10/17, ned to NA # 7 and she tith her. NA # 6 stated deat nor drink for breakfast ed care by swinging at en uruse also tried to feed she refused. NA # 6 stated the was everywhere." NA # 6 not been present when kesident # 1 to care, and when they and clothing to provide type bruises on her arms, d legs. NA # 6 stated the was everywhere." NA # 6 not 6/16/17. If a full to care. NA # 6 stated the was everywhere." NA # 6 not been present when kesident # 1 to 6/6/17. I'on 6/16/17 at 12:00 noon vealed she had not she reported to duty on anything wrong with ated Resident # 1 would nch and refused morning numers also the pares. NA # 7 ta the part of her d on her right head. symeter because the and when they were entipe builes back the so on both arms, both hips, arm, on the side of her and when they were et tipped backward which A# 7 stated the head ze of her hand. I

Facility ID: 922954

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	"everywhere." Nurse a understanding that the bruising and not a cha # 1 stated she called if the resident had bee she told the physician he therefore wanted h (Computerized tomog The nurse stated it wa to go to the hospital o way of a non-emergen According to the inter not thought Resident emergency transport Nurse # 1 also stated the hospital non-emer department was open Therefore Nurse # 1 also non-emergency transport how the resident ender room. Interview with the Dire 6/15/17 at 5:25 PM re her at home and the r the change in Resident DON stated Nurse # 1 commute DON stated the ender not conveyed to her o the facility when she w DON the resident left on 6/10/17 by non-emergent	Resident # 1 had bruises # 1 stated it was her e main concern was the ange in mental status. Nurse the physician and he asked en falling. Nurse # 1 stated the resident had fallen, and her sent for a CT traphy) scan at the hospital. as arranged for Resident # 1 ut-patient department via ncy transport service. view with the nurse she had # 1's condition necessitated to the emergency room. it was her understanding	F 309				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			-		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		-
	CARE OF RAEFORD			1:	206 N FULTON STREET			
AUTOWIN	CARE OF RAEFORD			R	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 309	Interview with Reside (RP) on 6/16/17 at 10 visited Resident # 1 o bruises on her arm an stayed with the reside leaving she later rece PM that the resident f RP stated she had rec 6/9/17 at 2:45 PM from know Resident # 1 ha was told "it was possi hit her head on anoth A review of the reside administration record received her prescribe of Aspirin daily from 6 MAR was reviewed w 5:30 PM and it was co MAR showed no docu held. Review of 6/10/17 Em medical records revea was extensive. The E resident had bruising her head; the right fla hip, the right knee, an noted she had critical level of 5.9 which the "likely secondary to a The resident's stool w for blood in the ER. <i>A</i> head on 6/10/17 reve frontoparietal subdura millimeters (mm) in th	ent # 1's responsible party :10 AM revealed she had in 6/8/17 and had noted in 6/8/17 and had noted in 6/8/17 and had noted in 6/8/17 and had noted in a hand. The RP stated she ent until 7:00 PM, and after ived a phone call at 10:45 had fallen but was okay. The ceived another call on im a staff member letting her id fallen. The RP stated she ble" the resident could have er resident's wheelchair. Ant's June 2017 medication (MAR) revealed she had ed dosage of 325 milligrams i/6/17 through 6/10/17. The ith the ADON on 6/15/17 at onfirmed with the ADON the umentation the Aspirin was the regency Room (ER) aled the resident's bruising R physician noted the on the right parietal area of nk, the right elbow, the right of the left flank. He further anemia with a Hemoglobin physician documented was GI (gastrointestinal bleed)." vas grossly guaiac positive A CT scan of the resident's aled she had a al hematoma measuring 5 ickness.	F	309				
	received her prescribe of Aspirin daily from 6 MAR was reviewed w 5:30 PM and it was co MAR showed no docu held. Review of 6/10/17 Em medical records revea was extensive. The E resident had bruising her head; the right fla hip, the right knee, an noted she had critical level of 5.9 which the "likely secondary to a The resident's stool w for blood in the ER. A head on 6/10/17 revea frontoparietal subdura millimeters (mm) in the	ed dosage of 325 milligrams //6/17 through 6/10/17. The ith the ADON on 6/15/17 at onfirmed with the ADON the umentation the Aspirin was hergency Room (ER) aled the resident's bruising R physician noted the on the right parietal area of nk, the right elbow, the right of the left flank. He further anemia with a Hemoglobin physician documented was GI (gastrointestinal bleed)." vas grossly guaiac positive A CT scan of the resident's aled she had a al hematoma measuring 5 ickness.						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			-		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF RAEFORD			1	206 N FULTON STREET			
AUTOWIN	CARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
F 309	resident's extensive b falls. According to the notified him of the bru but they had not notifi changes on Friday (6, bruising, or consulted Aspirin dosage. Accord change in mental stat head injury would req evaluation at the Eme Review of the resident she passed away on the death certificate the p cause of death as "su "complications of a fa 2. Resident # 2 was a 7/11/16 and had diaged dementia, osteoporos gastro-esophageal re- glaucoma, mood diso osteopenia, a history fractures affecting 12 ranged in severity from history of sternal fract review revealed the re- and her last weight, d 68.5 pounds. Review of Resident # set (MDS) assessment the resident was assi assistance with transf hygiene. The resident	most likely reason for the ruising was her repeated physician the staff had ise to the temple on 6/9/17, ed him of any other (9/17), the extent of the with him regarding the ording to the physician any us in conjunction with a uire an immedicate ergency Room. tt's death certificate revealed 6/14/17 at 6:30 PM. On the hysician had listed the bdural hematoma" and II." admitted to the facility on noses of failure to thrive, is, anemia, hypertension, flux disease, anxiety, rder, vitamin D deficiency, of multilevel compression	F	309				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		-		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 309	updated on 5/26/17, r be resistive to care ar plan also noted the re- altered skin integrity. I interventions included quarterly and as need changes in skin as need plan the resident requ transfers." A problem was also o plan which identified t pain. Staff were direct assess the resident for Review of the record progress note by Nurs 8:56 AM noting that th her right arm pit which centimeters (cm.) This 10:48 AM on 4/14/17 the area was bluish/re arm and inner upper a director of nursing) wa communication note w resident complained t was touched. Review of Resident # revealed no document any pain medication of documented Resident	e areas. 2's current care plan, last evealed the resident could ad combative. The care sident had potential for Some of the listed care plan 1: skin assessments led, and to notify MD of eded. According to the care ired a "total lift for In the resident's current care he resident had chronic ted on the care plan to or pain. revealed a dayshift nursing se # 5 on 4/14/17 (Friday) at he resident had a bruise to n measured 8 X 5 is same nurse noted at the following information: ed and was under her right arm, the ADON (assistant as notified, a physician vas completed, and that the hat the area hurt when it 2's April 2017 MAR tation Resident # 2 received	F 305		IEFICIENCY)		
	Following the nursing	progress note of 4/14/17					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·				(X3) DATE COMP	SURVEY LETED	
		345280	B. WING			_	C 06/21/2017		
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET RAEFORD, NC 28376				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S	PLAN OF CORRECTION	=	(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFEREN	NCED TO THE APPROPRIA DEFICIENCY)		DATE	
F 309	the bruise existed, an or the resident's physic progress notes until 4 PM. At this time Nurse seen by the NP (nurse hematoma to the right Review of the nurse p note revealed the resid addition to the right ar ordered a CT (comput chest and blood work. Review of the CT report completed on 4/20/17 Thursday after the bru Friday 4/14/17. The fit had a "large area of h pectoralis major music 6 cm (centimeter) most intramuscular hemator the extent of the resid fractures. The CT rep diffuse osteopenia; pr two of the compression compression fractures five of the compression documented as mode compression fractures severe. On the same day on w (4/20/17) showing the completed a Bi-weekl skin on 4/20/17. Nurse	there was no documentation assessment of the bruise, ical status in the nursing /19/17 (Wednesday) at 2:30 e # 5 noted the resident was e practitioner) for a t axilla. practitioner's (NP's) 4/19/17 ident had a chest bruise in killa (armpit) bruise. The NP terized tomography) of the ort revealed it was ' which corresponded to uise had been found on ndings revealed the resident igh density within the right cle measuring 8.5 X 4.1 X 4. st likely representing ima." The CT also showed lent's compression ort noted the resident had ior cement augmentation of on fractures; three of the s were documented as mild; on fractures were trate; and two of the s were documented as	F	309		DEFICIENCY)			
	progress notes for 4/2	-							

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		MEDICAID SERVICES				O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY	
			A. BUILDING	i	с		
		345280	B. WING				
		545260			06/21/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376			
				,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 309	Continued From page	o 55	F 30	0			
1 000			F 30	9			
		# 6 on 6/17/17 at 3:15 PM					
	revealed she had not Resident # 2's skin a	ssessment check because					
		or and documented for areas					
	of pressure sores and						
	Review of Resident #	≠ 2's May 2017 MAR					
	revealed the resident	t received nothing for pain					
	during the month of M	May.					
		r of nursing (ADON) was					
		17 at 1:06 PM. During the					
		reviewed Resident # 2's					
	-	the ADON, on a scheduled					
		mputer system prompts the					
	-	n assessment after a bruise to a resident's computerized					
		twenty-four hours up until a					
		riod post injury. The ADON					
		mplications related to the					
		the assessments would be					
		2 hour period. In reviewing					
	the record, the ADON	I stated Resident # 2's first					
		following the identification of					
		had not been completed by					
	a nurse. According to						
		t been done because the					
		nent had been missed and					
		ceive the prompting. The why the first 24 hour post					
		ad been missed. Interview					
		led Resident # 2 had always					
		al lift for transfer since her					
		with the ADON and a review					
	of her investigation ir	nto the hematoma and					
	bruising revealed sor	ne of the staff members had					
		and repositioning the					
	-	d the facility had concluded					
		have led to the resident's					
		service materials following					

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	-	D HUMAN SERVICES					FORM): 07/21/2017 1 APPROVED
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		345280	B. WING			-		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				12	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page the incident revealed forward with her uppe "guide her hips back" Resident # 2 was obs PM as nursing assista transferred the reside bed using a mechanic care. The resident was extremely thin and fra prominent. The NAs mechanical lift sling b complete the transfer, the resident was not of was observed to com to get the sling benea the bed, and she was they could place the s stated the NA who has bed earlier should hav so that they did not hav much to get it position completing the care the the resident back from and the resident comp hurting. According to resident complained of transferred her. The N knew the resident hur nurses did because the when she was transfer	e 56 staff were to "have her lean r body" in order that they in the wheelchair." erved on 6/15/17 at 3:55 ant (NA) # 6 and NA # 9 nt from her wheelchair to cal lift in order to provide s observed to appear il. Her bones were very worked to try to position the ack beneath the resident to and it was observed that cooperative. The resident plain of pain as they worked th her and transfer her into not leaning forward so that ling beneath her. NA # 6 d gotten the resident out of ve left the sling beneath her ave to move the resident as ned correctly. Upon the NAs again transferred in the bed to the wheelchair, plained once again she was these evening shift NAs the of pain anytime they IAs were asked if the nurse t, and responded that the ne nurses heard her scream arred.		309				
	residents who were co voice their pain level o facility also had a pair	sessment was intended for ognitively alert and could on a scale of 1-10. The						

Facility ID: 922954

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345280	B. WING			C 06/21/2017		
NAME OF P	ROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE	-		
AUTUMN	CARE OF RAEFORD				06 N FULTON STREET AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 309	assess if confused re other ways such as si A review of Resident the ADON revealed s been identified on 4/2 completed a pain ass assessment for a cog They had used a num According to the ADC been using the pain a impaired residents. T would need to tell the resident tolerated her her pain. Review of the resident for pain thus far in the was confirmed with N AM. The nurse stated anything routinely ord have Tylenol if she ne NA # 8 was assigned 6/17/17 and she was 6/17/17. According to say she hurt sometim was okay and therefor resident was okay an On 6/17/17 at 5:15 PI informed of the imme provided a credible all 6/18/17. The allegation F 309 Assessments of Credible Allegation of Resident # 1 has diag	sidents expressed pain in triking out or pushing away. # 2's pain assessments with ince the hematoma had 20/17 the nurses had not essment using the unitively impaired resident. heric evaluation of her pain. ON the nurses should have assessment for cognitively The ADON stated the NAs nurses about how the care so they could address ht's June 2017 MAR had not received anything e month of June 2017. This furse # 4 on 6/17/17 at 10:25 I the resident did not have lered for pain, but she could eeded it. to care for Resident # 2 on interviewed at 10:30 AM on to NA # 8, Resident # 2 would tes, but then would say she are she concluded that the d not in pain. M, the administrator was diate jeopardy. The facility legation of compliance on on of compliance indicated: of Residents	F	309				

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PRINTED: 07/21/2017

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE CON	STRUCTION		NO. 0938-039 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C	OMPLETED
							С
		345280	B. WING		·····		06/21/2017
NAME OF P	ROVIDER OR SUPPLIER				TADDRESS, CITY, STATE, ZIP COI	DE	
AUTUMN	CARE OF RAEFORD				FULTON STREET ORD, NC 28376		
					•		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 309	Continued From page	- 58	E	309			
		par, anemia, and A-fib.		503			
		was determined to be a risk					
	for falls. Subsequent						
		nt injuries. Resident #1					
		rate falls on 6/6/17, 6/8/17					
	-	ulted in bruising to multiple					
	areas of her body. T	he fall on 6/9/17 was					
	unwitnessed in the da	ayroom at approximately					
	-	1 was noted to be on one					
		oot flat on the floor. Her right					
		nd her left arm was on her					
		t was observed on the floor					
		and assisted to a chair in the					
	-	to toe assessment was no inical record. The ADON					
		resident's forehead and					
	spoke with the Unit N						
		it Manager observed the					
		e was located on resident					
		not complete a head to toe					
		uise to the forehead was not					
	completely assessed	by the UM and the extent					
	could not be determin	ned due to the UM not					
	removing the cap fror	m resident #1's head. The					
		at resident #1 didn't let UM					
		. The Unit Manager failed to					
	-	be assessment immediately					
		tion of the bruise to the					
		UM notified the attending					
		he fall and bruise to head. e bruise to resident #1's					
		d neuro checks at that time.					
		tarted following the MD					
		tinue based on the facility's					
	policy. On 6/10/17, r	-					
		efused to get out of bed or					
		offered by staff. She refused					
	lunch, pushing stan a	way. Thru encouragement,					

Facility ID: 922954

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		_	06/2) 21/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD		F	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	was alert but not spea informed and contact regarding the refusal and multiple bruising. send resident #1 to be Resident was transpo- wheelchair at 5:15pm transferred to another subdural hematoma a expired at hospital. T a thorough head to to per policy. The nurse MD to report change #2 sustained a bruise identified on 4/14/17. notified on that date, I to continue to assess In addition, the nurses MD of changes to res armpit. The Nurse Pr on 4/19/17 and order chest and X-Ray to rig results later revealed osteopenic bones. For the resident affec On 6/17/17 all resider since June 1, 2017 w DON/Designee by us determine completion assessments and MD changes in resident c audit included a revie ensure that all measu contacting the MD of current needs of the a	her body. At this time she aking. The nurse was ed the DON at 3:25 pm of meals, refusal of care An order was obtained to ospital for head CT. orted to hospital via . Resident was later r hospital and admitted with and GI bleed. Resident later the nurse failed to complete e assessment at time of fall e also failed to contact the to Resident #1. Resident to right armpit that was The RP and MD were however, the nurses failed the bruise for any changes. s also failed to advise the ident's #2 area to right ractitioner saw resident #2 ed CT without contrast to the ght shoulder in which the a hematoma with ted: ted: the swho sustained a fall ere assessed by the e of an audit tool to o fhead to toe notification regarding ondition. The assessment w of the medical record to ures were in place to include any changes to meet the affected residents. A review was conducted by the DON	F 309				

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED
					С
		345280	B. WING		06/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE
				1206 N FULTON STREET	
	CARE OF RAEFORD			RAEFORD, NC 28376	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLE HE APPROPRIATE DATE
F 309	Continued From page	a 60	F 30	00	
1 303				09	
		uent to each fall. Based on on was provided by DON.			
	-	residents who are at risk for			
	the deficient practice	are at risk for deficient			
		fied by an assessment audit			
		for all current residents that			
	have had falls since J	lune 1st. Assessments will			
p	be reviewed by Direc	tor of Nursing or delegated			
		ce. Based on findings			
	-	vided. Surveyor identified			
		had been affected by the			
		essments according to			
		sustained a bruise on 4/14/17			
		he MD and Responsible ed on that date. No further			
	documentation to incl				
		vould have indicated any			
		noted until 4/19/17. The			
	-	the Nurse Practitioner. At			
	that time a CT of che	st without contrast, Right			
		a CBC were ordered. The			
		vealed an intermuscular			
	hematoma. It was on the medical record the	letermined from review of			
		ducted for the resident. The			
		ts compound fracture to the			
		have been no follow up			
		affected area of the spine.			
	The compression frac	ctures were sustained prior			
		cility and are noted on			
	admission evaluation	-			
		calling out in pain during			
		d on 6/18/17 to have pain or resident #2 at which time			
	an order was received				

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	, <i>,</i>	3	· · · ·	IPLETED
						С
		345280	B. WING		06/21/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF RAEFORD			1206 N FULTON STREET		
AUTOMIN				RAEFORD, NC 28376		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	SHOULD BE COMPLE	
F 309	Continued From page	e 61	F 30	9		
Re-education to all nurses			1.00			
		staff to include licensed				
		ere educated on 6/17/17				
		n person regarding the				
		gement, which includes Safe				
		s regarding transfers, Head Abuse/Neglect policy and				
		ological Check Policy and				
Procedur that Eme		ng staff have been educated				
		lical Services (911) will be				
	contacted for any res	sident that has been				
		to need emergency care. All				
	CNAs have received					
		e in condition to nurse "Stop and Watch Tool." All				
	-	ived education via phone will				
		rial upon returning to work.				
		ecks education was provided				
		nsed nurses to specifically				
		cy and duration: It is as				
		nutes for 2 hours, then every				
		rs, then every hour for 4				
		hours for sixteen hours, and				
		hours. Education was g staff on 6/17/17 to include				
		esses to include assessment				
	for pain.					
		J removal on 6/18/17.				
		on was verified on 6/21/17 at no longer worked at the				
		be reached by phone for				
		of current resident records				
		lls, injury and staff action.				
	The Assistant Directo	or of Nursing was interviewed				
		M. She provided the Fall				
	Management Protoco	ol. Assessment and				
		policy inservice details. On				

Facility ID: 922954

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345280	B. WING			/21/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309 F 323 SS=J	6/21/17 from 2:02 PM nursing staff as well a involved with Resider able to articulate the s Watch Tool" for notific reporting. Staff memb describe education re assessment, the polic checks, physician not respond to changes in able to provide evider an audit of the resider on 6/17/17. Other res observed and there w immediate jeopardy w 483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI (d) Accidents. The facility must ensu (1) The resident envir from accident hazards (2) Each resident rece and assistance device (n) - Bed Rails. The f appropriate alternative bed rail. If a bed or si must ensure correct in maintenance of bed re to the following elements (1) Assess the reside from bed rails prior to	I through 5:42 PM, random is Nursing Assistants at #1 following the falls, were steps of the "Stop and action, assessment and bers interviewed were able to aceived regarding falls, by regarding neurological ification, neglect and how to in condition. The facility was not that they had completed its and inserviced all staff idents in the facility were were no concerns. The vas removed on 6/18/17. (3) FREE OF ACCIDENT SION/DEVICES ure that - onment remains as free is as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use es prior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited ents.	F 30			7/17/17

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PRINTED: 07/21/2017

							0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDIN	NG			
		345280	B. WING				С
		345280	B. WING _			06/	21/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD						
	1			RA	AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	e 63	F 3	323			
. 020		ent representative and obtain		525			
	informed consent prid	•					
	(3) Ensure that the b	ed's dimensions are					
		sident's size and weight.					
		Γ is not met as evidenced					
	by:						
		on, record review, staff			Preparation and submission of this PO	C	
	interviews and family	interview the facility failed to			is required by state and federal law. Th		
(ti	evaluate the adequa	cy of supervision for three			POC does not constitute and admission	า	
		ent # 2, and Resident # 3) of			for purposes of general liability,		
		ents who had experienced			professional malpractice or any other		
		cured unit; two (Residents # 1			court proceeding.		
	and # 2) of whom ha	d experienced hematomas.					
					Corrective action taken for the resident	S	
		began on 6/9/17 when			found to have been affected:		
		nced her third fall within a					
		vas found to have bruising to			1a. Resident #1 no longer resides at th	ne	
		Resident # 1 was identified			facility	1	
		om to have a subdural			1b. Resident #2 the MD and responsib		
		ing on multiple parts of her			party were both notified on 4/14/17 and		
	-	as also receiving 325			head to toe assessment was completed	Jal	
		daily without any consultation hysician in regards to			that time. Resident was seen by the Nurse Practitioner on 4/19/2017 and wa	20	
		ould be increasing her			ordered a CT of chest without contrast,		
	-	he administrator and the			right shoulder xray and a CBC. All wer		
		vere not aware of the extent			completed. The care plan for resident s		
	-	n outside entity (the county			and resident #3 addresses that "safety		
		Services) talked to them			needs will be met thru staff supervision		
		the resident's discharge. The					
		failed to document and			Correction action taken for those		
		the resident's injuries in			residents having the potential to have		
		tive staff assess for any			been affected:		
		which would need to be					
		upervision for residents on			2a. An assessment audit was conducted	ed	
		ere Resident # 1 had			on 6/17/2017 for current residents that		
		ate jeopardy was removed			had falls since 6/1/2017.		
	on 6/17/17 when the				2b. As of 6/1/2017 fall incidents have		
		allegation of compliance. The			been audited to include head to toe		

Facility ID: 922954

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ATCMENT O			a			
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING	i		
		345280	B. WING		C	
		545200			06/21	/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET		
				RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 64	F 32	3		
		t of compliance at a scope	1 02	assessments, RP notifica	ation MD	
	-	D (not actual harm with the		notification, Post fall hud	-	
	-	in minimal harm that is not		DON/designee notification		
		for the facility to complete				
		nsure monitoring systems		Measures that will be put	t into place or	
	-	tive. The facility is also out of		systemic changes made		
		scope and severity for		the deficient practice will		
	Resident # 2 and Res	sident # 3.				
	The findings included	1:		3a. Re-education on fall	management	
	1. Record review reve	ealed Resident # 1 resided		(including safe handling	of residents	
	at the facility from 4/1			regarding transfers, ensu	-	
	-	lical record the resident had		resident receives adequa		
		es: advanced Parkinson's		and assistance to prever		
		hronic atrial fibrillation, iron		review of/and following c	-	
		yperglycemia, hypertension,		to toe assessments and		
		of hair), healed fracture of		abuse/neglect policy and		
	disease, scoliosis, an	story of falls; chronic kidney		neurological check policy	-	
	uisease, scollosis, an	ia hypothyrolaism.		and stop and watch tool by DON/designee to lice		
	Review of physician r	progress notes revealed the		CNAs by 7/17/2017.	nseu nuises anu	
		he resident on 4/21/17 and		3b. New employees will	he educated on	
		no bruising or abnormal		fall management(includir		
	bleeding as of his as			of residents regarding tra		
				that each resident receiv	-	
	Review of Resident #	[‡] 1's admission Minimum		supervision and assistan	-	
	Data Set (MDS) asse	essment dated 4/25/17		accidents,head to toe as	-	
		was cognitively impaired,		fall huddles), abuse/negl	ect policy and	
		sistance from one staff		procedure, neurological		
		ility, transfers, dressing,		procedure, and stop and	watch tool by the	
		d bathing, and needed		don/designee.		
		ambulation. This MDS				
		ed the resident as having no		Monitoring		
		in the last 6 months prior to			ident and the Of	
	her facility admission			4a. A review of each inc		
	Deview of Desident #	the core plan deted		hour report will be discus		
	Review of Resident #			reviewed 5x/week in clini		
		e staff identified Resident # 1		ensure ongoing compliar	ice with policy for	
1	Was at rick tor tolla	he facility's goal for the		12 weeks.	1	

Facility ID: 922954

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	E CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	IPLETED
						С
		345280	B. WING		0	6/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 323	to a fall. Listed interver were: ambulation dev cognitive status, evalu- instruct on appropriat a safe environment, p therapy to evaluate a 4/25/17 "anti rollback added to the care pla "assess for fatigue ar (as needed)" and "as- ambulation" was adde interventions. On 6/9/ to bed between 7 PM care plan intervention Review of nursing no was transferred to the 4/23/17 due to exit set there until her dischart Review of a nursing r Resident # 1 sustaine AM. The note indicate of bed while getting ir landed on her buttock bed. An additional nu 7:18 AM, revealed that to her right flank but h discomfort. Both note Review of the nursing following the fall of 4/ documentation that R further falls until the o	entions added on 4/18/17 vices as needed; assess uate for unsteady gait, e safety measures; maintain proper nonskid foot wear; nd treat as ordered. On wheelchair brakes" was in interventions. On 4/26/17 nd provide rest periods PRN sist with transfers and ed to the care plan /17 "offer and assist resident to 8 PM" was added to the ns. tes revealed Resident # 1 e secured facility unit on eeking behavior and resided rge on 6/10/17. note dated 4/24/17 revealed ed a fall on 4/24/17 at 6:00 ed that Resident # 1 slid out no her wheelchair, and ks with her back against the rsing note dated 4/24/17 at at the resident had a bruise had no complaint of pain or es were signed by Nurse #2. g notes revealed that 24/17, there was no tesident # 1 sustained date of 6/6/17. 6/6/17 (Tuesday) at 5:42 PM d Resident # 1 was	F 32		ents, RP post fall e assigned type of fall, ew, what htributing I patient's	

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						IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · /	E SURVEY IPLETED
			A. BOILDING			С
		345280	B. WING		0	6/21/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD		1	RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 66	F 323			
	assessed for injuries	and none were noted.				
According to a nursing noted dated 6/8/17 (Thursday) at 7:55 PM Resident # 1 sustained another fall. The nurse noted Resident # 1 was "sitting on the edge of her wheelchair and slid out of the chair onto the floor landing on her						
4 t 7 a a v 4 a v 4 c c r r ((6 c r r r 2 t t c r r t t c r r t r t r r t r r t r r r r		vas signed by Nurse #2.				
		6/9/17 (Friday) at 6:56 AM ented the resident had a he right elbow.				
	assigned to care for F which began at 7 PM AM on 6/9/17 (Friday on 6/16/17 at 9:16 AM recalled Resident # 1 (activity room) when a 6/8/17 (Thursday) at nurse aide had been not get to her in time 2 stated she recalled the hall outside of the	sheets, Nurse # 2 was Resident # 1 during the shift on 6/8/17 (Thursday) until 7). Nurse # 2 was interviewed M. Nurse # 2 stated she had been in the TV room she sustained the fall on 7:55 PM. Nurse # 2 stated a with the resident, but could to prevent the fall. Nurse # she (Nurse # 2) had been in e TV room when the incident not recall the resident being				
	hurt when she checke According to Nurse # been three NAs on th had fallen on Thursda recall what all was tra there had been enoug residents. According	ed her right after the fall. 2, she thought there had le unit when Resident # 1 ay 6/8/17 and she could not anspiring that evening or if gh staff to supervise the to Nurse # 2 sometimes				
	at the same time on t therefore those reside more staff attention.	Id start displaying behaviors he secured unit and ents on the unit would need The nurse stated on days if they could use five or six				

Facility ID: 922954

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/21/2017 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			() 06/2	; 21/2017
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
			1	206 N FULTON STREET			
AUTUMIN	CARE OF RAEFORD		F	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 323	Interview with NA # 4 present on 6/8/17 (Th fell at 7:55 PM. NA # 4 get to Resident # 1 in stated the resident ha Interview with NA # 4 recall exactly what sh the incident and only could not get to the re Resident # 1's respon interviewed on 6/16/1 the RP she had conce supervision on Reside she had visited Resid 6/8/17 and she had an a man's sleeveless t-s the resident. The RP resident had a bruise hand. The RP stated evening at 5:12 PM w food tray had been sp and the tray's content activity room into the the staff an hour to cle it did not appear as if available. The RP sta Resident # 1 until 7 P and at 10:45 PM on 6	enough staff." ed on 6/16/17 at 3:40 PM. revealed she had been ursday) when Resident # 1 4 stated she was not able to time to stop the fall. NA # 4 d not appeared to be hurt. revealed she could not e was doing at the time of that she was present and esident before the fall. sible party (RP) was 7 at 10:10 AM. According to erns related to the ent # 1's unit. The RP stated ent # 1 on the evening of rrived to find the resident in shirt which did not belong to stated she noticed the to her arm and her left she was concerned that hen she saw a resident's willed in the TV/activity room s had extended from the hall. The RP stated it took ean it from the floor because a housekeeper was ated she stayed with M on 6/8/17 before leaving, /8/17 she received a phone at Resident # 1 had fallen	F 323		EFICIENCY)		
	and 6/16/17 at 9:46 A resident had fallen on	ewed on 6/15/17 at 2 PM M. Nurse # 1 stated the 6/9/17 (Friday) at 3:43 PM een logged as occurring on					

Facility ID: 922954

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF RAEFORD			1:	206 N FULTON STREET			
AUTOWIN	CARE OF RAEFORD			R	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	6/10/17 in the nursing an entry in the nursing 6/10/17 (Saturday) at entry revealed a fall o at 3:43 PM. The entry read, "Write Resident observed wi and her right elbow re Resident assessed fo Resident assessed fo Resident had old brui right temporal area. R of pain. MD in facility, Writer attempted to co inform of unwitnessed by Nurse #1. Interview with Nurse # and 6/16/17 at 9:46 A the nurse to respond PM. Nurse # 1 stated attendance with Reside was caring for anothe had not seen Resider Nurse # 1 revealed st 1 in the TV room, but room and look at her the incident. Nurse # some yellow bruising bruise to the right tem assessment. NA # 4 was interviewed According to NA # 4 s TV room when Reside Thursday of 6/9/17 at # 4 she had her back another resident who	 a notes. The nurse pointed to g notes which was dated 5:12 PM. This Saturday ccurred on 6/9/17 (Friday) ber called to TV room th her right knee on the floor esting on an arm-chair. r injuries; no injuries noted. sing to her arms and the resident had no complaints notified of unwitnessed fall. bottact RP [Name of RP] to a fall." The note was signed # 1 on 6/15/17 at 2:00 PM M revealed she had been to the fall on 6/9/17 at 3:43 NA # 4 had been in dent # 1 in the TV room, but r resident at the time and th # 1 fall. Interview with the had checked Resident # did not take her back to her entire body at the time of 1 stated the resident had on her arms and a purple to the fall on 6/16/17 at 3:40 PM. 	F	323				

Facility ID: 922954

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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) COMPLE DATE F 323 Continued From page 69 # 1 was on her knee on the floor. NA # 4 stated she did not recall helping with the resident for the rest of Friday evening nor did she see any bruises. F 323 F 323 According to staffing sheets Nurse # 2 was assigned to care for Resident # 1 for the shift which began at 7 PM on 6/9/17 and ended at 7 AM on 6/10/17. According to an interview with Nurse # 2 on 6/16/17 at 9:16 AM, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was F 323		-	ID HUMAN SERVICES				FORM): 07/21/2017 1 APPROVED
345280 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUTUMN CARE OF RAEFORD STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT COMMENT F 323 Continued From page 69 F 323 F 323 F 323 F 323 Continued From page 69 F 323 F 323<	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUTUMN CARE OF RAEFORD 1206 N FULTON STREET (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION MOUTE BE TRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (K9) (COMPLE DATE DEFICIENCY) F 323 Continued From page 69 # 1 was on her knee on the floor. NA # 4 stated she did not recall helping with the resident for the rest of Friday evening nor did she see any bruises. F 323 According to staffing sheets Nurse # 2 was assigned to care for Resident # 1 for the shift which began at 7 PM on 6/9/17 and ended at 7 AM on 6/10/17. According to an interview with Nurse # 2 on 6/16/17 at 9:16 AM, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was			345280	B. WING		_		
RAEFORD RAEFORD, NC 28376 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDEN'S PLAN OF CORRECTION (EACH DEFICIENCY) (SOMPLE DEFICIENCY) F 323 Continued From page 69 # 1 was on her knee on the floor. NA # 4 stated she did not recall helping with the resident for the rest of Friday evening nor did she see any bruises. F 323 F 323 According to staffing sheets Nurse # 2 was assigned to care for Resident # 1 for the shift which began at 7 PM on 6/9/17 and ended at 7 AM on 6/10/17. According to an interview with Nurse # 2 on 6/16/17 at 9:16 AM, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was Here and the price of the pr	NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
RAEFORD, NC 28376 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Comment Deficiency F 323 Continued From page 69 F 323 # 1 was on her knee on the floor. NA # 4 stated she did not recall helping with the resident for the rest of Friday evening nor did she see any bruises. F 323 According to staffing sheets Nurse # 2 was assigned to care for Resident # 1 for the shift which began at 7 PM on 6/9/17 and ended at 7 AM on 6/10/17. According to an interview with Nurse # 2 on 6/16/17 at 9:16 AM, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was				1:	206 N FULTON STREET			
PREFX 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) COMPLE DATE F 323 Continued From page 69 # 1 was on her knee on the floor. NA # 4 stated she did not recall helping with the resident for the rest of Friday evening nor did she see any bruises. F 323 F 323 According to staffing sheets Nurse # 2 was assigned to care for Resident # 1 for the shift which began at 7 PM on 6/9/17 and ended at 7 AM on 6/10/17. According to an interview with Nurse # 2 on 6/16/17 at 9:16 AM, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was F 323	AUTUMN	CARE OF RAEFORD		R	AEFORD, NC 28376			
 # 1 was on her knee on the floor. NA # 4 stated she did not recall helping with the resident for the rest of Friday evening nor did she see any bruises. According to staffing sheets Nurse # 2 was assigned to care for Resident # 1 for the shift which began at 7 PM on 6/9/17 and ended at 7 AM on 6/10/17. According to an interview with Nurse # 2 on 6/16/17 at 9:16 AM, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD B		(X5) COMPLETION DATE
acting differently and were wondering if she might have a urinary tract infection. According to Nurse # 2 it was difficult to remember how the resident was exactly acting differently and the details of any falls she had been experiencing because sometimes things "got hectic" on the unit where Resident # 1 resided. The nurse said sometimes "things run together." According to Nurse # 2 she thought she recalled calling Resident # 1's responsible party and telling her the resident may have hit the side of her face but she did not remember the day on which she did this or the reason why she told her this. Review of the nursing notes revealed no entry by Nurse # 2 documenting an incident where the resident may have hit her head or that she called the responsible party and informed her of this. Interview with the ADON on 6/16/17 at 3:55 PM revealed she was responsible for following up on falls and accidents. The ADON stated she had checked on Resident # 1 on the morning of 6/9/17 (Friday) beccuse the resident had fallen on 6/8/17 (Thursday). The ADON stated she had not	F 323	# 1 was on her knee of she did not recall help rest of Friday evening bruises. According to staffing assigned to care for F which began at 7 PM AM on 6/10/17. Accord Nurse # 2 on 6/16/17 ADON (assistant dire her the Friday evenin 1, and they discussed acting differently and have a urinary tract in # 2 it was difficult to re was exactly acting dif any falls she had bee sometimes things "go Resident # 1 resided. "things run together." thought she recalled of remember the day on reason why she told h Review of the nursing Nurse # 2 documentin resident may have hit the responsible party Interview with the AD revealed she was res falls and accidents. T checked on Resident 6/9/17 (Friday) becauting	on the floor. NA # 4 stated bing with the resident for the g nor did she see any a sheets Nurse # 2 was Resident # 1 for the shift on 6/9/17 and ended at 7 rding to an interview with at 9:16 AM, she recalled the ctor of nursing) talking to g of 6/9/17 about Resident # d that Resident # 1 was were wondering if she might affection. According to Nurse emember how the resident ferently and the details of n experiencing because t hectic" on the unit where The nurse said sometimes According to Nurse # 2 she calling Resident # 1's telling her the resident may er face but she did not which she did this or the her this. I notes revealed no entry by ng an incident where the her head or that she called and informed her of this. ON on 6/16/17 at 3:55 PM ponsible for following up on he ADON stated she had # 1 on the morning of se the resident had fallen on	F 323				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>				(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_	(//06	C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
A				1:	206 N FULTON STREET			
AUTUWIN	CARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Friday morning of 6/9. Friday evening of 6/9. resident again, and no temple which she had According to the ADO 6/9/17 she saw the re- the air as if she was m was not there, and he According to the ADO # 1 about this and it w # 1 was going to follow According to the ADO scheduled vacation for On 6/15/17 administra the facility schedule a who had been assign on 6/9/17 and 6/10/17 schedule, NA # 2's na NA who had been assign on 6/9/17 and 6/10/17 schedule, NA # 2's na NA who had been assign on 6/9/17 and 6/10/17 schedule, NA # 2's na NA who had been assign on the 3 PM to 11 P NA # 2 was interviewed Interview with NA # 2 being assigned to Re- PM. NA # 2 stated sho the unit during that tim residents who were a up, and Resident # 1 According to NA # 2 stated were not there as if sh she had spoken to a r recall the exact nurse spoken. NA # 2 stated Resident # 1 to bed s to her after 7 PM, and	 /17. The ADON stated on /17 she went to check on the oted she had a bruise to her I not seen earlier. IN on Friday evening of sident reach one time into eaching for something that is pupils seemed to be small. IN she had spoken to Nurse vas her understanding Nurse w up with the physician. IN she had gone on her Illowing Friday 6/9/17. Active staff provided a copy of nd had highlighted the NAs ed to care for Resident # 1 Y. According to this use was highlighted as the signed to care for Resident # 1 Y. According to this use was highlighted as the signed to care for Resident # 1 M. shift on 6/9/17. Ed on 6/16/17 at 11:10 AM. revealed she recalled only two NAs on he and she had three trisk for falls trying to stand was one of them. She also noticed that sing at things in the air that he was "hallucinating" and hurse about it. She did not 	F	323				

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		MEDICAID SERVICES	(X2) MULT	IPLE CONST	RUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	NG		· · ·	MPLETED
							С
		345280	B. WING				6/21/2017
NAME OF PI	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD				ULTON STREET RD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 71	F 3	323			
		ed on 6/17/17 at 10:45 AM.		20			
		rived to work at 7 PM on					
		tayed in the TV/activity room					
		PM to 9 PM. Interview with					
	when she arrived at w	ident # 1 was in the TV room					
		and elbowed NA # 3 when					
		he resident to sit down. NA #					
	3 stated the resident	screamed and became					
		she had not assisted her to					
		# 2 had done so. NA # 3 did					
	assisted to bed.	Resident # 1 had been					
	Resident # 1's RP wa	as interviewed on 6/16/17 at					
	10:10 AM. The RP st	ated she had received two					
	•	7 from staff letting her know					
		d fallen. The RP stated her					
		when the phone calls were ere on 6/9/17 at 2:45 PM and					
		he RP stated when she was					
		e staff member told her that					
		en from her chair and had					
		d on another person's					
		stated she was called again					
		and was told Resident # 1 her roommate's chair on the					
		she asked if the resident					
		ld she was just sitting there					
	and they put her bacl	k to bed.					
	There was no docum	entation in the nursing notes					
		sustained a fall on 6/9/17 at					
	8:45 PM. According	-					
	assigned for her care	ty, NA # 2 would have been					
		at 11:10 AM with NA # 2					
		think Resident # 1 had been					
	assigned to her after						

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	-	D HUMAN SERVICES					FORM): 07/21/2017 APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	LETED
		345280	B. WING					C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
				1:	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	272	F	323				
	Interview with NA # 5 Resident # 1 slept Fri which began at 11:00 stated Resident # 1 m herself and therefore not awaken her and w Interview with Nurse # revealed she had bee dayshift on 6/10/17 (S she had not received had been bruised or in duty at 7:00 AM on 6/ did not know the resid dayshift NAs (NA # 6 and reported they had giving her care. Nurse went to assess the re- have bruises on her b	day night during her shift PM on 6/9/17. NA # 5 ormally did everything for she looked in on her, but did vas not aware of bruises. # 3 on 6/15/17 at 12:25 PM						
	and she immediately her supervisor. NA # 6 was interviewed Interview with NA # 6 cared for Resident # 7 usually very cooperat prior to 6/10/17 (Satur her on 6/6/17 (Tuesda Saturday of 6/10/17, s Resident #1. NA # 6 s not eat nor drink for b refused care by swing after lunch they finally let them assist her wit pulled back her cover	called Nurse # 1, who was ed on 6/15/17 at 4:35 PM. revealed she had routinely 1, and the resident was ive with care. NA # 6 stated rday), she had last cared for						

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · /	IPLETED
						С
		345280	B. WING		0	6/21/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376		
				,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 323	Continued From page	e 73	F 3:	23		
		and legs. NA # 6 stated the				
		it was everywhere." NA # 6				
		ely got the nurse. NA # 6				
		ad not been present when r Resident # 1 on 6/6/17				
		with NA # 6 revealed no				
		ember had spoken to her as				
	of 6/15/17 regarding	the bruises she had found				
	and the events of the	resident's day.				
	NA # 7 was interview	ed on 6/16/17 at 12 noon.				
		revealed she had not				
		en she reported to duty on				
		s anything wrong with				
		stated Resident # 1 would				
		unch and refused morning ne nurse also tried to assist				
		e resident refused. NA # 7				
		e and NA # 6 went together				
	-	when they pulled back the				
		ses on both arms, both hips,				
	chest by her breast, a	er arm, on the side of her and on her right head				
	-	revealed she had not seen				
	the bruise on her hea					
		et and when they were				
		nnet tipped backward which . NA # 7 stated the head				
	bruise was about the					
	Review of the 6/10/17	7 nursing notes revealed no				
		ding the bruising that was				
	found by NA # 6; NA	# 7 and Nurse # 3 on				
	6/10/17.					
	Interview with Nurse	# 1 on 6/16/17 at 9:46 AM				
		ad called her at home on				
		Resident # 1 had bruises				
	"everywhere." Nurse	# 1 stated it was her				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345280	B. WING				C 21/2017
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	understanding that th bruising and not a cha # 1 stated she (Nurse and he asked if the re Nurse # 1 stated she resident had fallen, an sent for a CT scan at stated it was arranged the hospital out- patie non-emergency trans There was no notation the resident was trans The DON provided do called on 6/10/17 by the service at 5:15 PM in were in the facility and Resident # 1's room re transport. Interview with the RP revealed she had reco 6/10/17 at 4:50 PM fm she call. The RP state call at 6 PM and was resident to the hospital day and would not eas when she arrived at the resident disoriented at According to the RP the with a subdural hema 6/14/17. A review of the resided (medication administre had received her pres- milligrams of Aspirin to 6/10/17. There was no	e main concern was the ange in mental status. Nurse # 1) called the physician esident had been falling. told the physician the nd he therefore wanted her the hospital. The nurse d for Resident # 1 to go to ent department via way of a port service. In in the nursing notes when sported out of the facility. boumentation that she was the non-emergency transport order to let her know they d needed verification of number to pick her up for on 6/16/17 at 10:10 AM eived a voice mail on om the facility asking that ed she returned the phone told they were sending the al because she had slept all t. According to the RP, ne hospital she found the and with extensive bruising. he resident was diagnosed toma and expired on	F	323			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	resident began falling injuries from her falls. with the ADON on 6/1 confirmed with the AD documentation the AS Review of 6/10/17 Em medical records revea was extensive. The E resident had bruising her head; the right flat hip, the right knee, an noted she had critical level of 5.9 which the "likely secondary to a The resident's stool w for blood in the ER. <i>A</i> head on 6/10/17 revea frontoparietal subdura mm (millimeters) in th An interview with the for on 6/17/17 at 7:00 PM reason for the resider her repeated falls. Act staff had notified him on 6/9/17, but they had other changes on Frict the bruising, or consu Aspirin dosage. Interview with the DO 6/15/17 at 5:25 PM ar AM revealed Nurse # 6/10/17 (Saturday) an to be the change in R	n should be held when the in order to avoid further The MAR was reviewed 5/17 at 5:30 PM and it was iON the MAR showed no pirin was held. hergency Room (ER) aled the resident's bruising R physician noted the on the right parietal area of nk, the right elbow, the right d the left flank. He further anemia with a Hemoglobin physician documented was GI (gastrointestinal bleed)." as grossly guaiac positive A CT scan of the resident's aled she had a al hematoma measuring 5 ickness. resident's facility physician I revealed the most likely t's extensive bruising was cording to the physician the of the bruise to the temple d not notified him of any lay (6/9/17), the extent of Ited with him regarding the N (Director of Nursing) on nd again on 6/16/17 at 11:40 3 had called her at home on d the main concern seemed esident # 1's mental status. e # 1 was planning to go in	F	323				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
				1	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	DON the staff had not of the bruising or she facility on Saturday w at the resident. Accor- not been made aware related to the resident she was until an outsi Department of Social Tuesday (6/13/17) ab the DON that was the statements from her si happened regarding to The DON was not aw resident had fallen a si 8:45 PM. Interview with the adm PM revealed he relief him to clinical problem did follow up to falls a the administrator reve on vacation during the on 6/11/17. According staff had not alerted h bruising which was fo she left the facility on follow up regarding th received. According to an interv 6/17/17 at 3 PM, a sta stay within the secure room anytime there is so that there can be si ADON there is a sche based upon their assi According to the ADO	e physician. According to the t conveyed to her the extent would have gone to the hen she was called to look rding to the DON she had e there were concerns t being injured to the extent de entity (the County Services) spoke to her on out concerns. According to first date she started to get staff to determine what had he resident's care and falls. are of any report that the second time on 6/9/17 at 1:00 d on his clinical staff to alert ns, and the ADON routinely nd injuries. Interview with ealed the ADON had been e current week which began g to the administrator the tim to the extent of the und on Resident # 1 before 6/10/17 in order that he e supervision she had view with the ADON on aff member is required to ed unit's TV room/activity a resident within the room supervision. According to the edule for the NAs that is	F	323				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345280	B. WING				C / 21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF RAEFORD				1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	hour corresponds to the The ADON stated the room assignments: the "split," and the back of provided an example Room Schedule" for f schedule, a NA who is residents on the "back in the TV/Activity room and from 12 noon to schedule the NA assignment TV/Activity room from again from 1:00 PM to was assigned to care "back of 700" was ass TV/Activity room from again from 2:00 PM to There was no docume investigation of Resid had reviewed the resp were assigned for sup when she was experie On 6/17/17 at 5:15 P informed of the imme provided a credible al 6/18/17. The allegation Resident # 1 has diago limited to Lewy Body disease, Pseudo Bulk Upon admission, she for falls. Subsequent a fall risk as to prever sustained three separe	he NA room assignments. re are generally three NA the back of the 600 hall; the of the 700 hall. The ADON of the dayroom "Activity irst shift. According to the s assigned to care for k of 600" is assigned to be in from 9:00 AM to 10:00 AM 1:00 PM. According to the gned to care for residents on t was assigned to be in the 10:00 AM to 11:00 AM and to 2:00 PM, and the NA who for the residents on the signed to be in the 11:00 AM to 12 noon and to 3:00 PM. entation in the facility's ent # 1's falls showing they bonsibilities of the NAs who bervision to Resident # 1 encing the falls. M, the administrator was diate jeopardy. The facility legation of compliance on on of compliance indicated: gnosis including but not Dementia, Parkinson's bar, anemia, and A-fib. was determined to be a risk ly, she was care planned for nt injuries. Resident #1 rate falls on 6/6/17, 6/8/17 Juted in bruising to multiple	F	32:	3		

PRINTED: 07/21/2017

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>				(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_	(06/:) 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				1:	206 N FULTON STREET			
AUTUMIN	CARE OF RAEFORD			R	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION DTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	3:45 pm. Resident #1 knee with the other for arm was on a chair ar wheelchair. Resident by the Unit Manager a dayroom and a head documented in the cli observed a bruise to a spoke with the Unit M observation. The Unit area where the bruise forehead, but did not assessment. UM state didn't let UM remove the attending physicia bruise to head. MD w the forehead and ordet time. On 6/10/17, res She also refused to g personal care offered lunch, pushing staff ar staff were able to assi and noted bruises on was alert but not speat informed and contacter regarding the refusal and multiple bruising. send resident #1 to he Resident was transpor wheelchair at 5:15pm transferred to (hospital subdural hematoma a expired at hospital. T	ayroom at approximately I was noted to be on one of flat on the floor. Her right and her left arm was on her was observed on the floor and assisted to a chair in the to toe assessment was not nical record. The ADON resident's forehead and anager regarding the t Manager observed the e was located on the complete a head to toe ed to DON that resident her night cap. UM notified an regarding the fall and vas notified of the bruise to ered neuro checks at that sident #1 refused breakfast. et out of bed or allow by staff. She refused way. Thru encouragement, ist resident with ADL care her body. At this time she aking. The nurse was ed the DON at 3:25 pm of meals, refusal of care An order was obtained to ospital for head CT. orted to (hospital) via . Resident was later al) and admitted with and GI bleed. Resident later he nurse failed to complete e assessment at time of fall	F	323				
	bruise to head. MD w the forehead and orde time. On 6/10/17, res She also refused to g personal care offered lunch, pushing staff a staff were able to assi and noted bruises on was alert but not spea informed and contacte regarding the refusal and multiple bruising. send resident #1 to he Resident was transpo wheelchair at 5:15pm transferred to (hospital subdural hematoma a expired at hospital. T a thorough head to to per policy.	vas notified of the bruise to ered neuro checks at that sident #1 refused breakfast. et out of bed or allow by staff. She refused way. Thru encouragement, ist resident with ADL care her body. At this time she aking. The nurse was ed the DON at 3:25 pm of meals, refusal of care An order was obtained to ospital for head CT. orted to (hospital) via . Resident was later al) and admitted with and GI bleed. Resident later the nurse failed to complete e assessment at time of fall						

Facility ID: 922954

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · /	IPLETED
						С
		345280	B. WING		0	6/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				1206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD			RAEFORD, NC 28376		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIO
F 323	Continued From pag	e 79	F 32	23		
		stained a fall since June 1,				
		by DON/Designee for a				
		ent and appropriate MD				
	notification by use of					
	assessment audit inc	cluded a review of the				
	medical record to en	sure that all measures were				
	in place to meet the	current needs of the affected				
		of the medical record was				
		N to review appropriate				
		sessments subsequent to				
		findings, staff education was				
	provided by DON.					
		residents who are at risk for				
	the deficient practice	are at risk for deficient				
		fied by an assessment audit				
		d on 6/17/17 for all current				
		ad falls since June 1st. The				
		here 17 total falls that were				
		dents with three of those				
	-	eated falls. Assessment				
		ed by Director of Nursing or				
	delegated persons for	or compliance. Education will				
	be provided on 6/17/	17. Surveyor identified				
		had been affected by the				
		sessments according to				
		S.) sustained a bruise on				
	4/14/17 to the right a					
		ere both notified on that date				
		sessment was completed at no further assessment to				
		in identified area until				
		documentation was noted				
		e resident was seen by the				
		At that time a CT of chest				
		ht shoulder X-Ray and a				
	-	which results revealed an				
		oma. It was determined that				

Facility ID: 922954

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SUPPLIER/CLIA I'ON NUMBER: 345280	. ,	E CONSTRUCTION		(X3) DATE	
345280				COMPL	LETED
	B. WING		_	06/2	, 21/2017
	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		RAEFORD, NC 28376			
EDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
	F 323	3			
e licensed in 6/17/17 ling the includes Safe includes Safe sfers, Head t policy and Policy and d education condition to ad Watch education via upon returning 17/17. on 6/21/17 at ed at the phone for ent records taff action. as interviewed d the Fall t and d details. On PM, random istants the falls, were top and ment and ed were able to ing falls, eurological ect and how to he facility was					
	As began on e licensed n 6/17/17 ding the includes Safe nsfers, Head et policy and c Policy and d education condition to nd Watch education via upon returning /17/17. I on 6/21/17 at ed at the r phone for ent records staff action. ras interviewed ed the Fall t and e details. On PM, random sistants the falls, were Stop and ment and ed were able to ling falls, eurological ect and how to ne facility was had completed	As began on e licensed n 6/17/17 ding the includes Safe nsfers, Head et policy and c Policy and d education condition to nd Watch education via upon returning /17/17. I on 6/21/17 at ed at the r phone for ent records staff action. ras interviewed ed the Fall t and e details. On PM, random sistants the falls, were Stop and ment and ed were able to ling falls, eurological ect and how to ne facility was	As began on elicensed n 6/17/17 ting the includes Safe rsfers, Head ed education condition to nd Watch education via upon returning (17/17. lon 6/21/17 at ed at the r phone for ent records taff action. ras interviewed ed the Fall t and e details. On PM, random sistants the falls, were Stop and ment and ed were able to ing falls, eurological ect and how to ne facility was	As began on elicencies below by PuLL inFORMATION) As began on elicensed n 6/17/17 fing the includes Safe rsfers, Head t policy and condition to d dwatch education sondition to d Watch education sondition to d Watch education sondition to d Watch education sondition to d Watch education sondition to d dwatch education sondition to d dwatch education sistants the falls, were stop and ment and ed ware able to ling falls, eurological set and how to he facility was	As began on licencies EDB BY FULL INFORMATION) As began on licensed n 6/17/17 ing the includes Safe rsfers, Head t policy and d deducation condition to d Watch education via apon returning 1/17/17. lon 6/21/17 at ed at the r phone for ent records taff action. as interviewed d details. On PM, random sistants the falls, were stop and r deducation b falls, were stop and r defunction to d d ware able to ling falls, eurological act and how to te facility was STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376 PROVIDERS'S PLAN OF CORRECTION PROVIDERS'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDERS'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_	() 06/:	C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	an audit of the resider on 6/17/17. Other resi observed and there w immediate jeopardy w 2. Record review reve admitted to the facility revealed the resident thrive, dementia, oste hypertension, gastro-o anxiety, glaucoma, mo deficiency, osteopenia compression fractures which ranged in seven a history of sternal fra Review of the resident Set (MDS) assessment the resident had a BIM mental status) score of did not answer any qu cognitive ability assess assessed as needing transfers, dressing, to resident was totally de bathing. Review of the resident resident could be resi also listed on the resident 7/12/16 which noted s altered skin integrity. I interventions included quarterly and as need bilateral geri-legs at a	hts and inserviced all staff idents in the facility were ere no concerns. The vas removed on 6/17/17. ealed Resident # 2 was on 7/11/16. Record review had diagnoses of failure to oporosis, anemia, esophageal reflux disease, ood disorder, vitamin D a, a history of multilevel s affecting 12 of the vertebra rity from mild to severe; and cture with deformity. t's annual Minimum Data nt, dated 5/22/17, revealed <i>MS</i> (brief interview for of "0" which indicated she uestions correctly on her esment. The resident was extensive assistance with ileting, and hygiene. The ependent on staff for her t's care plan revealed the stive to care. A problem was dent's care plan dated she had the potential for Some of the listed care plan t: skin assessments led; assist resident to wear Il times; and notify MD of eded. According to the care	F	323				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_	(06/:	C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Review of a nursing n (Friday) at 8:56 AM re bruise to her right arm centimeters (cm). And 4/14/17 at 10:48 AM re bluish/red and was ur upper arm; the ADON nursing) was notified; note was completed; i complained that the a touched. The note was Following the nursing 10:48 AM there was r existed, an assessme resident's physical sta until 4/19/17 (Wedness A nurse's note dated a the resident was seen NP for a hematoma to to the note the NP or x-ray of the shoulder, Count for Resident #2 Nurse #5. A NP's (nurse practition revealed staff had rep bruise and swelling to for three days and it w noted the resident had Review of the CT repor completed on 4/20/17 resident had an intran- right pectoralis major which measured 8.5 2 The ADON (assistant	ote by Nurse # 5 on 4/14/17 evealed the resident had a n pit which measured 8 X 5 other nurse's note dated evealed the area was nder her right arm and inner (assistant director of a physician communication and that the resident rea hurt when it was is signed by Nurse #5. entry of 4/14/17 (Friday) at no documentation the bruise ent of the bruise, or the atus in the nursing notes eday) at 2:30 PM. 4/19/17 at 2:30 PM revealed by the (nurse practitioner) o the right axilla. According dered a CT of the chest, and a Complete Blood 2. The note was signed by oner's) note on 4/19/17 forted the resident had a o the resident's right arm pit was worsening. The NP also d a chest bruise.	F	323				

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUITI	PLE CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · ·	PLETED
						С
		345280	B. WING		06	/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF RAEFORD			1206 N FULTON STREET		
AUTOWIN	CARE OF RAEFORD			RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 323	the ADON revealed F required a mechanica	Resident # 2 had always al lift for transfer since her	F 32	23		
	identification of the an obtained information	from the NAs who had				
	they transferred her a chair. According to the					
	NAs had not been tra	she had found some of the ansferring the resident per had identified that one of				
	had been picking the The ADON's investig	n using a mechanical lift but resident up "like a baby." ation had revealed one of				
	resident. The ADON the NA had been doir	fting and pivoting" the was not able to explain how ng this. According to the				
	the resident correctly	also not been repositioning in the chair, and they at nder her armpits and pull her				
	According to the ADC	than repositioning her hips. DN she was unable to nty how the hematoma had				
	occurred but had con	included it could have been ining techniques from staff.				
	the incident. The inse	inservice records related to ervices were conducted on se was found on 4/14/17.				
	According to the inse were eight NAs who	attended. During the				
	were other NAs who unit but who had not	ON it was confirmed there worked on Resident # 2's attended the inservice				
	the NAs were directe with her upper body"	ne material covered revealed d to "have her lean forward and "then guide her hips				
		ADON's inservice records sed positioning for the				

Facility ID: 922954

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	S FOR MEDICARE &					0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING			~
		345280	B. WING			_ 21/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD		21/2017
			12	206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD		R	AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 323	Continued From pag	e 84	E 222			
1 525			F 323			
	resident, and the only notation about transfers for the resident in the inservice material was "we are a lift free facility."					
		served on 6/15/17 at 3:55				
		A # 9 transferred the resident				
		ed with a mechanical lift in				
		. The NAs worked to try to cal lift sling back beneath the				
		they complete the transfer,				
		that the resident was not				
		sident would not lean forward				
	-	t they position the sling				
		stated the NA, who had				
	gotten the resident o	ut of bed earlier, should have				
		her so that they did not have				
		as much to get it positioned				
		nt was observed to complain				
		ed to get the sling beneath				
	her and transfer her i	the NAs again transferred				
		m the bed to the wheelchair				
	with the mechanical					
		ain she was hurting and was				
		e sling placement. According				
	to these evening shif					
		nytime they transferred her				
		lift. The NAs were asked if				
		esident hurt, and responded				
	scream when she wa	ecause the nurses heard her				
	scream when she wa	as udhsiehed.				
	During the care. the	resident was also observed				
	-	er right posterior leg and a				
		left posterior leg. The				
		ot observed over a typical				
	pressure point. The e	elastic in the resident's socks				
	was observed to be o	compressing into her fragile bbed area" and it was				

Facility ID: 922954

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	LETED
		345280	B. WING		_		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
AUTUMN	CARE OF RAEFORD			206 N FULTON STREET			
			ŀ	RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	not to have geri-legs of in place as per her plat tube (a thicker protect and it was not entirely was on but had becom The resident was aga 9:50 AM in her wheel present. The resident any geri-legs in place # 1 did not know why place. Interview with NA # 8 to care for her on 6/17 resident's geri-legs to day because they had skin tear. The NA stat fetal position and the a skin tear to her arm The ADON was interv During the interview to from her follow up rec area" to the resident's Interview with the ADO are thicker than geri-le resident to remove, al resident should have times. On 6/17/17 a review of May 2017, and June 3 resident had not rece There was no docume investigation following	he resident was observed (a thin protective covering) an of care. She had one skin tive covering) to one leg, v covering the lower leg it me displaced. in observed on 6/17/17 at chair as Nurse # 1 was was observed not to have per her plan of care. Nurse the geri-legs were not in revealed she was assigned 7/17 and she had sent the the laundry the previous d blood on them from an arm ted the resident slept in a resident, who currently had , had gotten them soiled. riewed on 6/17/17 at 3 PM. he ADON could not verify cords where the "scabbed is left lower leg originated. ON revealed the skin tubes	F 323		JEFICIENCY)		
	identification that staf						

Facility ID: 922954

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING		-		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 323	the resident's pain wa cooperate with position sling for mechanical life 3. Record review reverse admitted to the facility diagnoses included by following: vascular de disturbance, generaliz history of cerebral infa depressive disorder, a affective mood disord Review of the resident and needed extensive staff with his transferse bathing needs. Review of the resident revealed the staff had resident had sustaine future falls. One of the encourage the resident areas while out of bed Review of nursing not was ambulatory with s when he experienced hip fracture. Per the n was transferred to the open reduction interna- the facility on 4/20/17 status. Review of the nursing	as impacting her ability to oning and placement of the ft transfers. ealed Resident # 3 was on 9/8/16. The resident's ut were not limited to the ementia with behavioral zed weakness, glaucoma, arction, osteoarthritis, major anxiety disorder, and er tt's readmission MDS assessment, dated 5/4/17, was cognitively impaired e to total assistance from s, toileting, hygiene, and tt's current care plan l identified on 9/8/16 the d a fall and was at risk for e interventions was to nt to remain in high traffic d. tes revealed Resident # 3 supervision up until 4/12/17, a fall and sustained a left pursing notes, the resident e hospital where he had an al fixation and returned to under a non-weight bearing	F 323	3			
	open reduction internative facility on 4/20/17 status. Review of the nursing continued to try to get	al fixation and returned to under a non-weight bearing					

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345280	B. WING			_		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
	CARE OF RAEFORD			1	206 N FULTON STREET			
AUTUMIN	SARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 323	Continued From page accidents and nursing sustained five unwithe from the hospital. The 6/3/17; 6/9/17, and 6/ A nursing note on 5/3 resident had been fou There was no docume hurt. The note was sig There was no nursing the fall of 5/27/17. The the accident revealed Resident # 3 was four and he told the staff h On 5/7/17 the residen include a new interven visual checks." A nursing note entry of the resident was obse roommate's bed on hi not have injuries. The # 2. A nursing note entry of the resident had been with his head resting if room. There was no of note was signed by N A nursing note entry of the resident had been	e 87 g notes revealed the resident essed falls since his return ese were 5/3/17, 5/27/17, 11/17. /17 at 4:50 PM noted the ind sitting in his doorway. entation the resident was gned by Nurse # 5. g entry in the record noting e facility's documentation of on 5/27/17 at 5:09 AM nd on the floor in his room ie was going to get his boat. At's care plan was updated to intion of "every fifteen minute on 6/3/17 at 11:30 PM noted erved sitting beside his is buttocks and was found to in note was signed by Nurse on 6/9/17 at 10:55 AM noted of found lying on his left side in his left hand in the TV documentation of injury. The		323			TE	
	was observed laying of the dining room. Ther injury. The note was s	on the floor on his left side in e was no documentation of signed by Nurse # 3. ntation of the incident noted						

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		O. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,		CON	IPLETED
						С
		345280	B. WING		06/21/2017	
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	E	
	CARE OF RAEFORD			1206 N FULTON STREET		
				RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 88	F 323			
	On 6/17/17 at 3 PM the resident's falls were reviewed with the ADON (Assistant Director of Nursing) who had investigated the circumstances					
		According to the ADON,				
		both as a farmer and in a				
	job prior to residing a					
		busy all the time and arising				
		d poor safety awareness According to the ADON a				
	staff member is requi	-				
		om/activity room anytime				
		thin the room so that there				
	-	According to the ADON there				
		NAs that is based upon their				
		ers. According to the ADON				
	each NA is assigned room/Activity room. T					
	-	A room assignments. The				
		re generally three NA room				
		ck of the 600 hall; the "split,"				
	-	00 hall. The ADON provided				
	•	yroom "Activity Room				
	Schedule" for first sh	-				
		is assigned to care for				
		k of 600" is assigned to be m from 9:00 AM to 10:00 AM				
		1:00 PM. According to the				
		igned to care for residents on				
		t was assigned to be in the				
		n 10:00 AM to 11:00 AM and				
	-	o 2:00 PM, and the NA who				
	-	for the residents on the				
	"back of 700" was as	-				
	-	n 11:00 AM to 12 noon and				
	-	o 3:00 PM. The ADON en assigned to be in the				
		en assigned to be in the				1
	activity room during t	he time that Resident # 3 fell				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		345280	B. WING			0 /21/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323 F 329 SS=D	the activity room sche 6/8/17, and therefore activity room to monit According to the ADC and she had not yet ic which had let to Resid dining room floor on 6 There was no docume investigation of Resid had reviewed the resp were assigned for sup when he was experie staff members were be every fifteen minutes 483.45(d)(e)(1)-(2) DI FROM UNNECESSA 483.45(d) Unnecessa Each resident's drug unnecessary drugs. drug when used (1) In excessive dose therapy); or (2) For excessive dure (3) Without adequate (4) Without adequate (5) In the presence of which indicate the dose discontinued; or	edule had been changed on she had not been in the or the resident when he fell. IN she had been on vacation dentified the circumstances dent # 3 being found on the 5/11/17 at 8:30 AM. The tailon in the facility's ent # 3's falls showing they bonsibilities of the NAs who bervision to Resident # 3 noing the falls to assure the being able to check on him per his plan of care. RUG REGIMEN IS FREE RY DRUGS ry Drugs-General. regimen must be free from An unnecessary drug is any (including duplicate drug ation; or	F 32			7/17/17

Event ID: C5BS11

Facility ID: 922954

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PRINTED: 07/21/2017

		MEDICAID SERVICES	(X2) MULT	IPI E C	CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,			1 Y /	IPLETED
							С
		345280	B. WING			00	6/21/2017
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD		1206 N FULTON STREET RAEFORD, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329		e 90 ough (5) of this section.	F3	329			
	483.45(e) Psychotrop Based on a comprehe resident, the facility m	ensive assessment of a					
(1) Residents who have not use drugs are not given these drug medication is necessary to trea condition as diagnosed and do clinical record;	nese drugs unless the ary to treat a specific						
	gradual dose reduction interventions, unless an effort to discontinue This REQUIREMENT by: Based on record revis facility failed to consust determine the necess dosage for one (Resist residents who sustain	clinically contraindicated, in ie these drugs; is not met as evidenced iew and staff interviews the ilt with the physician to sity of a resident's Aspirin dent # 1) of two sampled hed multiple falls which I hematoma and extensive			Preparation and submission of this P is required by state and federal law. POC does not constitute an admissio purposes of general liability, professio malpractice or any other court procee Corrective action taken for the resider	This n for onal ding.	
	until 6/10/17. Review of physician of was admitted on 4/18	at the facility from 4/18/17 orders revealed the resident 6/17 with an order for Aspirin aily) for Atrial Fibrillation.			found to have been affected: 1a. Resident #1 no longer resides in facility. Corrective action taken for those resid having the potential to have been		
	(Aspirin can be used	as an anti-coagulant.)			affected:		
	4/21/17, the resident	sician's progress note, dated had the following diagnoses: s disease, frontotemporal			2a. Subsequent to each fall a review medications will be completed by the nurse to determine if the resident is	of	

Facility ID: 922954

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345280 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1206 N FULTON STREET** AUTUMN CARE OF RAEFORD RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 Continued From page 91 F 329 dementia with pseudo bulbar affect, chronic atrial receiving anticoagulants. fibrillation, iron deficiency anemia, hyperglycemia, 2b. For each resident that has a fall, the hypertension, alopecia, history of a healed MD will be notified if a resident is fracture, and history of falls. The physician receiving an anticoagulant. 2c. An audit tool has been put in place to indicated in this note that Resident #1 had no bruising or abnormal bleeding as of his include head to toe assessments. RZP assessment date, and her last hgb (hemoglobin) and MD notifications, and medication was 9.8. The physician also noted, "Please let me review for each fall. know about any changes in behavior that indicate an exacerbation of today's issues." Measures that will be put into place or systemic changes made to ensure that A nursing note on 4/24/17 at 7:18 AM indicated the deficient practice will not occur: Resident # 1 had slid to the floor and sustained bruising to her right flank. 3a. Re-education will be provided to licensed nurses regarding Anticoagulants Review of the resident's MDS (Minimum Data including: identification, side effects and Set) assessment, dated 4/25/17, revealed the contraindications by 7/17/2017. resident was cognitively impaired. 3b. Re-education will be provided to licensed nurses regarding protocol of A pharmacy review note dated 5/30/17 at 4:12 medication review and MD notification by PM contained no recommendations or notations 7/17/2017. related to the resident's Aspirin dosage. 3c. Education for newly hired nurses will be provided regarding Anticoagulants, Review of the nursing notes and facility protocol for medication review and MD documentation of accidents revealed that notification. Resident # 1 sustained three falls on 6/6/17, 6/8/17, and 6/9/17. Monitoring: A nurse's note dated 6/10/17 at 5:38 PM 4a. The fall audit will be completed by revealed, "Writer called to TV room Resident DON/designee for each fall for 12 weeks. observed with her right knee on the floor and her 4b. Audits will be reviewed by the QAPI right elbow resting on an arm-chair. Resident committee monthly for 3 months. assessed for injuries; no injuries noted. Resident 4c. Each fall will be discussed and had old bruising to her arms and the right reviewed in clinical meeting 5x/week to temporal area. Resident had no complaints of ensure ongoing compliance with protocol pain. MD in facility, notified of unwitnessed fall." for 12 weeks. The note was signed by Nurse #1. Nurse # 1 was interviewed on 6/15/17 at 2:00 PM

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 07/21/2017

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
			A. BOILDING			С
		345280	B. WING		0	6/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF RAEFORD			1206 N FULTON STREET		
AUTOMIN				RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 329	Continued From page	e 92	F 32	00		
		y which noted the resident	1 02			
		ead, was a documentation of				
		on 6/9/17 at 3:43 PM.				
	A review of the regide	ent's June 2017 MAR				
		ration record) revealed she				
		scribed dosage of 325				
	milligrams of Aspirin daily from 6/6/17 through 6/10/17.					
	Review of 6/10/17 ho	spital records revealed the				
		ed in the emergency room				
		tensive bruising. The ER				
		esident had bruising on the				
		her head; the right flank, the hip, the right knee, and the				
		noted she had critical anemia				
	with a Hemoglobin le					
		ed was "likely secondary to a				
		leed)." The resident's stool				
		ositive for blood in the ER. A raphy (CT) scan of the				
	-	10/17 revealed she had a				
		al hematoma measuring 5				
	mm (millimeters) in th	nickness.				
	Interview with Nurse	# 1 on 6/15/17 at 2:00 PM				
		AM revealed she had been				
	-	to the fall on 6/9/17 at 3:43				
		I the resident had some				
	the right temple area	r arms and a purple bruise to				
		e did not take her back to her				
	room to check her en					
	Nurse # 2 was intervi	iewed on 6/16/17 at 9:16 AM.				
		staffing sheets, Nurse # 2				
		care for Resident # 1 from				
	U	ay) until 7 AM on 6/10/17				

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 07/21/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE COMP	SURVEY LETED
		345280	B. WING					C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 329	(Saturday). According the ADON (assistant of her the Friday evening 1, and they discussed acting differently and a a urinary tract infection Interview with the ADO Resident # 1 had a br she had not seen earl ADON on Friday ever resident reach one tim reaching for somethim her pupils seemed to she had spoken to Nu understanding that Nu up with the physician. Interview with Nurse # revealed she had bee dayshift on 6/10/17 (S she had not received had been bruised or in did not know the reside dayshift NAs (NA # 6 and reported they had giving her care. Nurse went to assess the reaching her supervisor. NA # 7 was interviewed Interview with NA # 7 assigned to care for F # 7 stated the residen lunch, and when they	to Nurse # 2, she recalled director of nursing) talking to g of 6/9/17 about Resident # I that Resident # 1 was wondering if she might have n. ON on 6/16/17 at 3:55 PM uise to her temple which lier. According to the hing of 6/9/17 she saw the he into the air as if she was g that was not there, and be small. The ADON stated urse # 1 and it was her urse # 1 was going to follow # 3 on 6/15/17 at 12:25 PM	F	329				

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	-	D HUMAN SERVICES					FORM): 07/21/2017 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345280	B. WING			-		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				1:	206 N FULTON STREET			
AUTUMN	CARE OF RAEFORD			R	AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 329	bruises on both arms, under her arm, on the breast, and on her rig 7 revealed she had no head earlier because and when they were p tipped backward whic # 7 stated the head buther her hand. Interview with Nurse # revealed Nurse # 3 ha 6/10/17 and told her F "everywhere." Nurse # physician and he wan at the hospital. The nut for Resident # 1 to go department via way of service. The MAR was review 6/15/17 at 5:30 PM ar ADON the MAR show Aspirin was held. The nursing notes the faci- the physician regardin dosage when the resi- they had observed the An interview with the on 6/17/17 at 7 PM re- reason for the resident her repeated falls. Ac- staff had not consulte resident's Aspirin dos- on her head and the to The physician stated	both hips, on her legs, e side of her chest by her ht head. Interview with NA # of seen the bruise on her the resident wore a bonnet providing care the bonnet h revealed the bruising. NA ruise was about the size of # 1 on 6/16/17 at 9:46 AM ad called her at home on Resident # 1 had bruises # 1 stated she called the ted her sent for a CT scan urse stated it was arranged to the hospital out- patient f a non-emergency transport ed with the ADON on nd it was confirmed with the re was no indication in the lity staff had consulted with ng the resident's Aspirin dent began falling or when e head bruise on 6/9/17. resident's facility physician wealed the most likely ut's extensive bruising was cording to the physician the d with him regarding the age when she had a bruise hree falls within four days. he did not usually order e for residents, and Resident	F	329				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DATE COMP		
		345280	B. WING _				21/2017	
NAME OF P	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET AEFORD, NC 28376			
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u>к</u>	PROVIDER'S PLAN OF CORRECTION			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 514 SS=E		TE/ACCURATE/ACCESSIB	F	514			7/17/17	
	standards and practic	h accepted professional ces, the facility must ords on each resident that						
	(i) Complete;							
	(ii) Accurately docum	ented;						
	(iii) Readily accessible	e; and						
	(iv) Systematically or	ganized						
	(5) The medical recor	d must contain-						
	(i) Sufficient informati	on to identify the resident;						
	(ii) A record of the res	sident's assessments;						
	(iii) The comprehensing provided;	ve plan of care and services						
	(iv) The results of any and resident review e determinations condu							
	(v) Physician's, nurse professional's progres	e's, and other licensed ss notes; and						
	services reports as re This REQUIREMENT by:	logy and other diagnostic equired under §483.50. is not met as evidenced iew and staff interviews the			Preparation and submission of this P0)C		
		e the medical records were			is required by state and federal law. T			

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PRINTED: 07/21/2017

OLITICI		MEDICAID SERVICES	-				IO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	1 Y /	TE SURVEY MPLETED
		345280	B. WING			0	C 6/21/2017
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD				06 N FULTON STREET AEFORD, NC 28376		
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 514	Continued From page	e 96	F 51	14			
		te for three (Resident # 1,			POC does not constitute an admission	n for	
	Resident # 2, and Re	sident # 3) of three sampled			purposes of general liability, profession	nal	
	residents who had su The findings included	istained accidents or injuries. I.			malpractice or any other court proceed	ding.	
					Corrective action taken for the residen	ts	
	at the facility from 4/1				found to have been affected:		
	u u u u u u u u u u u u u u u u u u u	lical record the resident had			1a. Resident #1 no longer resides in the	he	
		es: advanced Parkinson's			facility.		
	bulbar affect, chronic	ral dementia with pseudo			1b. A review of resident #2's medical record was conducted by the DON to		
		/perglycemia, hypertension,			validate the most recent assessments	are	
		of hair), healed fracture of			reflective of the resident's current	uro	
		story of falls; chronic kidney			condition.		
	disease, scoliosis, an	id hypothyroidism.			1c. A review of resident #3's medical		
					record was conducted by the DON to		
		ing notes revealed an entry			validate the most recent assessments	are	
		e" of 6/10/17 at 5:12 PM			reflective of the resident's current condition.		
		alled to TV room Resident ht knee on the floor and her			condition.		
	-	an arm-chair. Resident			Corrective action taken for those reside	ents	
		no injuries noted. Resident			having the potential to have been	onto	
	had old bruising to he				affected:		
		ent had no complaints of					
		otified of unwitnessed fall.			2a. An assessment audit was conduct		
		ontact RP [Name of RP] to			on 5/17/2017 for current residents that		
	by Nurse #1.	d fall." The note was signed			had falls since 6/1/2017. The audit too included head to tote assessments, RI		
	by Nuise #1.				notifications and MD notification.	1	
	Nurse # 1 was intervi	ewed on 6/15/17 at 2 PM			2b. The DON/designee will review the	;	
		/ was documentation of an			medical records for changes in condition		
		d on 6/9/17 at 3:43 PM and			to ensure that assessments and medic	cal	
	had not occurred on 6 record reflected.	6/10/17 at 5:12 PM as the			record are accurate.		
					Measures that will be put into place or		
		se # 3 on 6/15/17 at 12:25			systemic changes made to ensure that	t	
		been on duty during the			the deficient practice will not occur.		
		Saturday). Nurse # 3 stated			20 Do advection on fall monoscores		
	she had not received	a report that Resident #1			3a. Re-education on fall management	L	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· · ·	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		B. WING	C 06/21	/2017				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
AUTUMN CARE OF RAEFORD				1206 N FULTON STREET RAEFORD, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	ICOLD DE	(X5) COMPLETIO DATE			
F 514	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 514					

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	-	D HUMAN SERVICES				FORM): 07/21/2017 1 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
345280			B. WING		C 06/21/2017		
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE	, ZIP CODE		
AUTUMN CARE OF RAEFORD				06 N FULTON STREET AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 514	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 98 NP for a hematoma to the right axilla. According to the note the NP ordered a CT (computerized tomography) of the chest. The NP's note on 4/19/17 revealed the resident also had a chest bruise. Review of the CT report revealed it was completed on 4/20/17. The findings revealed the resident had an intramuscular hematoma to her right pectoralis major muscle (chest muscle) which measured 8.5 X 4.1 X 4. 6 cm. On the same day when the CT was done (4/20/17) showing the hematoma, Nurse # 6 completed a Bi-weekly check of the resident's skin on 4/20/17. Nurse # 6 documented the resident had no current skin issues. There was no documentation on 4/20/17 of the bruise in the nursing notes on 4/20/17. Review of a Bi-Weekly skin check dated 4/23/17 revealed Resident # 2 had bruising and hematoma to the right arm pit. The Bi-Weekly Skin Check was signed by Nurse #5. A Bi-Weekly skin check dated 4/26/17 revealed that Resident # 2 had no current skin issues. The skin check was signed by Nurse #6. There was no documentation on 4/26/17 of the bruise in the nursing notes on 4/26/17. On 4/29/17 Nurse # 7 documented on a Bi-weekly skin check that Resident # 2 had a bruise under her right arm. Interview with the DON on 6/17/17 at 5:30 PM revealed it was her expectation that the nursing staff document any bruising or abnormal skin		F 514				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/21/2017 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345280		B. WING		_	C 06/21/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD		1206 N FULTON STREET RAEFORD, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	admitted to the facility diagnoses included b following: vascular de disturbance, generaliz history of cerebral infa depressive disorder, a affective mood disord On 6/17/17 at 3 PM tt of Nursing) was interv resident had sustaine of the resident's medi Resident # 3 had sus 5:09 AM and the incid documented in the resident	e record until it was ealed Resident # 3 was o on 9/8/16. The resident's ut were not limited to the ementia with behavioral zed weakness, glaucoma, arction, osteoarthritis, major anxiety disorder, and er. The ADON (Assistant Director riewed regarding falls the d. This interview and review cal record revealed tained a fall on 5/27/17 at lent had not been sident's medical record. The ses should have entered the	F 514		DEFICIENCY)		

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