DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING		04/20/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET	
				MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
		vey was conducted from 20/18. Immediate Jeopardy			
	J.	689 at a scope and severity 835 at a scope and severity			
	Tag F 689 constituted Care.	l Substandard Quality of			
		began on 12/27/17 and was . An extended survey was			
	05/09/18 at tag F-689				
F 641 SS=D		ents	F 641	1	5/14/18
	resident's status.	of Assessments. It accurately reflect the is not met as evidenced			
	Based on record rev facility failed to accur comprehensive minin	num data set for a resident services for 1 of 2 residents		This plan of constitutes our written pla ofcompliance for deficiencies cited; however,submission of the plan of correction is notan admission that a deficiency exists orthat one was cited	an
	The findings included			correctly. This plan ofcorrection is submitted to meet requirements established by state and federal law.	
		mitted to the facility on cently readmitted to the		The plan of correcting the specific	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				05/14/2018

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: 07/11/2018

	S FOR MEDICARE &				OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345129	B. WING		04/20/2018	
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
UTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC	
F 641	Continued From page	e 1	F 641			
	facility on 01/06/18 w dependence on renal	ith diagnoses that included:		deficiency. The plan should addres processes that lead to the deficienc cited: The facility failed to accurately code	y	
	dated 01/06/18 read i dialysis 3 times a wee	n part, please take to		dialysis on the MDS for resident #33	3.	
		ehensive minimum data set 8 revealed dialysis was not #33's MDS.		acceptable plan of correction for the specific deficiency cited: Regional MDS nurse provided educ for MDS care plan team on 5/14/20	ation	
	coordinator stated that	ducted with the MDS /18 at 10:05 AM. The MDS at she completed most of the including the section that		which includes Dietary Manager, So Worker, Activities Director, and MDS nurse.		
	included dialysis. She her information to cor	e indicated that she obtained nplete the MDS from cluded Nursing Assistant		The monitoring procedure to ensure the plan of correction is effective an specific deficiency cited remains con and/or in compliance with the regula	d that rrected	
	assessments, doctor' orders. The MDS co	s notes, and physician		requirements: The DON will audit 2 MDS assessm for accuracy per week for 4 weeks a	ients	
	coordinator confirmed comprehensive MDS 01/13/18 and stated s	me to the facility. The MDS d that she had completed the on Resident #33 dated she had just missed it but		then 2 MDS assessments monthly thereafter for 12 months. The MDS assessment audits will be brought by the DON to the Quality		
	would immediately m	on the subsequent DS coordinator stated she odify and correct the MDS. ducted with the Director of		Assurance Committee for review to ensure sustained compliance for 12 months. Any areas of concern will b corrected at the time it is identified.		
	Nursing (DON) on 04 stated that the MDSs accurately as possible	/20/18 at 3:45 PM. The DON		The title of the person responsible for implementing the acceptable plan of correction: Director of Nursing		
F 689	she had completed th inaccuracy.	ne modification to correct the		Ŭ		

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				E CONSTRUCTION	OMB NO. 0938-0		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345129	B. WING		04/20/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MOCKSVILLE		1007 HOWARD STREET MOCKSVILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETI		
F 689	Continued From page	e 2	F 689	9			
SS=J				-			
The fa §483. as free §483. super accide This F by: Base reside facility facility facility facility facility facility facility facility facility facility affect service Imme extern facility assist the va falled detern van th jeopa facility remai	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and						
	supervision and assis accidents.	esident receives adequate stance devices to prevent F is not met as evidenced					
	Based on observation resident, and Medica facility failed to ensure transported on extern was safely transferred back to the facility. We facility the resident we facility failed to thorous determine root cause affected 1 of 2 resident services (Resident #22 Immediate jeopardy be	e of the incident. This onts who received dialysis 33). began on 12/27/17 when the		 The plan of correcting the specific deficiency addressing the process the lead to the deficiency cited: Facility did not thoroughly investigate occurrence related to resident #33 fa from wheelchair on external transportion on 12/27/2017. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: In the event of an accident related to the specific deficiency cited to the specific def	e all rtation		
	facility and stated to t assistance in getting the van. Following the failed to thoroughly in determine the root ca van that involved Res jeopardy was remove facility provided and i credible allegation of	bortation driver entered the the staff that he needed Resident #33 off the floor of e incident, the facility staff hypestigate the incident and to ause of the incident on the sident #33. Immediate ed on 04/20/18 when the implemented an acceptable compliance. The facility iance at a lower scope and		external contracted transportation, fa administrator/DON will collaborate w external contracted transportation in to investigate to determine root caus event. In the event of an accident re to external contracted transportation Administrator/DON will notify superv that their services will be suspended investigation is completed and corre action taken.	vith order se of lated , isor until		
	severity of D (no actu more than minimal ha jeopardy) to complete	al harm with potential for arm that is not immediate e staff education and ensure out into place are effective for		The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remain corre and/or in compliance with the regula	that ected		

Facility ID: 922953

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
		345129	B. WING		04	4/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 689	Continued From page	- 3	F 68	99		
	part, the contractor (e company) will follow t drivers are drug teste checks done prior to A copy of the externa company's safety plat the hiring process and included defensive dr distracted driving edu use policy), emergend the wheel training. Resident #33 was init on 12/20/17 and read 01/13/18 with diagnos	I: contract titled Public ment dated 07/12/17 read in external public transportation the approved safety plan. All ed and criminal background hiring. I public transportation n was obtained and outlined d training process that		To ensure safety of our restransports on facility transp Administrator will perform observation of transport aid that the transport aid is co- utilizing the Competency: Wheelchair and Resident which includes Wheelchai Securing Passenger, Rele Wheelchair, and Releasing loading and unloading of r x 4, then monthly x 3, and completed annually on cur transportation staff. In add transportation hires, initial will be completed to ensur transport and at least annu-	port van, direct id and validate mpetent by Securing in Van form r Securement, easing g Passenger on residents weekly will be rrent lition, for new competencies re safety during ually thereafter.	
	above the knee ampurenal dialysis. Review of the compression (MDS) dated 01/13/18 had long and short-te	ehensive Minimum Data Set 8 revealed that Resident #33 9 rm memory problems but		Wheelchair and Residents brought to the Quality Ass Committee monthly for rev Administrator for 12 month	s in Van will be urance view by the ns.	
	skills. Resident #33 re people for transfers. Review of a nurses n PM signed by the Dir in part, the external p driver came to the nu Resident #33 was on	n daily decision-making equired total assistance of 2 ote dated 12/27/17 at 2:00 ector of Nursing (DON) read ublic transportation van rse's station and stated that the floor of the van. He have slid out of her wheel		The Administrator will colla contracted transportation of obtain a list of drivers that services to our facility in or initial competencies by util Competency: Securing WI Resident in Van form whic Wheelchair Securement, S Passenger, Releasing Wh	company to will be providing rder to perform lizing the heelchair and h includes Securing	
	chair during transport Environmental Servic the van to observe th called for assessmen			Releasing Passenger on le unloading of residents for and any new hires prior to transported. The compete performed quarterly therea	oading and current drivers residents being ncies will be	

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	TE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED	
		345129	B. WING		0	4/20/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 689	Continued From page	2 4	F 6	89			
	public transportation vocalize how long she van during the transport there were cameras in that. The external pub DON and ESD stayed Emergency Medical S assist in transferring. her wheelchair and th EMS stretcher. EMS th #33 to the hospital. Re notified of the transport transportation compar He stated they would investigation on the e transport company an recordings. Nurse pra Resident #33 was una happened or how long An interview was compared transportation compared out the external company's director has investigation. An interview was compared transportation Director 11:18 AM. The PTD s work on 01/02/18 and further stated that the investigate the incider footage and made the believed happened. He investigation led us to	van driver was unable to e had been in the floor of the ort however stated that in the van that would show olic transportation van driver, d with Resident #33 until Services (EMS) arrived to EMS assisted resident to teen down the lift and to the then transported Resident esident #33's family was ort and the external public my's security officer called. be completing the nd of external public ad monitoring the camera actitioner (NP) was notified. able to verbalize what g she had been in floor. ducted the external public my's security officer on . He stated that he could not ent that it was a personnel il public transportation ad the full details of the ducted with the Public or (PTD) on 04/19/18 at tated that he returned to I learned of the incident. He y immediately began to nt and watched the video e determination of what they		Administrator. To ensure sa residents during external c transportation, the Adminis perform initial competencie on proper on loading and s residents properly. Until the to secure a contract with a company to provide wheele the facility will provide the f services. In the event that transport is required, the fa the services of a medical tr company that specializes in transports. The title of the person resp implementing the acceptate correction: Administrator	ontracted trator will es for all drivers ecuring of a facility is able transportation chair transports, transportation a stretcher icility will utilize transport n stretcher		

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATI	<u>D. 0938-039</u> E SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	СОМ	PLETED	
		345129	B. WING		04/20/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MOCKSVILLE		1007 HOWARD STREET MOCKSVILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		OULD BE	(X5) COMPLETIO DATE	
F 689	contracture of Reside her head to go back a forward and slid unde with her back against arrived at the facility a discovered Resident a and entered the facilit facility staff contacted was transported to th The PTD stated they however the video for needed to know. The because he did not re- medical emergency. received education of defensive driving, blo first aid, cardiopulmor external defibrillator u car seat booster seat procedure and evacu call center issues, use inclement weather, an procedures. He adde class room training th seasoned drivers for get acclimated to the took 2-5 days depend of the driver. The PT never indicated why o he did not see her in directly above his hea when he reviewed the to ascertain why he d his mirror. An observation of the external public transp 04/19/18 at 4:06 PM.	and she pushed her hips and she pushed her hips or the seat belt to the floor the wheelchair. The driver and opened the door and #33 on the floor of the van ty to get some help. The I EMS and Resident #33 e hospital. interviewed the driver, btage told us what we driver was terminated espond appropriately to a The PTD state that drivers n lift position procedure, od and air borne pathogens, hary resuscitation, automatic use, special needs children, security, emergency ation, customer sensitivity, e of the push to talk phones,	F 6	89			

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		IO. 0938-039 E SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	• •	G	· · /	IPLETED		
		345129	B. WING		04/20/2018			
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF	HOULD BE	(X5) COMPLETIO DATE		
F 689	front of the van, one of camera was directly of camera was directly of 12:32 PM the driver w #33 onto the van and the floor of the van and the floor of the van and came over her left sh and fastened to the fl The driver began to of 12:36 PM and at 12:3 observed to begin to appear to become rig back and her hips slice	e 6 on the rear of the van, one on Resident #33 and one on the driver. On 12/27/17 at vas noted to push Resident secure her 4-point straps to nd apply the seat belt which oulder across her abdomen oor behind her right side. By PM Resident #33 was violently twitch, her hands id and she threw her head de forward. The driver was his cell phone and proceeded	F 6	89				
ol tc cl A br w fr R fl tw w	to make a personal c checking his mirror of As the van proceeded bump, Resident #33 with her head back, h front of the wheelcha Resident #33 slipped floor of the van. The s was now resting acro	all at 12:37 PM, never r speaking to Resident #33. d down the road with each who was now unconscious her hips inched closer to the ir seat and at 12:39 PM from the wheelchair to the seat belt still secured but ss her chest. The driver ne with no knowledge of						
	checked his mirror or At 12:41 PM Resider consciousness and lii disoriented and tried was heard coughing a pull her shirt down ov again never checked his cell phone. At 12: the facility parking lot space and placed the remained in his seat	fted her head, she appeared to lift her arm. Resident #33 and appeared to be trying to ver her abdomen. The driver his mirror and remained on 47 PM the driver returned to backed the van into the e van in park. The driver continuing his conversation d yet to observe Resident						

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							IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTI		· · /	E SURVEY IPLETED
		345129	B. WING			04/20/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE			1007 HOV			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 689	Continued From page	e 7	F 6	389			
		lift gait up to the van and		.03			
		#33's wheelchair, at which					
		dent #33 was not in the					
	wheelchair, he then h						
		er loosened the seat belt and					
	attempted to pick up	Resident #33 and when he					
	could not, he exited the	he van and proceed to enter					
		esident #33 was still on the					
		ne seat belt was now resting					
		of her neck and was looped					
	under her left arm.						
		t 12:56 PM and completely					
		t from Resident #33. The					
	-	the van at 12:58 PM, the the the driver. At 1:00					
		the van and got down on the					
		33 and states are you feeling					
		stated "NO". The DON then					
		'are you a diabetic?" and					
		nt #33 and checked a pulse					
		DON was then overheard					
	stating "I can't touch I	her she is on your property",					
	she then dialed a nur	nber on her cell phone and					
		en EMS would be there and					
		ergency" and indicated					
	Resident #33 was pa						
		I on the scene and entered					
		assess Resident #33, she er wheelchair and exited the					
		. Once outside the van the					
	EMS workers placed						
	-	back of the ambulance. At					
		ntered the van and left the					
	parking lot while the I	EMS van was still parked in					
	the facility parking lot						
	-	v was conducted with the					
		:00 PM. The PTD stated					
		nated for violating the cell					
	Induced and included	pulling over and contacting	1	1			1

	S FOR MEDICARE &						<u>IO. 0938-03</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				TE SURVEY MPLETED	
		345129	B. WING			0	4/20/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MOCKSVILLE				HOWARD STREET CKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		SHOULD BE	(X5) COMPLETIO DATE		
F 689	F 689 Continued From page 8 emergency personnel when a medical emergency occurred. The PTD verified that the external public transportation driver had received the education on the lift position procedure, defensive driving, blood and air borne pathogens, first aid, cardiopulmonary resuscitation, automatic external defibrillator, special needs children, car seat booster seat security, emergency procedure and		F	589				
	· · · · · · · · · · · · · · · · · · ·							
	them. The driver expl that if there was an en- they were to pull over and to notify our dispa- was never appropriate patient on the floor of	es and how to respond to ained that they were trained mergency or an accident to a safe place and call 911 atch. The driver stated that it e to drive around with a the van. She also stated driver involved in the incident						
	added that she ensurvisible in her mirror and her during the communand certainly did not the driving the van.	t she was aware of it. She ed Resident #33 was always nd she would often talk to ute to make sure she was ok talk on her cell phone while ducted with Resident #33 on						
	not recall the incident no idea she had faller being in the hospital a any recent seizures.	Resident #33 stated she did on the van at all, she had n. Resident #33 recalled and stated she has not had Resident #33 stated she river now and she felt very						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/2018 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE	
		345129	B. WING			04/	20/2018
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	1007 HOWARD STREET		
AUTUMN	CARE OF MOCKSVILLE			r	MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	04/18/18 12:54 PM. 12/27/17 he was called DON at the public trans when he walked onto #33 sitting on her butt Resident #33 was ver much. The ESD state happed and he stated of my supervisor." He EMS and they came a her back in the wheel her to the stretcher ar The ESD stated that i out from under the se he did not have anyth transportation compare they have the ability to He added that he had drivers of the external company before and of safe driving practices. Resident #33 returned anti tippers to both the wheelchair and tilted her center of gravity s amputee. An interview was com 04/19/18 at 9:10 AM. 12/27/17 the public trat to the nursing station someone to come and resident on the floor of she entered the van F her butt in front of her like her usual self but was not complaining of	ESD was conducted on The ESD stated that on a to go outside to meet the hsportation van. He stated the van he found Resident in front of her wheel chair. y sleepy and would not say d he asked the driver what l, "I am trying to get a hold added that the DON called and picked her up and put chair and then transferred hd took her to the hospital. t appeared that she had slid at belt. The ESD stated that ing to do with the public my, and stated "we believe o do what they need to do." I never ridden with the l public transportation did not verify any training or . He stated that when d from the hospital he added e front and back of her her seat back a bit to alter ince she was a bilateral ducted with the DON on The DON stated that on ansportation driver walked and stated that he needed d help because he had a of the van. She stated when Resident #33 was sitting on "wheelchair and did not look had no obvious injury and of any pain. She added she	F	689			
	like her usual self but was not complaining o had already called EN	had no obvious injury and					

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		MEDICAID SERVICES					IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		NSTRUCTION	· · · ·	FE SURVEY MPLETED
		345129	B. WING			o	4/20/2018
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE		1007 HOWARD STREET MOCKSVILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 689	Continued From page	e 10	É F	689			
		ng lot this was what he					
		t insisting that we needed to					
	get Resident #33 up and he was informed that						
		shortly to get her up. The					
		r refused to answer any					
		le a statement about the					
	incident.						
		ed Resident #33 back in her					
		the lift and then transferred					
		nd they took her to the					
		ver left the facility the DON the transportation company					
		nd the safety officer returned					
		med about the incident.					
		public safety officer called					
		to the DON that the driver					
	had not driven since t	the incident and he had					
		nd it appeared that Resident					
		ity and the fall occurred					
		e parking lot. She added that					
	-	ned that the driver had been					
		ions that day and when she he investigation the request					
		N stated that the driver					
		tely pulled over and called					
		she had not seen the video					
		aware of any modification					
	that were made to the	e van or the manner in which					
		nsported. She added that					
		d any further transported					
		d stated, "she was not the					
		added that Resident #33 had					
		but did return to the facility and has had no further					
	seizure activity.						
	-	v was conducted with the					
	-	3:45 PM. The DON stated					
		nking a lot about what she					
	could have done diffic		1				

Facility ID: 922953

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		MEDICAID SERVICES			CONSTRUCTION	(X3) DATE	0.0938-039
		IDENTIFICATION NUMBER:	· ,			· /	PLETED
		345129	B. WING			04/20/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 689	incident which should		Fe	689			
	investigation from the external public transportation company and watching the video footage. An interview was conducted with the Administrator on 04/19/18 08:57 AM. The						
	Administrator stated t the external public tra Resident #33 from dia facility van was tied u						
	for consistency the fa public transportation stated the contract co training and safe drivi	cility used the external company. The Administrator ompany was responsible for ing. He added that he had lysis to watch them load and					
	unload Resident #33 at the facility and nev staff or the way they u	but at times seen them here er had concerns with the unload or load a resident. ON, and Regional Director of					
	Clinical Operations w jeopardy on 04/19/18	ere notified of the immediate at 2:58 PM. an acceptable credible					
	Compliance	F689 Accidents Credible Allegation of					
	deficiency. The plan processes that lead to o On 12-27-2017,	o the deficiency cited: upon return of Resident #33					
	notified facility staff th	tract transportation driver nat Resident #33 was on needed assistance at which ursing (DON) and					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				ORM APPROVE NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	IPLE CONSTRUCTION	. ,	OATE SURVEY OMPLETED
		345129	B. WING _			04/20/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	- ·	STREET ADDRESS, CITY, S	STATE, ZIP CODE	
				1007 HOWARD STREET		
AUTUMIN	AUTUMN CARE OF MOCKSVILLE			MOCKSVILLE, NC 270	028	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	X (EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689		e 12 ces Director immediately a and noted Resident #33	F6	689		
	sitting on floor of van Environmental Servic time he entered the v wheelchair was secu transportation compa staff that the he had	in front of wheelchair. The ce Director reports that at the				
	DON did not recall w the external contracte stated that resident # onto the floor. No ob Emergency Medical \$	heelchair securement and ed transportation driver 33 slid under the seatbelt vious injuries were noted.				
	the contract transport of this occurrence, budid not hear anything assisted Resident #3 exited the van via the	tation driver about the details ut he would only state that he j. Once EMS arrived, they 3 to her wheel chair and e lift. EMS then transferred				
	placed into ambuland the contract transport occurrence, but he re- information. The driv	and resident was then ce. The DON again asked tation driver for details of this efused to provide any ver also refused to contact				
	parking lot in the external transportation van. This provide the public transport the public transmediately contacted to the public tra	driver then left the facility ernal contracted The facility staff did not nsportation van. The DON ed the driver's Supervisor to he public transportation				
	supervisor then inform were cameras on the review the video. He would not drive again	med the DON that there e van and that he would e also stated that this driver n until this investigation was				
	transportation supervised the information	followed up with the public visor on 12-29-2017. He on regarding the review of that it appeared that the				

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PRINTED: 07/11/2018 FORM APPROVED

	-	D HUMAN SERVICES				FORM): 07/11/2018 1 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345129	B. WING		_	04/2	20/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
			10	007 HOWARD STREET			
AUTUMN	CARE OF MOCKSVILLE		м	OCKSVILLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	requested to view the denied; therefor, the f the video. As reporte actions of Resident # have contributed to th wheel chair. o On January 3, 20 up call to the public tr she was informed tha employed. At the time was made aware that as a result of his action The facility was only i actions resulted in ter analysis completed by determined that this w contracted transporta the external contracted emergency procedure monitoring Resident # ensure the resident resident resident resident The procedure contracted education of thorough investigation prevent re-occurrence Administrator, DON, a Nursing. All incidents regardless if the incid facility property, must o All external trans 19-2018 for at least th facility can determine	d a seizure. The facility video and the request was facility staff has not viewed d by the Supervisor, the 33 during her seizure could be resident sliding from her 18, the DON placed a follow ansportation Supervisor and t the driver was no longer e of the incident, the facility the driver was terminated ons on December 27, 2017. Informed that the employee's mination. Root cause y facility on 1-3-2018, vas caused by the external tion driver 's failure to follow ed transportation's policy on es by not supervising or 433 during transport to emained safe. The for implementing the rrection for the specific in root cause analysis and in of incidents/accidents to es on 4-20-2018 to and Assistant Director of	F 689				

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If continuation sheet Page 14 of 34

						NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · · ·	TE SURVEY MPLETED
		345129	B. WING			4/20/2018
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD	E	
	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 689	Continued From page	e 14	F 6	89		
			10			
	documentation/evidence of training and competency. The facility will not utilize external					
		tion company until contract				
	•	the thorough investigation				
		any accident involving a				
		ne facility will have the right				
		lating to the accident. The				
		aborate with contracted				
		ny to obtain a list of drivers services to our facility in				
	· •	al competencies for current				
		hires prior to residents being				
		eantime, residents will be				
	transported with the f	acility van other than				
	emergency transports					
		, resident's wheel chair was				
	modified by facility's					
		es director on 1-11-2018. /ho have amputations and/or				
		facility occupational/physical				
		aluation of their wheelchairs				
		ions/modifications need to				
	be made in order to e					
		residents with amputations				
		hysical Therapist on 4-20-				
		no modifications in order to				
	ensure safe transport	n accident related to external				
	o In the event of a contracted transporta					
	•	ill collaborate with external				
		ition in order to investigate to				
		of event. In the event of an				
	accident related to ex					
	-	histrator/DON will notify				
	-	services will be suspended				
	action taken.	completed and corrective				
	o On 4-20-2018, A	dministrator re-educated the				

Facility ID: 922953

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	S FOR MEDICARE &					IO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · /	TE SURVEY MPLETED	
		345129	B. WING		0,	4/20/2018	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MOCKSVILLE		1007 HOWARD STREET MOCKSVILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 689	if a resident has a met transport, loading, an facility van. In the eve facility transportation DON will be notified in transports by facility t suspended. Staff will investigation is comple root cause and the co- place. . The monitor the plan of correction deficiency cited rema compliance with the F o To ensure safety transports on facility t will perform direct obs and validate that the f by utilizing the Compe and Resident in Van f Wheelchair Secureme Releasing Wheelchai onloading and unload then monthly x 3, and on current transportation hill be completed to ensu and at least annually The Administrator will transportation compa that will be providing a order to perform initia the Competency: Sec	application, reporting o do if there is an accident or edical emergency during d unloading of residents into ent of an accident in the van, the administrator and mmediately and all other ransportation van will be be suspended until an leted in order to determine orrective action is put into ing procedure to ensure that is effective and that specific ins corrected and/or in Regulatory requirements. of our residents during transport van, Administrator servation of transport aid transport aid is competent etency: Securing Wheelchair form which includes ent, Securing Passenger, r, and Releasing Passenger ling of residents weekly x 4, d will be completed annually tion staff. In addition, for res, initial competencies will ure safety during transport	F 689				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/11/207 FORM APPROVE OMB NO. 0938-039
TATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING		04/20/2018
NAME OF PF	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
	CARE OF MOCKSVILLE			007 HOWARD STREET IOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 689		e 16 easing Passenger onloading dents for current drivers and	F 689		
	any new hires prior to transported. The cor quarterly thereafter b ensure safety of our r contracted transporta perform initial compe proper onloading and properly.	o residents being npetencies will be performed y the Administrator. To residents during external tion, the Administrator will tencies for all drivers on I securing of residents			
F 835	implementing the acc o The Administrato Immediate jeopardy when interviews with transportation staff re educated on reporting investigating incident cause for each incide Administration	was removed on 04/20/18 administrative and evealed that they had been g and thoroughly s and determining root	F 835		5/14/18
SS=J	enables it to use its m efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on observation interviews the facility identify the root caus occurred on external and then failed to ma	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced ons, record review, and staff 's administration failed to		The plan of correcting the specific deficiency. The plan should address th processes that lead to the deficiency cited: Facility Administration did not identify t root cause of an incident that occurred	he

Facility ID: 922953

If continuation sheet Page 17 of 34

<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES			OM	<u>3 NO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	, ,	DATE SURVEY COMPLETED
		345129	B. WING			04/20/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY,	STATE, ZIP CODE	
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27		
						(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 835	Continued From page	e 17	F 83	55		
		o continue to be transported			ansportation van and	
		affected 1 of 2 residents			e any process systemic	
		services (Resident #33).			anges with the company	
					dent #33 to continue to be	
	Immediate jeopardy b	began on 12/27/17 after an		transported by th	e external transport	
	incident occurred on t			company.		
		d the facility failed to discern				
		incident, failed to make any			or implementing the	
	-	al changes, failed to make			of correction for the	
		afety plan and continued to		specific deficienc	-	
	use the external publi		-	r of Clinical Services		
	transport Resident #3			on on root cause analysis		
	removed on 04/20/18 and implemented an		and thorough inv incidents/accider			
	-	nce. The facility remains out		re-occurrences o		
		wer scope and severity of D			ON, and Assistant	
		potential for more than			ng. All incidents involving	
		not immediate jeopardy) to			dless if the incident	
		tion and ensure monitoring			of facility property, must	
	systems put into place are effective for			be thoroughly inv		
	investigating incidents to determine root cause				nsports are suspended as	
	and making subseque	ent changes to ensure the		of 4-19-2018 for	at least the next two (2)	
	incident does not hap	ppen again.			ty can determine safety of	
					ring transports in which	
	The findings included	:		our facility will re	-	
	This tag is cross refer	rred to F689:		competency. The	vidence of training and e facility will not utilize	
					ed transportation	
		ns, record review, staff,			ontract is updated to	
		Director interviews the		include the thoro		
		e that a resident who was al public transportation van		u	s of any accident involving	
		d from the dialysis center		-	and the facility will have Il evidence relating to the	
		hen the van returned to the		accident. The Ad	-	
		as on the floor and the			ght and direction, will	
	facility failed to thorou				contracted transportation	
	determine root cause				in a list of drivers that will	
		nts who received dialysis			vices to our facility in	
	services (Resident #3				initial competencies for	

Facility ID: 922953

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345129	B. WING		04/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	JLD BE COMPLETIO
F 835	Continued From page	e 18	F 83	5	
	An interview with the Director (ESD) was complete PM. The ESD stated following the incident and the facility continue public transportation of Resident #33 back for believe they have the to do." He stated that returned from the hos a bit to alter her center bilateral amputee but An interview was complete Nursing (DON) on 04, stated that following the terminated and she be action and continued transportation compare knowledge no system had been made. The was unable to discerre because her request investigation was den once the driver was the action to continue the An interview was complete An interview was complete action to continue the An interview was complete action to continue the An interview was complete Administrator stated to the external public transponsible for training had not provided any	Environmental Service onducted on 04/18/18 12:54 that to his knowledge the driver was terminated ued to use the external company to transport om dialysis. He stated, "we ability to do what they need when Resident #33 pital he tilted her seat back er of gravity since she was a that was the extent of it. ducted with the Director of /19/18 at 9:10 AM. The DON he incident the driver was elieved that was appropriate to use the external public ny. She added that to her nic or contractual changes DON also stated that she n the cause of the incident for the full detail of the nied and she believed that erminated that was sufficient e use of the services. ducted with the 9/18 08:57 AM. The hat primarily the facility used unsportation van to bring		 current drivers and any new hires presidents being transported. In the meantime, residents will be transport with the facility van other than emetransports. In the event that a stretcher transport equired, the facility will utilize the sof a medical transport company that specializes in stretcher transports. o In the event of an accident relate external contracted transportation, administrator/DON, with corporate oversight, will collaborate with externat contracted transportation in order t investigate to determine root cause event. In the event of an accident relate investigate to determine root cause event. In the event of an accident relate investigation is completed and corraction taken. o On 4-20-2018, Administrator re-educated the transportation staff proper wheelchair securement, sea application, reporting requirements to do if there is an accident or if a r has a medical emergency during transport, loading, and unloading or residents into facility van. In the evan accident in the facility transportation be suspended. Staff will be suspert until an investigation is completed to determine root cause and the construction is put into place. 	orted ergency ort is services at d to facility ernal o e of elated on, rvisor ed until rective f on atbelt s, what resident of eation ll be van will oded in order

Facility ID: 922953

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING		04/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE COMPLETIC D THE APPROPRIATE DATE
F 835	Continued From page	e 19	F 83	35	
F 633	incident and they had systemic, or process continued to use the transportation compa back from dialysis be terminated and he fel action and continued transport Resident #3 The Administrator, DC Clinical Operations w jeopardy on 04/19/18 On 04/20/18 the facili credible allegation of F835 ADMINISTE Plan for Immediate Je Submission of the co- immediate jeopardy r that a deficiency exis correctly. This correct to meet requirements federal law. . The plan of deficiency. The plan processes that lead to o On 12-27-2017, from dialysis, the con notified facility staff th floor of their van and time the Director of N Environmental Service responded to the van	I not made any contractual, changes. He stated they external public ny to transport Resident #33 cause the driver had been t like that was appropriate to use their services to 33. ON, and Regional Director of ere notified of the immediate at 2:58 PM. Ity provided an acceptable compliance. RATION- Corrective Action eopardy Removal rrective action plan for emoval is not an admission ts or that one was cited ctive action plan is submitted a established by state and correcting the specific should address the o the deficiency cited: upon return of Resident #33 tract transportation driver nat Resident #33 was on needed assistance at which	F 83	the plan of correction is e specific deficiency cited r and/or in compliance with requirements. o To ensure safety of our transports on facility trans Administrator will perform observation of transport at that the transport aid is co x 4, then monthly x 3, and completed annually on cu transportation staff. The F of Clinical Services will ov one of these audits per p ensure they are being pe correctly. In addition, for r transportation hires, initia will be completed to ensu transport and at least anr The Administrator, with co oversight, will collaborate transportation company to drivers that will be providi our facility in order to perf competencies for current new hires prior to residen transported. The competen performed quarterly there Administrator. To ensure residents during external transportation, the Admin perform initial competenci on proper on loading and residents properly. Regional Director of Clini provided education on roor	emains corrected in the Regulatory residents during sport van, in direct aid and validate ompetent weekly d will be urrent Regional Director versee at least eriod specified to rformed new al competencies ure safety during nually thereafter. orporate e with contracted o obtain a list of ing services to form initial drivers and any ths being encies will be safetr by the safety of our contracted istrator will securing of cal Services

Facility ID: 922953

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		D. 0938-039 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED	
		345129	B. WING		04/20/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 835	Continued From page	e 20	F 83	5			
	transportation comparison staff that the he had a belt from resident #33 DON did not recall which the external contracter stated that resident #3 onto the floor. No object Emergency Medical S contacted via 911. The the contract transport of this occurrence, but did not hear anything, assisted Resident #33 exited the van via the resident to stretcher a placed into ambulance the contract transport occurrence, but he re- information. The drive his supervisor. The drive his supervisor. The drive his supervisor. The drive parking lot in the exter transportation van. T inspect the public trar- immediately contacter report occurrence. The supervisor then inform were cameras on the review the video. He would not drive again complete. The DON transportation supervi- relayed the information the video. He stated resident may have ha requested to view the denied; therefore, the the video. As reporte	ny driver stated to facility already removed the seat 3. At the time of the event, heelchair securement and ed transportation driver 33 slid under the seatbelt vious injuries were noted. Services (EMS) was he DON repeatedly asked ation driver about the details the would only state that he . Once EMS arrived, they 3 to her wheel chair and lift. EMS then transferred and resident was then e. The DON again asked ation driver for details of this fused to provide any er also refused to contact lriver then left the facility		Administrator, DON, and Assistant Director of Nursing. Regional Director of Operations or Regional Director of Clinical Servic audit one investigation weekly x 4 a monthly x 3, if applicable, to ensure investigations are being conducted correctly. o Monitoring results will be discuss monthly QAPI as information is ava from results of audits of investigation cause analysis of investigation of incidents/accidents. In addition to e sustained compliance, after complet the four-month monitoring of the investigation of accidents, Regional Director of Clinical Services will co one random review of accident investigations per month for the ne months. In addition, Regional Director of Services will audit training and competencies for completion on ne related to internal and external tran- van drivers. The title of the person responsible implementing the acceptable plan of correction: Regional Director of Clinical Services	es will and e ed in ailable on root ensure etion of l mplete xt six ctor of Clinical ew hires isport		

Facility ID: 922953

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/11/2018 APPROVED). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	ECONSTRUCTION		(X3) DATE	
		345129	B. WING		_	04/2	20/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	CARE OF MOCKSVILLE			1007 HOWARD STREET			
Actorial				MOCKSVILLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835		18, the DON placed a follow	F 835				
	she was informed that employed. At the time was made aware that as a result of his action	ansportation Supervisor and t the driver was no longer e of the incident, the facility the driver was terminated ns on December 27, 2017. nformed that the employee s					
	actions resulted in terr requesting additional of the incident, the fac the employee's action thereby leading the fa						
	Thus, because the inc terminated, the facility this company to trans administration did not	· · ·					
	thorough investigation incident occurred and reoccurrence. Root c	stration failed to conduct a to determine how the how to possibly prevent a ause analysis completed by					
	administration believe complete a thorough i	etermined the facility's d the facility did not need to nvestigation of this incident, ent #33, since the transport the facility's property.					
	acceptable plan of con deficiency o Regional Director	re for implementing the rrection for the specific of Clinical Services n root cause analysis and					
	-	of incidents/accidents to					

Facility ID: 922953

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345129	B. WING _		04/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028	
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 835	Continued From page	22	F 8	335	
		and Assistant Director of			
	Nursing. All incidents				
	•	ent occurs on or off of			
		be thoroughly investigated.			
		ports are suspended as of 4-			
		ne next two (2) weeks until			
		safety of our residents			
		hich our facility will require			
	documentation/evider				
		ility will not utilize external			
		tion company until contract			
		the thorough investigation			
		iny accident involving a			
		ne facility will have the right			
		lating to the accident. The			
		prporate oversight and			
	direction, will collabor				
	transportation compa	ny to obtain a list of drivers			
		services to our facility in			
	order to perform initia	I competencies for current			
		nires prior to residents being			
	transported. In the m	eantime, residents will be			
	transported with the f				
	emergency transports	6.			
		n accident related to external			
	contracted transporta				
		ith corporate oversight, will			
	collaborate with exter				
	-	r to investigate to determine			
		In the event of an accident			
		ntracted transportation,			
		ill notify supervisor that their			
		ended until investigation is			
	completed and correct				
		dministrator re-educated the			
	transportation staff or				
	securement, seatbelt				
		o do if there is an accident or			
	if a resident has a me	dical emergency during	1		

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		10. 0938-039	
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED	
		345129	B. WING		0	4/20/2018	
NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MOCKSVILLE		1007 HOWARD STREET MOCKSVILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 835	transport, loading, an facility van. In the ev facility transportation DON will be notified in transports by facility t suspended. Staff will investigation is comple root cause and the co- place. The monitor the plan of correction deficiency cited rema compliance with the F o To ensure safety transports on facility t will perform direct obs and validate that the f weekly x 4, then mon completed annually of staff. The Regional E will oversee at least of period specified to em performed correctly. transportation hires, i completed to ensure at least annually there	d unloading of residents into ent of an accident in the van, the administrator and mmediately and all other ransportation van will be be suspended until an leted in order to determine orrective action is put into ing procedure to ensure that is effective and that specific ins corrected and/or in Regulatory requirements. of our residents during ransport van, Administrator servation of transport aid transport aid is competent thly x 3, and will be n current transportation Director of Clinical Services one of these audits per usure they are being In addition, for new nitial competencies will be safety during transport and	F 83	35			
	providing services to perform initial compet and any new hires pri transported. The con quarterly thereafter by ensure safety of our r	list of drivers that will be our facility in order to tencies for current drivers					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/2018 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		345129	B. WING			04/	20/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				007 HOWARD STREET IOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	education on root cau investigation of incide re-occurrences on 4-2 DON, and Assistant D Regional Director of O Director of Clinical Se investigation weekly x applicable, to ensure conducted correctly. o Monitoring results monthly QAPI as infor results of audits of inv analysis of investigati addition to ensure sus completion of the four investigation of accide Clinical Services will of review of accident inv the next six months. Director of Operations Clinical Services will a competencies for com to internal and externa . The title of th implementing the acci o Regional Director Director of Clinical Services, Adm Assistant DON had be process of identifying	Clinical Services provided use analysis and thorough ints/accidents to prevent 20-2018 to Administrator, Director of Nursing. Director of Nursing. Services will audit one (4 and monthly x 3, if investigations are being) is will be discussed in rmation is available from vestigation root cause on of incidents/accidents. In stained compliance, after -month monitoring of the ents, Regional Director of complete one random restigations per month for In addition, Regional is or Regional Director of audit training and inpletion on new hires related al transport van drivers. The person responsible for eptable plan of correction. In of Operations and Regional ervices was removed on 04/20/18 the Regional Director of ninistrator, DON, and een educated on the the root cause of the appropriate changes to	F	335			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345129	B. WING		04/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
AUTUMN	CARE OF MOCKSVILLE			1007 HOWARD STREET MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 865	Continued From page	25	F 86	65	
F 865 SS=D	10	closure/Good Faith Attmpt	F 86		5/14/18
	§483.75(a) Quality as improvement (QAPI)	surance and performance program.			
		t its QAPI plan to the State er than 1 year after the egulation;			
		ary may not require rds of such committee ch disclosure is related to ch committee with the			
	and correct quality de a basis for sanctions.	by the committee to identify ficiencies will not be used as			
	Based on observatio interviews the facility' Assurance Committee implemented procedu interventions that the April 2017 following a subsequently recited	ns, record reviews, and staff s Quality Assessment and e failed to maintain ares and monitor these committee put into place in a recertification survey and in May of 2017 on the follow vey and then subsequently		F641 - Accuracy of Asset The plan of correcting the deficiency. The plan shou processes that lead to the cited: The facility failed to accur dialysis on the MDS for re	specific uld address the e deficiency ately code
	recited in April 2018 c survey. The repeat de of accuracy of the ass (F689) and administra deficiencies were rec current recertification failure of the facility d	on the current recertification eficiencies are in the areas sessment (F641), accidents		The procedure for implem acceptable plan of correct specific deficiency cited: Regional MDS nurse prov for MDS care plan team of including Dietary Manage Activities Director, and MI	tion for the rided education n 5/14/2018 r, Social Worker,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345129 B. WING 04/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1007 HOWARD STREET** AUTUMN CARE OF MOCKSVILLE MOCKSVILLE, NC 27028 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 865 Continued From page 26 F 865 sustain an effective Quality Assurance Program. The monitoring procedure to ensure that the plan of correction is effective and that The findings included: specific deficiency cited remains corrected and/or in compliance with the regulatory This tag is cross referred to: requirements: The DON will audit 2 MDS assessments 1a. F641: Accuracy of the assessment: Based on for accuracy per week for 4 weeks and record review and staff interviews the facility then 2 MDS assessments monthly failed to accurately code the comprehensive thereafter for 12 months. minimum data set for a resident that received The MDS assessment audits will be dialysis services for 1 of 2 residents sampled for brought by the DON to the Quality dialysis (Resident #33). Assurance Committee for review to ensure sustained compliance for 12 438.20 (Resident Assessment): During the follow months. Any areas of concern will be up and complaint survey in May 2017 accuracy of corrected at the time it is identified. assessments was cited for failing accurately code the minimum data set to reflect a resident's Monitoring effectiveness of corrective height for 1 of 9 residents sampled. action: Audits brought to QA Committee monthly 1b. F689: Accidents: Based on observations. for ongoing review to determine sustained record review, staff, resident, and Medical compliance of MDS accuracy. Director interviews the facility failed to ensure that a resident who was transported on external public The title of the person responsible for transportation van was safely transferred from the implementing the acceptable plan of dialysis center back to the facility. When the correction: external public transportation van returned to the Director of Nursing facility the resident was on the floor of the external public transportation van. Once the external public transportation van returned to the F689 - Accidents facility the facility failed to thoroughly investigate and determine root cause of the incident. This The plan of correcting the specific affected 1 of 2 residents who received dialysis deficiency addressing the process that services (Resident #33). lead to the deficiency cited: Facility did not thoroughly investigate 483.25 Accidents: During the recertification occurrence related to resident #33 fall survey in April 2017 accidents was cited for failing from wheelchair on external transportation to have a side rail securely attached to the bed for van on 12/27/2017. 1 of 40 residents. The procedure for implementing the

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

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PRINTED: 07/11/2018

						OMB NO T	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			I ` '	SURVEY PLETED
		345129	B. WING			04	/20/2018
NAME OF PF	ROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MOCKSVILLE				07 HOWARD STREET OCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 865	Continued From page	27	F 86	35			
		on: Based on observations,	1 00	5	acceptable plan of correction for the		
		aff interviews the facility's			specific deficiency cited:		
		o identify the root cause of			In the event of an accident related to		
		red on external public			external contracted transportation, faci	lity	
		d then failed to make any			administrator/DON will collaborate with		
	process, systemic, or			external contracted transportation in or	der		
	the company and allo			to investigate to determine root cause			
	to be transported by t			event. In the event of an accident related	ed		
		of 2 residents that received dialysis services (Resident #33).			to external contracted transportation,	.r	
	(Resident #33).				Administrator/DON will notify supervise that their services will be suspended up		
	483.75 Administration			investigation is completed and correctiv			
		administration was cited for			action taken.		
	-	n plans of correction to			The monitoring procedure to ensure the	at	
	-	not have a medication error			the plan of correction is effective and the		
	rate of 5 percent or gi				specific deficiency cited remain correct		
	observations during n				and/or in compliance with the regulator	У	
		of 6.66 percent. The facility communication occurred			requirements: To ensure safety of our residents durin	a	
	from staff to administ			transports on facility transport van,	Э		
	system was functionin			Administrator will perform direct			
	-	, Room 204 W, and 216 D)			observation of transport aid and validat	te	
	on 1 of 3 resident hal				that the transport aid is competent by		
					utilizing the Competency: Securing		
		: During the follow up and			Wheelchair and Resident in Van form		
		lay 2017 administration was			which includes Wheelchair Securemen	it,	
	•	ain dignity and respect of 1			Securing Passenger, Releasing	0.0	
	resident's weight and	ving staff to talk about the			Wheelchair, and Releasing Passenger loading and unloading of residents wee		
	-	resident (Resident #72),			x 4, then monthly x 3, and will be	, i i y	
		he 200 hall with a broken			completed annually on current		
	-	of the door on the hinge side			transportation staff. In addition, for new	/	
	to prevent smoke or f	ire penetration. The facility			transportation hires, initial competencie		
		smoke prevention doors on			will be completed to ensure safety duri	-	
		1 on the 300 hall, failed to			transport and at least annually thereaft	er.	
	-	rs of the main dining room			The competencies for Converse		
	failed to repair 1 of 18	of 3 residents' hallways,			The competencies for Securing Wheelchair and Residents in Van will b		

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		MEDICAID SERVICES			OMB NO. 093	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345129	B. WING		04/20/20	18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
AUTUMN	CARE OF MOCKSVILLE	E		1007 HOWARD STREET MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE COMP D THE APPROPRIATE D	(X5) PLETIO DATE
F 865	Continued From pag	e 28	F 86	35		
	on the 200 hall (Roor resident room doors the 200 hall (Room # room doors on the 30 doors were observed laminate and wood th facility also failed to it interventions by not H position as instructed sampled residents du record. An interview was cor Nursing (DON) and t at 5:08 PM. The Adm Quality Assurance (O quarterly but they ge committee was made heads, the consultan Medical Director. He the process of review infections, infection of wounds. The Administ quarterly meetings the and the use of antips DON stated that they year survey results a effectiveness of the s into place on a as ne	m #214) and failed to repair in 1 of 18 resident rooms on t217) and 1 of 13 resident 00 hall (Room #302). The d with broken and splintered hat were rough to touch. The mplement care plan having a resident's bed in low d by the care plan for 1 of 3 uring 2 federal surveys of hducted with the Director of he Administrator on 04/20/18 hinistrator stated that that the QA) committee met at least nerally met monthly. The QA e up of all the department th pharmacist, and the stated that they go through wing rehospitalization rates, control, weight loss, and strator stated that at the hey discussed medication sychotics in the facility. The v continued to report on last and continue to monitor the systemic changes they put		brought to the Quality Ass Committee monthly for re Administrator for 12 mont The Administrator or 12 mont obtain a list of drivers tha services to our facility in o initial competencies by ut Competency: Securing W Resident in Van form whi Wheelchair Securement, Passenger, Releasing W Releasing Passenger on unloading of residents for and any new hires prior to transported. The compete performed quarterly there Administrator. To ensure residents during external transportation, the Admin perform initial competenc on proper on loading and residents properly. Until to to secure a contract with company to provide whee the facility will provide the services. In the event that transport is required, the the services of a medical	eview by the ths. laborate with company to t will be providing order to perform ilizing the /heelchair and ch includes Securing heelchair, and loading and c current drivers or residents being encies will be eafter by the safety of our contracted istrator will ties for all drivers securing of he facility is able a transportation elchair transports, e transportation at a stretcher facility will utilize	
	monitoring the extern challenging. He adde have to review admis the residents daily so if they could adequat	facility employees but nal entities was going to be ed that they were going to ssions more closely and what chedule would look like to see tely take the residents and The Administrator stated		company that specializes transports. Monitoring effectiveness of action: Root cause analysis will b	of corrective be reviewed in	
DRM CMS-256	challenging. He added have to review admiss the residents daily so if they could adequate meet all their needs. that he was going to	ed that they were going to ssions more closely and what chedule would look like to see tely take the residents and The Administrator stated try to limit the use of the portation and other outside	211	Monitoring effectiveness action:	be reviewed in horough	

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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
	345129	B. WING		04/20/2018
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CARE OF MOCKSVILLE	E		1007 HOWARD STREET MOCKSVILLE, NC 27028	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	JLD BE COMPLETIO
resources. The DON stated, that this has b change the admission contract employees. will complete a full so conduct root cause a	and the Administrator been eye opening and would on process and how we view The DON added that they cope investigation and will analysis to determine how to	F 86	The title of the person responsible	
			 processes that lead to the deficient cited: Facility Administration did not idem root cause of an incident that occur external public transportation van a then did not make any process syst or contractual changes with the co and allowed resident #33 to contint transported by the external transported by the external transported company. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Regional Director of Clinical Service provided education on root cause and thorough investigation of incidents/accidents to prevent re-occurrences on 4-20-2018 to Administrator, DON, and Assistant 	cy tify the rred on and stemic mpany ue to be ort e e ses analysis
	CONTINUED FOR SUPPLIER CARE OF MOCKSVILLE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag resources. The DON stated, that this has change the admission contract employees. will complete a full so conduct root cause a	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA CORRECTION IDENTIFICATION NUMBER: 345129	IDENTIFICATION NUMBER: A. BUILDING 345129 B. WING ROVIDER OR SUPPLIER B. WING CARE OF MOCKSVILLE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 29 F 86 resources. The DON and the Administrator stated, that this has been eye opening and would change the admission process and how we view contract employees. The DON added that they will complete a full scope investigation and will conduct root cause analysis to determine how to	PEFICIENCIES CORRECTION (M1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: (M2) MULTIPLE CONSTRUCTION A BUILDING 345129 STREET ADDRESS, CITY, STATE, ZIP CODE: 1007 HOWARD STREET ADDRESS, CITY, STATE, ZIP CODE: 1007 HOWARD STREET MOCKSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 resources. The DON and the Administrator stated, that this has been eye opening and would change the admission process and how we view contract employees. The DON added that they will complete a full scope investigation and will conduct root cause analysis to determine how to correctly identify issues as they arise. F 865 F835 - Administration The plan of correcting the specific deficiency. The plan should addre processes that lead to the deficien cited: Facility Administration did not iden root cause of an incident that cocu external public transportation win the did not make any process sys or contractual changes with the co and allowed resident #33 to contin transported by the external transported company. The procedure for implementing th acceptable plan of correction for th specific deficiency cited: Regional Director of Clinical Servic provided education on root cause a and thorough investigation of the specific deficiency cited: Regional Director of the prevent

Event ID: 7PX911

Facility ID: 922953

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	OF DEFICIENCIES	X MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345129	B. WING		04/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
AUTUMN	CARE OF MOCKSVILL	E		1007 HOWARD STREET MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 865	Continued From par	ge 30	F 86	5 weeks until facility can det our residents during trans our facility will require documentation/evidence of competency. The facility w external contracted transp company until contract is a include the thorough invest including all facts of any a a facility resident and the the right to see all evidend accident. The Administrate corporate oversight and d collaborate with contracted company to obtain a list of be providing services to o order to perform initial cor current drivers and any ne residents being transporte meantime, residents will b with the facility van other th transports. In the event th transports. In the event th transports. In the event th transports. o In the event of an accide external contracted transp administrator/DON, with c oversight, will collaborate contracted transportation investigate to determine re event. In the event of an ac to external contracted transp atto external contracted transp	ports in which of training and will not utilize portation updated to stigation accident involving facility will have ce relating to the or, with irection, will d transportation f drivers that will ur facility in mpetencies for ew hires prior to ed. In the be transported than emergency hat a stretcher facility will utilize transport in stretcher ent related to portation, facility corporate with external in order to oot cause of accident related hsportation, fully supervisor suspended until

Event ID: 7PX911

Facility ID: 922953

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	S FOR MEDICARE 8	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345129	B. WING		04/20/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	·
AUTUMN	CARE OF MOCKSVILLI	E		1007 HOWARD STREET MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 865	Continued From page	ge 31	F 86	For the end of the second o	atbelt s, what resident of rent of ation ill be van will nded in order orrective re that nd that orrected ulatory s during alidate weekly Director least cified to encies during reafter.

Event ID: 7PX911

Facility ID: 922953

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		345129	B. WING		04/20/2018
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•
AUTUMN	CARE OF MOCKSVILLI	E		1007 HOWARD STREET MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
F 865	Continued From page	je 32	F 86	 drivers that will be providing service our facility in order to perform initia competencies for current drivers ar new hires prior to residents being transported. The competencies will performed quarterly thereafter by the Administrator. To ensure safety of a residents during external contracte transportation, the Administrator wiperform initial competencies for all on proper on loading and securing residents properly. Regional Director of Clinical Service provided education on root cause a and thorough investigation of incidents/accidents to prevent re-occurrences on 4-20-2018 to Administrator, DON, and Assistant Director of Nursing. Regional Director of Clinical Service audit one investigation weekly x 4 a monthly x 3, if applicable, to ensure investigations are being conducted correctly. o Monitoring results will be discuss monthly QAPI as information is avaa from results of audits of investigation of incidents/accidents. In addition to e sustained compliance, after complet the four-month monitoring of the investigations per month for the ne months. In addition, Regional Director of Services will audit training and 	l dany be ne bur d ll drivers of es analysis es will and e d in ailable on root ensure etion of l mplete xt six ctor of

Event ID: 7PX911

Facility ID: 922953

If continuation sheet Page 33 of 34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER B. WING 04/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 04/20/2018 AUTUMN CARE OF MOCKSVILLE STREET ADDRESS, CITY, STATE, ZIP CODE 1007 HOWARD STREET MOCKSVILLE, NC 27028 STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE (x5 COMPLE			ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/11/2018 MAPPROVED 0. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUTUMN CARE OF MOCKSVILLE STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATI	E SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUTUMN CARE OF MOCKSVILLE 1007 HOWARD STREET MOCKSVILLE, NC 27028 MOCKSVILLE, NC 27028 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE DAT (X5 COMPLE COMPLE DAT			345129	B. WING				120/2018
AUTUMN CARE OF MOCKSVILLE MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE COMPLE DAT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAT	NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	04	12012010
MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAT					1007	HOWARD STREET		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLE DAT	AUTUWIN	CARE OF MOCKSVILLE			мос	CKSVILLE, NC 27028		
DEFICIENCY)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
F 865 Continued From page 33 F 865 competencies for completion on new hires related to internal and external transport van drivers. Monitoring effectiveness of corrective action: RVPO and RDCS will review QA data monthly to ensure accuracy of MDS assessments, audits are completed, and the completion of a root cause analysis for accidents. The title of the person responsible for implementing the acceptable plan of correction: Regional Director of Operation and Regional Director of Clinical Services.	F 865	Continued From page	e 33	F	r R F r a t t i i c f F	related to internal and external trans van drivers. Monitoring effectiveness of corrective action: RVPO and RDCS will review QA dat monthly to ensure accuracy of MDS assessments, audits are completed, the completion of a root cause analy accidents. The title of the person responsible fo implementing the acceptable plan of correction: Regional Director of Operation and	oort a and sis for r	

Facility ID: 922953

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