## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2013 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 20		TIPLE CONSTRUCTION (X3)		MB NO. 0938-039  3) DATE SURVEY  COMPLETED	
		345165	B. WING					
NAME OF P	ROVIDER OR SUPPLIER	10 min 1 min	-			0	6/06/2013	
AUTUMN CARE OF MARION				STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 339 MARION, NC 28752				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	(a) a stab Hortor Olytti IIIO		F3	356	this plan of correction of not constitute an admiss or agreement by the Provi of the correctness of the conclusion stated on the statement of deficiencies. This plan of correction is prepared and submitted so because of requirements us state and Federal Law.  The Administrator has provided the constitution of the provided the provided the constitution of the provided the constitution of the provided the provided the constitution of the provided the provided the constitution of the provided the	loes sion der s ley nder		
i s	specified above on a day of each shift. Data must residents and visitors.  The facility must, upon a make nurse staffing data for review at a cost not estandard.  The facility must maintained at a minimizer of each shift of	aily basis at the beginning st be posted as follows: ormat.  readily accessible to   oral or written request, a available to the public to exceed the community   in the posted daily nurse aum of 18 months, or as whichever is greater.  Is not met as evidenced and staff interviews, the ontly post the daily staffing			to the ADON, DON and all necessary staff members of cerning posting of Nurse of Information as set forth of the Regulation in regards proper posting and data required in order for complitation or the Nurse Staff Information being posted as set forth the regulation.  ADON/DON will post the Nurse Staffing Information Monda Friday on a daily basis be each shift. The ADON/DON monitor and update Nurse Staffing/Census changes and make corrections at the being of 1st and 2nd shift.	on- Staff by to e- iance on is by rse will		
	ON O ON FROVIDER/SUP	FLIER REPRESENTATIVE'S SIGNATURE			TITLE	1	X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency Man Meinstitution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except of nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. Extracting fromes, 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

JUN 2 6 2013 Event ID:9QPQ11

> by: MMI

Facility ID: 922951

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 American	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345165	B. WING	B. WING		06/06/2013	
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF MARION			•	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 339 MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETION DATE
F 356	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		sponsi- ected on  ned to 11 11 be ng, roper ne  ed a post- forma- /DON nce 3  oper equire- y on ns.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	345165 B. WING			06	06/06/2013		
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF MARION				STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 339 MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	on Monday 06/03/13 She stated she did no 06/04/13 she inadver staffing.  On 06/05/13 at the end ADON, the Director of interview and stated a someone on the week information, however designated and it worksomeone thought to come on 06/0/13 at 4:07 Pt.	ald not recall what happened about the staffing posting. of realize on Tuesday tently posted Monday's and of the interview with the of Nursing joined the they used to designate kends to post the staffing , no one was currently ald only be posted if do it.  M, the Administrator stated days were included in the	F	356			