STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	C 09/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SHALLOTTE	**237 MULBERRY STREET SHALLOTTE, NC 28459**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure that staff transferred a resident with 2 persons as directed in the resident ' s Care Plan for 1 of 2 sampled residents reviewed for transfers (Resident #4). The findings included: Resident #4 was admitted to the facility on 4/12/13 and had diagnoses that included Dementia, Parkinson ' s Disease, Abnormal Posture, Difficulty in Walking and Generalized Muscle Weakness. The Annual Minimum Data Set (MDS) assessment dated 5/29/14 revealed the resident was cognitively intact, required limited assistance with transfers and extensive assistance with toileting. The MDS revealed the resident was not steady and only able to stabilize with staff assistance when moving on and off the toilet. The Care Area Assessment (CAA) for Falls dated 6/2/14 revealed the resident was alert and oriented with confusion at times. The CAA revealed the resident had a history of falls and	F 323	This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to HCFA 2567 for the 9-16-14 survey and does not constitute an agreement or admission of Autumn Care of Shallotte of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it□s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 9/24/14 Resident Affected Resident #4 - Evaluated by attending	9/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/24/2014

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.

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F 323	Continued From page 1 had one fall during the review period. Resident #4 was re-admitted to the facility from the hospital on 7/16/14. A Resident Mobility/Transfer Profile dated 7/17/14 revealed the resident was to be transferred with 2 person assist. The resident ' s Care Plan updated on 7/31/14 for falls revealed the resident was at a high risk for falls. The Care Plan under Transfer Needs revealed the resident required 2 person assist for transfers. On 9/16/14 at 11:31 AM, the Director of Nursing (DON) stated in an interview that Physical Therapy reassessed the resident on 7/17/14 as a 2 person assist for transfers. NA (nursing assistant) #2 stated in an interview on 9/16/14 at 12:02 PM that on 8/8/14 about 2:50 PM she assisted Resident #4 to the bathroom and transferred the resident from the wheelchair to the toilet and back to the wheelchair by herself. The NA stated she knew the resident was a 2 person assist for transfers but she was off the clock and was trying to complete the documentation for her shift, the resident wanted to go to the bathroom and she was just trying to help. The DON stated in an interview on 9/16/14 at 12:40 PM that she had started a plan of correction and the staff had already been in-serviced on transferring residents and they were in the process of re-evaluating all residents to determine their current transfer needs.	F 323	physician immediately after an episode of syncope and was sent to hospital for further evaluation. Resident With The Potential To Be Affected Nursing staff was in-serviced by DON on 8/19/14, 8/20/14, 8/26/14, 8/27/14 and 8/28/14 on wheelchair positioning, transfers and mobility status, and adhearing to resident transfer assessment. Systemic Changes DON or designee will observe at least 4 C.N.A. weekly, times 4 weeks and then monthly for 3 months during transfer of residents to ensure C.N.A.'s adhere to transfer/mobility status as indicated on transfer assessment. (On-Going) DON and Administrator or designee will review 5 times a week for 3 months, all incidents involving transferring of residents to ensure adhearance to resident transfer assessment. (On-Going) Monitoring Changes/Systems to Ensure No Deficient Practices Findings of the above stated audits will be reviewed by the Quality Assurance/Performance Improvement Committee, monthly for 3 months for recommentations and further follow-up, as indicated. If substantial compliance has been met and no further areas of concerns are identified, review of the audits for resident mobility status will be discontinued for the purpose of this audit	

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F 323	Continued From page 2	F 323	and PoC. (On-Going)	