STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345110	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF WAYNESVILLE	360 OLD BALSAM ROAD WAYNESVILLE, NC 28786

(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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, review of the facility Grievance policy and record review, the facility failed to communicate grievance resolution to 1 of 1 resident (Resident # 29) that had submitted a grievance to the facility. Findings included: The facility policy, titled Grievances, with an effective date of 11/1/13, indicated under Procedure, Bullet 5 that all grievances and complaints would be investigated. Person filing the grievance will be informed of the findings. Resident # 29 was most recently readmitted on 4/1/14 with diagnosis that included hyperlipidemia, hypertension and arthritis. A Readmission/Quarterly Minimum Data Set (MDS), dated 4/8/14, indicated the resident was cognitively intact. Behaviors were not coded for Resident # 29. Review of the March 2014 facility investigation indicated Resident # 29 had spoken to a nurse regarding an issue with an employee. The facility investigated the concern including witness statements from the resident and the involved employee. There was no documentation in the	F 166	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F166 Corrective Action □ Affected Resident (s) For Resident #29 a meeting was held with the social worker (SW) on 8/12/14 to notify Resident #29 of the resolution to his grievance from 3/18/14. Resident #29 was informed that the employee that was the cause of his concern was no longer employed at the facility. Resident #29 was satisfied with the resolution. Corrective Action □ Potential Resident(s) Any resident with a grievance has the potential to be affected. The facility SW audited the grievance log to ensure that all grievances in the last six months had been properly documented, investigated, and resolved according to the Grievance Policy by the appropriate department manager. The facility activities director audited all grievances from the last six	8/26/14

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

Electronically Signed | 08/26/2014

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F 166	Continued From page 1 investigation that indicated the resident had been notified of what steps the facility had taken to resolve the grievance. An interview was held with Resident # 29 on 08/03/14 at 3:10 PM. He stated after filing the grievance with the nurse, the Social Worker (SW) spoken with him about the incident. Resident # 29 added facility representatives had not spoken to him regarding what steps were taken to resolve his grievance. An interview was held with the SW on 8/6/14 at 2:04 PM. The SW stated she had been notified of Resident # 29's concerns with a staff member and had spoken with him the same day the concern was filed. She added she had listened to the resident's concerns and assured him she was there to help anytime he needed assistance. The SW stated she normally documented conversations with residents, but on review of her notes was unable to locate notes regarding Resident # 29's concerns. Resident # 29 was described by the SW as alert, oriented and able to make decisions about his care. An interview was held with the Director of Nursing (DON) on 8/7/14 at 2:10 PM. The DON stated she had spoken with Resident # 29 many times about multiple issues and was sure she had talked with him about the grievance he had submitted in March 2014. The DON stated she had reviewed her notes and acknowledged she had no documentation to validate she had spoken with Resident # 29 about his grievance or resolution of his grievance.	F 166	months to ensure that all resident concerns from the monthly Resident Council meeting had been addressed, documented, and resolved by the appropriate department manager. Both audits were completed on 8/25/14. Systemic changes to prevent recurrence An in-service was conducted on 8/22/14, by the facilities Staff Development Coordinator (SDC). The in-service included what is considered a grievance, which can make a grievance, how a grievance form is filled out, and procedures for resolving a grievance. The in-service was attended by all staff. Any staff unable to attend will need to make up the in-service prior to working their next shift. On 8/08/14, the Administrator met with the department managers to go over the Grievance Policy and the importance of documenting the resolution with the concerned party. This Grievance Policy will be a focal point in the standard orientation training and will be included in a yearly in-service as a reminder to all staff of the Grievance Policy and Procedure. Quality Assurance All grievances will be discussed in the facilities morning meeting Monday through Friday. The Administrator will monitor compliance by signing off on all grievances prior to the Department Manager□s resolution and will then sign off on all grievances after the issue has been resolved and the appropriate parties notified of the resolution. The Grievance Log will be audited daily by the SW for four weeks, then weekly for three months,	

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F 166	Continued From page 2	F 166	then quarterly hereafter. Reports will be submitted in the facilities monthly Quality Assurance and Performance Improvement meeting hereafter.	
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 observation, staff interviews and review of facility policy the facility failed to keep housekeeping chemicals covered, labeled and out of the reach of residents on 1 of 3 housekeeping carts observed. Findings included: 1) The Material Safety Data Sheet (MSDS) for Clean on the Go Concentrate (a disinfectant cleaning solution), with an effective date of 6/8/11, assigned the product a serious health rating if ingested. The chemical was identified with hazardous ingredients that included alkyl dimethy benzl ammonium chloride, alcohol ethoxylate, isopropyl alcohol and fragrance. Thresholds limit values had not been established for the Health Hazard Data. Primary routes of entry were identified as inhalation, skin contact, eyes and oral. The product was identified as potentially	F 323	F323 Corrective Action □ Affected Resident (s) No residents were negatively affected by the alleged deficient practice. Corrective Action □ Potential Resident(s) All residents have the potential to be affected by the alleged deficient practice. On 8/7/14, the facilities Housekeeping Supervisor (HKS) removed all Clean on the Go Concentrate from the housekeeper carts. The disinfectant was then put in a new, smaller container that was labeled as a hazardous material. On 8/27/14, the disinfectant was then reordered in a smaller container size with the manufacturer□s label remaining on the container. The container was then placed in the locked cabinet of the housekeeper□s cart. The label gives all appropriate safety precautions and first	8/29/14

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F 323	Continued From page 3 causing irreversible eye damage, skin irritation with symptoms of pain and possible chemical burns, nausea, vomiting, coughing and difficulty breathing. On 8/7/14 at 9:15 AM a housekeeping cart was observed outside Room 401. The Housekeeper was in Room 402. The housekeeper was observed cleaning the nightstand, under the bed and then facing the wall with her back to the cart in the hallway. On the bottom of the cart, was a white jug that had been cut to accommodate a blue liquid and a scrub brush. The liquid was clearly seen and easily accessible with no lid covering the contents. There was no label identifying the contents or any safety warnings. Beside this container was a plastic purple container with a blue liquid. The plastic container had no label identifying the contents and did not contain any warnings or safety instructions. The contents were uncovered and easily accessible. During the observation, the housekeeper did not turn to face the doorway or observe the cart. During the observation, multiple residents were in the hallway near the cart. The housekeeper exited the room at 9:20 AM. She stated that even with her back to the doorway and the cart, she checked the cart every few minutes. The housekeeper acknowledged that it would only take a few minutes for a resident to ingest the liquid in the containers or to place their hands in the containers. The liquid in the unlabeled and uncovered plastic containers were identified as a disinfectant solution by the housekeeper. During an interview with the Housekeeping Supervisor on 8/7/14 at 2:00 PM, she stated	F 323	aid instructions in the event the disinfectant is swallowed, absorbed in the skin, or gets in an individual□s eyes. The label also includes all appropriate storage and disposal methods. The HKS then instructed all housekeepers that from hereafter that the disinfectant would be kept in the locked cabinet on the cart before and after its use; and should always remain in its original container with the manufacturers label intact. Systemic changes to prevent recurrence An in-service was completed on 8/8/14 by the HKS to the housekeeping staff of the new policy to keep the disinfectant locked at all times while it is not being used. The in-service also included a refresher on following Material Safety Data Sheets (MSDS) for all cleaning agents and that the MSDS sheets are located at each nurse□s station and in the designated housekeeping storage closets. Any housekeepers that did not attend the in-service were not allowed to work until the training was completed. A follow up in service was conducted on 8/27/14 instructing all housekeepers and maintenance staff that the disinfectant is to be kept in its original container with the manufacturers label still intact at all times from hereafter. Quality Assurance Effective 8/7/14, a Quality Assurance and Performance Improvement program was implemented to ensure continued compliance. The HKS/ designee will audit all housekeeping carts daily x1 week, weekly x 1 month, and then monthly x3. The deficiency was corrected, and the	

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F 323	Continued From page 4 chemicals should be labeled, covered and kept locked in the cart and out of the reach of residents when not in use. She presented a copy of an in-service that was held on 6/6/14 that addressed the need to keep supplies in the housekeeping cart and also indicated all containers needed labels identifying the contents. Housekeeper # 1 had signed as attending the in-service.	F 323	findings of the quality assurance checks will be documented and submitted at the monthly Quality Assurance and Performance Improvement Committee meeting for further review and/or corrective action. The HKS/ designee is responsible for monitoring compliance.	