STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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
E 000	Initial Comments A recertification survey was conducted 1/28/19 - 1/31/19. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID: YX6E11.	E 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to ensure a resident that needed assistance with dressing had her call bell within reach for 1 of 1 resident sampled for accommodation of needs (Resident #14). The finding included: Resident #14 readmitted to the facility on 08/03/18 with diagnoses that included Alzheimer's disease, wedge compression fracture, anxiety, major depressive disorder and others. Review of the quarterly minimum data set (MDS) dated 11/04/18 revealed that Resident #14 was severely cognitively impaired for daily decision making and required extensive assistance with dressing. The MDS further revealed that no rejection of care occurred during the assessment reference period.	F 558	F558 Reasonable Accommodations of Needs Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. ELEMENT 1 The call light was placed in reach of resident #14 by NA #1 immediately upon realization of call bell being secured to bed. Resident #14 did not suffer any negative outcome and all needs were met by staff. ELEMENT 2 To identify other residents that have the potential to be affected, a 100% audit was completed on 1/30/19 to ensure all	2/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/22/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 558	Continued From page 1 Review of a care plan updated on 11/15/18 read in part, Resident #14 had a self-care deficit. The goal read, Resident #14 would achieve maximum functional ability and the interventions included dressing and grooming with assistance of 1 person. An observation and interview were conducted with Resident #14 on 01/28/19 at 12:26 PM. Resident #14 was sitting in her wheelchair beside her bed with no shirt on. She was attempting to put a shirt on that was very snug and backwards. Resident #14 stated, "help me honey get this shirt on." The call bell was observed to be secured to the side rail that was down and pinned against the wall. The call bell could not be accessed without moving the bed away from the wall and lifting the side rail. After attempting to put her shirt on for approximately 5 minutes, Resident #14 got the shirt on backwards and then transferred herself to bed and covered herself up with a blanket. An observation of Resident #14 was made on 01/29/19 at 8:59 AM. Resident #14 was resting in bed with her eyes open. Her call light was secured to the side rail that was down and pinned against the wall by the bed. The call bell could not be accessed without moving the bed away from the wall and raising the rail. An observation of Resident #14 was made on 01/29/19 at 4:30 PM. Resident #14 was resting in bed with her eyes open. She was alert and verbal. Her call bell remained secured to the side rail that was down and pinned against the wall by the bed. The call bell could not be accessed without moving the bed away from the wall and raising the rail.	F 558	residents had access to their call lights. No other residents were identified as not having their call light within reach. ELEMENT 3 To prevent this from reoccurring, all departments will be in-serviced on proper call light placement By Administrator on 2/7/19. New Hires and Agency Staff will be educated in orientation. The administrator in-serviced the department heads on 1/29/19 to observe for proper placement of call lights will during routine rounds. A facility rounds checklist will be completed 3 times per week by assigned staff member. Any identified concerns will be corrected. ELEMENT 4 To monitor and maintain ongoing compliance, the Administrator will review the results weekly for trends for 12 weeks. Any trends will be addressed to the appropriate staff by the administrator. The results of the audits will be forwarded to the facility QAPI committee for recommendations and further review. Date of Compliance 2/26/19 The facility Administrator is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 558	Continued From page 2 An observation of Resident #14 was made on 01/30/19 at 8:43 AM. Resident #14 was resting in bed with her eyes open. She was alert and verbal. Her call bell remained secured to the side rail that was down and pinned against the wall by the bed. The call bell could not be accessed without moving the bed away from the all and raising the rail. An interview was conducted with Nursing Assistant (NA) #1 on 01/30/19 at 2:53 PM. NA #1 stated that she was familiar with Resident #14 and confirmed that she was able to use her call bell on her good days but probably not on her bad days. She added that the she had made up her bed early on the shift and confirmed that the call bell was not in Resident #14's reach because it was secured to the side rail that was down and pinned against the wall by the bed. She stated she had to pull the bed away from the wall and unsecure it from the rail to give Resident #14 access to it. NA #1 stated that the call bell should always be in the residents reach so they could call for help if they need it. An interview was conducted with the Director of Nursing (DON) on 01/30/19 at 4:29 PM. The DON stated call bells should always be in the residents reach and easily accessible, so the resident could call for help if they needed it.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE** **STATESVILLE, NC 28625**

(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 580	Continued From page 3 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 580	Continued From page 4 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Nurse Practitioner interview the facility failed to notify the medical provider when a resident complained of chest pain for 1 of 1 resident sampled for chest pain (Resident #49). The findings included: Resident #49 was admitted to the facility on 12/02/17 with diagnoses that included: Parkinson's disease and chronic pain. Review of the quarterly minimum data set (MDS) dated 12/23/18 revealed that Resident #49 was cognitively intact for daily decision making and required limited assistance with activities of daily living. No pain or shortness of breath was reported on the MDS. A continuous observation was made on 01/29/19 at 4:37 PM to 4:43 PM. Nursing Assistant (NA) #2 came to the nurse's station and told Nurse #4 who was standing at his medication cart parked at the station that Resident #49 was complaining of chest pain. Nurse #4 turned towards NA #2 and replied to her report. NA #2 walked away from the nurse's station and Nurse #4 pushed his medication cart down the hallway where Resident #49 resided. Nurse #4 stopped at the room directly across from Resident #49's room and handed the resident a cup of pills and once swallowed, Nurse #4 pushed his medication cart	F 580	F580 Notify of Changes Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. ELEMENT 1 The nurse practitioner was in the facility at the time of the observation and assessed resident #49 when notified of the complaint and additional orders were obtained. Resident #49 remains in the facility and has had no negative outcome related to the observation. ELEMENT 2 To identify other residents that have the potential to be affected, a review of current residents was reviewed by the licensed staff, and no other change in conditions were identified that required notification to the physician or nurse practitioner. ELEMENT 3 To prevent this from recurring, the DON or designee educated licensed staff on notifying the resident physician upon	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE** **STATESVILLE, NC 28625**

(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 580	Continued From page 5 back to the nurses station locked the cart and left the unit. Nurse #4 never entered Resident #49's room. An observation and interview were conducted with Resident #49 at 01/29/19 4:43 PM. Resident #49 was resting in her bed grabbing her left upper chest area with her right hand. She stated, "honey my chest hurts can you find me some help." An interview was conducted with the Nurse Practitioner (NP) on 01/29/19 at 4:58 PM. The NP stated that she was unaware that Resident #49 was complaining of chest pain. She stated she had been made aware earlier in the day by Nurse #4 that she was having some left elbow pain and an x-ray had been ordered. The NP stated if it was reported to Nurse #4 that Resident #49 was having chest pain she would have expected him to immediately report that to the medical provider. A follow up interview was conducted with the Nurse Practitioner (NP) on 01/29/19 at 5:12 PM. The NP stated that at the state surveyor's report she went to assess Resident #49's chest pain. She stated that Resident #49's vital signs were stable, and she was not diaphoretic but when her left arm was moved she screamed in pain. The NP stated she believed that the chest pain was musculoskeletal pain and she was going to orders some additional medication and confirmed that the x-ray that had been ordered were of left shoulder and elbow not a chest x-ray. She again stated that the nursing staff should have reported the chest pain to the medical provider. An interview was conducted with Nurse #4 and the Director of Nursing (DON) on 01/29/19 at 5:16 PM. Nurse #4 stated that NA #2 had reported	F 580	change of condition or new onset of pain/symptoms on 2/7/2019. All New Hires and Agency Staff will be educated on facility expectations at orientation. The clinical team will review resident change of conditions during clinical meeting to ensure timely change of condition notification. Any deficient practice will be addressed immediately. ELEMENT 4 To monitor and maintain ongoing compliance, the DON or designee will audit 3 residents charts per week for 12 weeks, to see if there was a change in condition and to ensure that the physician or nurse practitioner was notified timely. The results of the audits will be forwarded to the facility QAPI committee or further review and recommendations. DON is responsible for Compliance Compliance Date 2/26/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 580	Continued From page 6 Resident #49 was having shoulder pain and not chest pain and that he had given her pain medication. Nurse #4 stated that when he moved Resident #49's left arm she would scream in pain and an x-ray had been ordered. He stated that he was confident the pain that Resident #49 was having was coming from her arm pain but confirmed that he had not reported to the NP or medical provider that Resident #49 was having chest pain. Nurse #4 stated that he had given Resident #4 pain medication and what else was he supposed to do for her. The DON replied that she expected Nurse #4 to immediately go and assess Resident #49 when she complained of chest pain and to then notify the NP or medical provider for further orders.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 584	Continued From page 7 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store bath basins, lids to potty chairs and a bed pan off the bathroom floor in 3 resident bathrooms (#213, #302 and #310) on 2 of 5 resident hallways and failed to repair stained and cracked caulking around the base of toilets in 4 resident bathrooms (Room #213, #302, #309 and #310) on 2 of 5 resident hallways. Findings included: 1. a. Observations in the bathroom of resident room #213 on 01/28/19 at 4:56 PM revealed 2 bath basins in plastic bags stored on the bathroom floor. Observations in the bathroom of resident room #213 on 01/29/19 at 11:20 AM revealed 2 bath	F 584	F584 Safe, Clean, Comfortable Environment Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. Element 1 The facility staff removed the unlabeled items as well as the improperly stored personal items for resident residing in rooms #213, #302, #310. Items were replaced, labeled, and placed in proper storage areas. Bathrooms for rooms #213, #302, #309, #310, and were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 584	Continued From page 8 basins in plastic bags stored on the bathroom floor. Observations in the bathroom of resident room #213 on 01/30/19 at 8:55 AM revealed 2 bath basins in plastic bags stored on the bathroom floor. b. Observations in the bathroom of resident room #302 revealed on 01/28/19 at 1:39 PM revealed there were 2 bath basins were on the bathroom floor with a lid to a potty chair on top of them. Observations in the bathroom of resident room #302 on 01/29/19 at 11:47 AM revealed there were 2 bath basins were on the bathroom floor with a lid to a potty chair on top of them. Observations in the bathroom of resident room #302 on 01/30/19 at 10:23 AM revealed there were 2 bath basins were on the bathroom floor with a lid to a potty chair on top of them. c. Observations in the bathroom of resident room #310 on 01/28/19 at 2:20 PM revealed there was a fracture bed pan on the bathroom floor. Observations in the bathroom of resident room #310 on 01/29/19 at 10:10 AM revealed there was a fracture bed pan on the bathroom floor. Observations in the bathroom of resident room #310 on 01/30/19 at 12:35 PM revealed there was a fracture bed pan on the bathroom floor. During an interview on 01/31/19 at 10:51 AM with Nurse Aide (NA) #1 she stated bedpans and bath basins should be placed in plastic bags and stored on a shelf in the resident's closet and they should not be left on the bathroom floor. During an interview on 01/31/19 at 10:55 AM with NA #4 she stated bedpans and bath basins should be stored in plastic bags and placed in the	F 584	cleaned and the stained cracked caulking was re-caulked by the maintenance director. Element 2 To identify other residents that have the potential to be affected, a 100% sweep of all resident rooms, bathrooms and commons bathing rooms was completed by 1/31/19. All areas identified as having unlabeled items, or items not stored properly was corrected immediately. Element 3 To prevent this from recurring, the facility administrator will in-service all IDT, clinical and housekeeping staff on appropriate labeling and storage of personal care items 2/7/19. Assigned staff will complete a facility rounds audit three times per week, observing for items not stored or labeled properly, as well as observing for any area of caulking repair needs. Identified areas will be corrected immediately for labeling and storage, and for caulking needs, a work order slip will be completed and turned into maintenance. All caulking around the toilets were re-caulked by 2/25/19 by the maintenance director. Element 4 To monitor and maintain compliance, the administrator will audit the rounds checklist weekly for trend, any areas of concern will be addressed immediately with the appropriate department head for 12 weeks. The administrator will check weekly on the completion of the work order slips submitted for caulking repairs for 12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE** **STATESVILLE, NC 28625**

(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 584	Continued From page 9 resident's closet. During a tour and interview on 01/31/19 at 11:02 AM with the Director of Nursing she confirmed in resident bathroom #213 there were 2 bath basins in plastic bags on the bathroom floor. She stated it was her expectation for these items to be stored in the resident's night stand or in their closet. She also verified the lid of a potty chair was on the bathroom floor and should not be left on the floor. During an observation in Resident room #302 she verified there were 2 bath basins on the bathroom floor with a lid to a potty chair on top of them. She stated these items should be discarded in the trash. During an observation in Resident room #310 she verified there was a fracture bedpan was on the bathroom floor. She further stated it should have been stored in the night stand or closet and the item was discarded in the trash. 2. a. Observations in the bathroom of resident room #213 on 01/28/19 at 4:56 PM revealed the caulking at the base of the toilet was stained with dark brown stains. Observations in the bathroom of resident room #213 on 01/29/19 at 11:20 AM revealed the caulking at the base of the toilet was stained with dark brown stains. Observations in the bathroom of resident room #213 on 01/30/19 at 8:55 AM revealed the caulking at the base of the toilet was stained with dark brown stains. b. Observations in the bathroom of resident room #302 on 01/28/19 at 1:39 PM revealed the caulking at the base of the toilet was stained with dark brown stains. Observations in the bathroom of resident room	F 584	weeks. The results of the audits will be forwarded to the facility QAPI committee for recommendations and further review. The facility administrator is responsible for compliance. Compliance date is 2/26/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 584	Continued From page 10 #302 on 01/29/19 at 11:47 AM revealed the caulking at the base of the toilet was stained with dark brown stains. Observations in the bathroom of resident room #302 on 01/30/19 at 10:23 AM revealed the caulking at the base of the toilet was stained with dark brown stains. c. Observations in the bathroom of resident room #309 on 01/28/19 at 2:15 PM revealed the caulking at the base of the toilet was cracked and stained with dark brown stains. Observations in the bathroom of resident room #309 on 01/29/19 at 10:02 AM revealed the caulking at the base of the toilet was cracked and stained with dark brown stains. Observations in the bathroom of resident room #309 on 01/30/19 at 12:30 PM revealed the caulking at the base of the toilet was cracked and stained with dark brown stains. d. Observations in the bathroom of resident room #310 on 01/28/19 at 2:20 PM revealed the caulking at the base of the toilet was cracked and stained with dark brown stains. Observations in the bathroom of resident room #310 on 01/29/19 at 10:10 AM revealed the caulking at the base of the toilet was cracked and stained with dark brown stains. Observations in the bathroom of resident room #310 on 01/30/19 at 12:35 PM revealed the caulking at the base of the toilet was cracked and stained with dark brown stains. During an environment tour and interview on 01/31/19 at 11:42 AM with the Maintenance Assistant and the Administrator, the Administrator verified the facility utilized a work order system and maintenance and housekeeping were	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 584	Continued From page 11 expected to make necessary repairs. The Maintenance Assistant stated all work orders should be done as soon as possible but if they could not get to them they were expected to be completed within 24 hours. During an observation in the bathroom of resident room #213 the Assistant Maintenance Director verified the caulking around the base of the toilet was stained and needed repair. During an observation in the bathroom of resident room #302 the Assistant Maintenance Director verified caulking at the base of the toilet was stained with a brown substance. During an observation in the bathroom of resident room #309 the Maintenance Assistant stated there were dark brown stains around the base of the toilet and looked like it needed to be replaced. During an observation in the bathroom of resident room #310 the Maintenance Assistant verified the caulk was stained at the base of the toilet and needed to be replaced. The Administrator stated they had a program where department heads were assigned resident rooms and they were required to check them every day and document their findings and sign them and turn them in to her. She explained it was her expectation for concerns to be reported and staff should fill out work orders. She stated they had a triple check system and it was everybody's responsibility to report concerns and they should be fixed.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 641	Continued From page 12 Based on record review and staff interview the facility failed to accurately code the minimum data set in the area of Preadmission Screening and Resident Review (PASRR) for 2 of 2 residents sampled for Pasarr (Resident #79 and #56) and failed to accurately code a discharge location for 1 of 3 residents sampled for closed records (Resident #86). The findings included: 1. Resident #79 was admitted to the facility on 03/12/15 with diagnoses that included: schizoaffective disorder, major depressive disorder, anxiety and others. Review of a Preadmission Screening and Resident Review (PASRR) dated 03/12/15 revealed that Resident #79 had been issued a level two Pasarr due to a mental illness. Review of a comprehensive minimum data set (MDS) dated 01/13/19 indicated that Resident #79 was not a level two PASRR. The MDS further revealed that Resident #79 was cognitively intact and required extensive assistance with activities of daily living. The MDS was completed by MDS Coordinator #2. An interview was conducted with MDS Coordinator #2 on 01/30/19 at 4:00 PM. The MDS Coordinator #2 confirmed that she had completed the comprehensive assessment dated 01/13/19 for Resident #79. She added that all the PASRR information was scanned into the electronic medical record and was available to her. MDS Coordinator #2 state that she over looked the PASRR information on Resident #79 and it should have been captured on the MDS	F 641	F641 Accuracy of Assessments Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. ELEMENT 1 Resident #86 had modification of MDS to reflect accurate discharge location. Resident #79 and #56 had modifications of the MDS to have accurate coding of level 2 PASSR. No residents suffered any negative outcome as a result the miscoding. ELEMENT 2 To identify other residents that have potential to be affected the MDS Coordinators completed an audit on 1/30/19 to ensure the last month of discharges were coded correctly and that all level 2 PASSR are coded correctly. No other discrepancies were found. ELEMENT 3 To prevent this from recurring on 1-31-2019 the Regional Reimbursement Nurse provided and reviewed education to MDS coordinators and social service director that included copies of RAI Manual pages A 18 thru A 22, A 29 thru A 30. All new hired MDS Coordinators will receive training on this requirement. The discharge report from the Electronic Health Record will be utilized by the MDS nurses prior to coding discharge location to ensure accuracy. Social Services will code the MDS for PASSR level. A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 641

Continued From page 13
assessment.

An interview was conducted with the Director of Nursing (DON) on 01/30/19 at 4:20 PM. The DON stated she expected the MDS to be completed as accurately as possible included PASRR information.

2. Resident #56 admitted to the facility on 02/20/17 and recently readmitted to the facility on 02/03/18. Resident #56's diagnoses included major depressive disorder, nontraumatic intracerebral hemorrhage and others.

Review of a Preadmission Screening and Resident Review (PASRR) dated 09/10/18 indicated that Resident #56 had been issued a level two PASRR due to mental illness.

Review of the comprehensive minimum data set (MDS) dated 10/08/18 indicated that Resident #56 was not a level two PASRR. The MDS further indicated that Resident #56 was cognitively intact and required extensive assistance with activities of daily living. The MDS was completed by MDS Coordinator #1.

On 01/30/19 at 4:00 PM MDS Coordinator #1 was unavailable for interview.

An interview was conducted with MDS Coordinator #3 on 01/30/19 at 4:00 PM. She confirmed that she supervised MDS Coordinator #1 and #2 and stated felt certain that when MDS Coordinator #1 was completing Resident #56's MDS she just over looked the PASRR information. MDS Coordinator #3 stated that the PASRR information was scanned into the electronic system and was available to them and

F 641

Tracking system has been implemented to track all level 2 PASRR.
ELEMENT 4
To monitor and maintain ongoing compliance the MDS Coordinators will audit 3 MDSs for accuracy for the next 12 weeks to ensure accurate discharge location and PASSR levels. No Coordinator will audit their own work. Immediate corrections will be made w/ any negative findings.

The results of the audit will be forwarded to the facility QAPI committee for further review.

MDS Nurse is responsible for compliance. Date of Compliance 2/26/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 641	Continued From page 14 was just on an oversight and should have been captured on the assessment. An interview was conducted with the Director of Nursing (DON) on 01/30/19 at 4:20 PM. The DON stated she expected the MDS to completed as accurately as possible included PASRR information. 3. Resident #86 was admitted to the facility on 11/12/18 with diagnosis that included bilateral above the knee amputations. A progress note dated 12/14/18 specified the resident discharged home with home health services. A discharge MDS dated 12/14/18 specified the resident was discharged to a hospital. The assessment was completed by MDS Coordinator #1. A discharge summary dated 12/20/18 specified the resident's discharge location was a private home. On 01/29/19 at 3:17 PM MDS Coordinator #1 was interviewed and explained that when completing a discharge MDS assessment she relied on notes in the medical record to determine the discharge location. She stated she recalled Resident #86 and knew he had discharged home with his wife at his request. She reviewed the discharge MDS assessment and reported the discharge location was an error and an oversight.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 656	Continued From page 15 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 656	Continued From page 16 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to implement fall care plan interventions for 1 of 3 residents sampled for supervision to prevent accidents (Resident #14). The findings included: Resident #14 admitted to the facility on 08/08/17 with diagnoses that included: Alzheimer's Disease, anxiety, difficulty in walking, depression, hypertension, wedge compression fracture, and others. Review of Situation, Background, Assessment, and Recommendation (SBAR) dated 04/06/18 at 11:14 AM read, Resident #14 was witnessed by staff sliding out of wheelchair. No injuries were noted. Resident #14 forgot to ask for help and got up and tried to walk on her own. The notes section read, resident was sitting in wheelchair in her room and staff was passing by her room in the hallway and noted Resident #14 trying to stand up while her wheelchair breaks where not on, this resulted in the wheelchair sliding back and the resident sliding down on to the floor. No injuries noted, and she denied pain. The SBAR was signed by the Director of Nursing (DON). Review of a physician order dated 04/16/18 read, anti-roll back (self-locking device) to wheelchair. Review of a fall care plan revised on 04/16/18 read, Resident #14 was at risk for falls related to decreased mobility, weakness, history of falls and short/long term memory deficits. The goal of the	F 656	F656 Develop/Implement Comprehensive Care Plan Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. ELEMENT 1 Anti Rollbacks were immediately placed on Resident #14 wheelchair as stated on careplan when identified ELEMENT 2 To identify other residents that have the potential to be affected, the team reviewed all fall careplans and updated accordingly regarding active interventions on 1/29/19. ELEMENT 3 The regional reimbursement nurse In serviced MDS team 1/31/2019 on expectation of reviewing and updating care plans to reflect active fall interventions. To prevent this from reoccurring, all careplans will be updated post fall and interventions will be verified to be in place prior to careplan update by MDS Nurse. Nursing staff will be educated on the expectation of ensuring that fall interventions are in place by the DON or designee by 2/26/19. ELEMENT 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 656	Continued From page 17 care plan read, Resident #14 will have no preventable injury from falls through next review. The interventions included: anti roll back to wheelchair. Review of the quarterly minimum data set (MDS) dated 11/04/18 revealed that Resident #14 was severely cognitively impaired for daily decision making and requires extensive assistance with activities of daily living. No falls since the previous assessment were noted on the MDS. An observation of Resident #14 was made on 01/28/19 at 12:26 PM. Resident #14 was sitting in her wheelchair next to her bed attempting to stand to sit on her bed. Each time she would push up on the arms of her wheelchair and try to stand the wheel chair would roll back. There were no anti roll backs noted to the wheelchair. An observation of Resident #14 was made on 01/28/19 at 6:25 PM. Resident #14 was sitting in her wheelchair in the dining room. There were no anti roll backs to her wheelchair. An observation of Resident #14 was made on 01/29/19 at 8:59 AM. Resident #14 was in bed with her wheelchair sitting directly next to her. No anti roll backs were noted to the wheelchair. An observation of Resident #14 was made on 01/29/19 at 4:30 PM. Resident #14 was up in wheelchair propelling self around the facility. There were no anti roll backs noted to her wheelchair. An observation of Resident #14 was made on 01/30/19 at 2:30 PM. Resident #14 was up in wheelchair propelling self around the facility.	F 656	To monitor and maintain ongoing compliance, the DON or designee will review 5 post fall careplans per week for 12 weeks, to ensure active interventions are in place. The results of the audits will be forwarded to the facility QAPI committee for recommendations and further review. Date of Compliance 2/26/19 DON is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ____ B. WING ____	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 656	Continued From page 18	F 656		

There were no anti roll backs noted to her wheelchair.

An interview was conducted with Nursing Assistant (NA) #3 on 01/30/19 at 2:53 PM. NA #3 stated she was familiar with Resident #14 and her needs. NA #3 stated that she was not aware that Resident #14 needed the anti-roll backs to her wheelchair and did not recalling seeing them on her wheelchair anytime recently. She stated that they may have been there a while ago but could not say for sure. NA #3 stated that they had the resident specific information in the electronic medical record and could refer to anytime they needed. She stated that she referred to that information if she had questions but not something she reviewed on a regular basis.

An interview was conducted with the DON on 01/30/19 at 4:29 PM. The DON stated that when a fall occurred in the facility the staff called a huddle to the place of the fall to obtain more details about the fall. After the resident was assessed we try to determine a root cause and completed the incident report and then implement interventions based on the root cause of the fall. Once the root cause has been identified and implemented then we revise the care plan to reflect the new intervention. The DON stated that after Resident #14 fell while attempting to transfer and the wheelchair rolled back the interdisciplinary team decided to add the anti-roll back to her wheelchair because Resident #14 could not retain the education to lock her brakes. The DON stated that she was not aware that the wheelchair that Resident #14 had did not have the anti-roll backs but confirmed that she certainly still needed them to help keep her safe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 684	Continued From page 19	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and Nurse Practitioner interview the facility failed to respond to and assess a resident's complaints of chest pain for 1 of 1 resident sampled for chest pain (Resident # 49). The findings included: Resident #49 was admitted to the facility on 12/02/17 with diagnoses that included: Parkinson's disease and chronic pain. Review of the quarterly minimum data set (MDS) dated 12/23/18 revealed that Resident #49 was cognitively intact for daily decision making and required limited assistance with activities of daily living. No pain or shortness of breath was reported on the MDS. Review of a physician's order dated 01/29/19 read, x-ray left shoulder 2 views and left elbow 1 view. A continuous observation was made on 01/29/19 at 4:37 PM to 4:43 PM. Nursing Assistant (NA) #2	F 684	F684 Quality of Care Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. Element 1 The nurse practitioner was in the facility at the time of the observation and assessed resident #49 when notified of the complaint and additional orders were obtained. Resident #49 remains in the facility and has had no negative outcome related to the observation. Element 2 To identify other residents that have the potential to be affected, a review of current residents was reviewed by the licensed staff, and no other change in conditions were identified that required additional treatment or cares from staff that was not already being done.	2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 684 Continued From page 20

came to the nurse's station and told Nurse #4 who was standing at his medication cart parked at the station that Resident #49 was complaining of chest pain. Nurse #4 turned towards NA #2 and replied to her report. NA #2 walked away from the nurse's station and Nurse #4 pushed his medication cart down the hallway where Resident #49 resided. Nurse #4 stopped at the room directly across from Resident #49's room and handed the resident a cup of pills and once swallowed, Nurse #4 pushed his medication cart back to the nurses station locked the cart and left the unit. Nurse #4 never entered Resident #49's room.

An observation and interview were conducted with Resident #49 at 01/29/19 4:43 PM. Resident #49 was resting in her bed grabbing her left upper chest area with her right hand. She stated, "honey my chest hurts can you find me some help."

An interview was conducted with NA #2 on 01/29/19 at 4:44 PM. NA #2 stated that Resident #49 had complained of chest pain and she reported it to Nurse #4. She stated that Nurse #4 replied that he had given Resident #4 all the pain medication she could have and that a chest x-ray had been ordered.

An interview was conducted with the Nurse Practitioner (NP) on 01/29/19 at 5:12 PM. The NP stated that at the state surveyor request she went to assess Resident #49's chest pain. She stated that Resident #49's vital signs were stable, and she was not diaphoretic but when her left arm was moved she screamed in pain. The NP stated she believed that the chest pain was musculoskeletal pain and she was going to orders some additional medication and confirmed

F 684

Element 3
To prevent this from recurring, the DON or designee educated licensed staff on responding to and assessing resident needs to ensure that each resident receives quality treatment and quality of care in accordance with professional standards, the residents plan of care and resident’s choice on 2/7/19.
All New Hires and Agency Staff will be educated on facility expectations at orientation.
The clinical team will review resident change of conditions during clinical meeting to ensure that quality of care was provided. Any concerns will be addressed immediately.
Element 4
To monitor and maintain ongoing compliance, the DON or designee will audit 3 resident charts per week for 12 weeks, to see if there was a change in condition and to ensure that the were not quality of care concerns.
The results of the audits will be forwarded to the facility QAPI committee or further review and recommendations.
DON is responsible for Compliance
Compliance Date 2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 684	Continued From page 21 that the x-ray that had been ordered were of left shoulder and elbow not a chest x-ray. An interview was conducted with Nurse #4 and the Director of Nursing (DON) on 01/29/19 at 5:16 PM. Nurse #4 stated that NA #2 had reported Resident #49 was having shoulder pain and not chest pain and that he had given her pain medication. Nurse #4 stated that when he moved Resident #49's left arm she would scream in pain. Nurse #4 was questioned about what NA #2 had actually reported and he replied, "I have already ordered a chest x-ray for her." Again, when Nurse #4 was questioned about the x-ray order being for the left shoulder and left elbow he stated that he was confident the pain that Resident #49 was having was coming from her arm pain. Nurse #4 stated he had been in Resident #4 ' s room earlier in the shift but denied leaving the unit after NA #2 had reported the chest pain. The DON reminded him that he had left the unit to go and get a cup of coffee. Nurse #4 stated that he had given Resident #4 pain medication and what else was he supposed to do for her? The DON replied that she expected Nurse #4 to immediately go and assess Resident #49 when she complained of chest pain.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 689	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to maintain safe hot water temperatures at or below 116 degrees Fahrenheit (F) when the maximum temperature obtained was 150.8 degrees during observations of water temperatures in 5 resident bathrooms (Room #301, #306, #202, #215 and #213) on 2 of 5 resident hallways. Findings included: A review of the facility Hot Water Temperature Logs were reviewed from October 2018 until January 2019 revealed water temperatures were recorded on a weekly basis in resident rooms on the 200 and 300 halls. The logs revealed the most recent recorded water temperatures on the 200 and 300 halls were documented on 01/24/19 as follows: 01/24/19 Room #214 water temperature 112.5 degrees F 01/24/19 Room #204 water temperature 112.6 degrees F 01/24/19 Room #305 water temperature 110.5 degrees F 01/24/19 Room #313 water temperature 110.8 degrees F During an observation on 01/29/19 at 10:48 AM in the bathroom of resident room #214 the water temperature from the faucet felt hot to touch and steam was visible. During an observation on 01/29/19 at 10:52 AM in the bathroom of resident room #301 the water temperature from the faucet was too hot to touch and steam was visible.	F 689	F 689 Free of Accident Hazards/Supervision/Devices Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. Element 1 On 1/29/19 the hot water supply was shut off to the affected resident hallways to include rooms for residents in rooms #301, #306, #202, #215, and #213. Alternative measures for providing warm water for ADL care were taken. No residents suffered any harm due to water temperatures being out of range. On 1/29/19, the facility maintenance director, maintenance assistant, and floor tech completed water temperatures on all resident rooms to ensure facility water temps did not exceed 116 degrees. On 1/30/19, the water pressure was reduced, which resulted in lowering the water temperatures. Assigned facility staff began hourly water checks to ensure no spikes in temperatures. On 1/31/19, a broken circulating pump was identified and replaced. For 48 hours, half the rooms on each affected hallway, were checked hourly by a designated employee until the maintenance director was able to confirm fluctuations had subsided. This was completed on 2/2/19. On 2/5/19, both maintenance directors	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 689 Continued From page 23

During an interview on 01/29/19 at 11:04 AM, the Maintenance Director stated he had worked at the facility for approximately 3 months. He further stated it was his usual process to check water temperatures on a weekly basis and he recorded them on a water temperature log and his acceptable temperature range was 100-116 degrees F. He explained water temperatures had been reported to him as too cold last Friday on 01/25/19 and he had adjusted the mixing valve and he was told again on 01/28/19 that the water was too cold so he increased the temperature on the mixing valve again. He stated when he arrived at work on 01/29/18 he checked the thermometer above the mixing valve in the Pump Room and it was in the 130 degree range but he couldn't remember the exact number because he didn't write it down. He explained he did not go to check temperatures in resident rooms but he did run some water in a staff bathroom on a service hall nearest the Pump Room and felt it was too hot. He further explained the hot water tank and mixing valve in the Pump room supplied hot water to a section of the 200 hall and 300 hall which were in an older area of the building and the other resident hallways were new additions to the facility and had hot water supplied from separate hot water tank systems.

During a tour and observation on 01/29/19 at 11:11 AM in resident room #301 the Maintenance Director checked the water temperature in the bathroom with a digital thermometer and verified the temperature was 150.8 degrees F. He also verified steam was rising from the faucet and stated the water was too hot.

During a tour and observations on 01/29/19 at

F 689

replaced pipes in effort to open all valves as normal. No water spikes occurred, and temperatures remained within acceptable range.
Element 2
All residents not residing on 200 or 500 halls, have the potential to be affected by this practice. On 1/29/19, the hot water was to remain shut off until a solution to the spikes in water temperatures was achieved.
Element 3
To prevent this from recurring, on 1/29/19, the facility administrator in-serviced the maintenance director and assistant maintenance director, that water temperatures are to be obtained and logged daily, beginning on 1/29/19, including random areas, to include resident rooms.
The maintenance director or assistant maintenance director will in-service all housekeeping and laundry staff on monitoring and logging temperatures including random locations. Also included are resident rooms throughout the facility. Staff is to notify the maintenance director immediately if temperatures were outside appropriate range. No housekeeping or laundry staff member will be able to work until education has been provided starting 1/29/19.
New hires will be oriented on this process in general orientation. No agency staff is to be used in housekeeping or laundry departments.
Staff have been educated by Maintenance Director on 1/29/19 to notify maintenance prior to use if water temperatures feel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 689	Continued From page 24 11:13 AM in resident room #306 the Maintenance Director checked the water temperature in the bathroom with a digital thermometer and verified the temperature was 147.2 degrees F. He also verified steam was rising from the faucet and stated the water was the hottest he had ever seen it. During a tour and observation on 01/29/19 at 11:15 AM in resident room #202 the Maintenance Director checked the water temperature in the bathroom with a digital thermometer and verified the temperature was 150.1 degrees F and steam was visible from the faucet. During a tour and observation on 01/29/19 at 11:18 AM in resident room #215 the Maintenance Director checked the water temperature in the bathroom with a digital thermometer and verified the temperature was 138.1 degrees F. During a tour and observation on 01/29/19 11:20 AM in resident room #213 the Maintenance Director checked the water temperature in the bathroom with a digital thermometer and verified the temperature was 140.1 degrees F. During the observation Resident #56 who lived in room #213 stated staff had put bath water in a bath basin for him earlier but the water was too hot and he had to let it cool off before he could take his bath. During an observation on 01/29/18 at 11:30 AM in the Pump Room there was a large hot water tank with pipes which supplied hot water and pipes which supplied cold water and a mixing valve to adjust water temperatures. A thermometer was mounted above the mixing valve and the Maintenance Director verified the thermometer	F 689	abnormal to touch. Alert residents have been educated by IDT on 1/29/19 to report any abnormal temperatures to nursing immediately. Facility continues to work with an outside contracted plumbing company to obtain and install a hot water heater with a projected work completion for 2/21/19. Element 4 To monitor and maintain compliance, Maintenance director or designee will daily audit the water temperatures as part of our ongoing process improvement. The Administrator or designee will audit and sign off on the water temperatures logs weekly for 3 months. Any abnormal findings will be immediately addressed by maintenance. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Compliance Date: 2/26/19 Responsibility: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 689 Continued From page 25 F 689

indicated the water temperature was 130 degrees F. A floor technician was observed outside of the Pump Room with a water hose draining water from the pipes in the Pump Room and further observations revealed the temperature dropped to 128 degrees F but the Maintenance Director stated he did not think the mixing valve was working correctly. He explained they were draining hot water out of the water lines to lower the water temperature but it could take between 12 and 24 hours to stabilize after the mixing valve was adjusted. He stated staff reported to him if water was too hot or too cold but most of the time it was too cold. He further stated he was not aware of any resident who had received an injury or burn because of hot water. He confirmed he had not checked water temperatures in resident bathrooms until surveyors had requested for him to check them.

During an interview on 01/29/19 at 2:50 PM, Nurse Aide #4 stated most of the time the water was cool but if it felt too hot she added cold water to cool it down. She explained Housekeeper #1 had told her earlier that morning on 01/29/19 the water was too hot and she thought Maintenance staff were working on it. She stated she was not aware of any residents who had been injured because of hot water.

During an observation on 01/29/19 at 4:50 PM the Maintenance Director verified the thermometer above the mixing valve in the Pump Room indicated 142 degrees. He stated he would have to pump more hot water out of the pipes to lower the temperature because when he ran hot water out of the pipes the hot water temperatures dropped but when they stopped running hot water out of the pipes the hot water temperature went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 689	Continued From page 26	F 689		

back up.

During an interview on 01/29/19 at 5:27 PM, the Administrator, with the Maintenance Director present, stated a local plumbing company had checked the water system and the mixing valve today on 01/29/19 that provided water for the old section of the building on 200 and 300 halls. She explained water temperatures decreased when hot water was drained out of the system but when they stopped draining hot water the hot water temperatures increased again. She stated they had shut off the hot water to the old section of 200 and 300 halls because more work needed to be done to fix the problem. She explained resident's showers would be given on adjacent resident halls which had separate water tanks and mixing valves and had no problems with hot water.

During a follow up interview on 01/30/19 at 8:08 AM, the Maintenance Director verified the hot water was still turned off on the older section of 200 and 300 halls until they found a solution to fix the problems with hot water.

During an interview on 01/30/19 at 8:42 AM, Resident #18 stated she had not noticed the water was too hot because most of the time it was too cold.

During an interview on 01/30/19 at 8:47 AM, Housekeeper #1 stated after she clocked in for work on 01/29/19 she washed her hands and the water was comfortably warm but was not hot. She explained approximately mid-morning on 01/29/19 the water felt hot and she reported it to the Maintenance Director and around the same time the NAs complained the water was too hot.

PRINTED: 02/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE** **STATESVILLE, NC 28625**

(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 689	Continued From page 27 During an interview on 01/30/19 at 11:00 AM, the Administrator stated when hot water was identified she expected for Maintenance staff to drain hot water from the system to reduce the water temperatures. She stated they were working to find solutions to the hot water problem and the hot water would remain off until it was fixed.	F 689		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE** **STATESVILLE, NC 28625**

(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 732	Continued From page 28 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to post nurse staffing information in a prominent place and readily accessible to residents and visitors for 3 of 4 days during the survey. The findings included: A tour of the facility was made on 01/28/19 at 12:15 PM. The nurse staffing information was found in the front lobby of the facility on end table. There was a large glass planter sitting directly in front of the information and was not visible without moving the glass planter. An observation of the nurse staffing information was completed on 01/28/19 at 5:20 PM. The nurse staffing information was found in the front lobby of the facility on an end table. There was a large glass planter sitting directly in front of the information and was not visible without moving the glass planter. An observation of the nurse staffing information was completed on 01/29/19 at 9:34 AM. The nurse staffing information was found in the front lobby of the facility on an end table. There was a	F 732	F732 Staff Posting Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. Element 1 Staff posting was relocated to both nurse's station for more visibility for our residents. No residents were harmed by this deficiency. Element 2 All residents have the potential to be affected by this deficient practice. Element 3 To prevent this from recurring, an in-service was conducted by the Administrator on 1/31/19 to the management staff of this requirement. The administrator will assign a staff member daily to post the required staff posting in a predominant area each day. Element 4 To monitor ongoing compliance, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 732	Continued From page 29 large glass planter sitting directly in front of the information and was not visible without moving the glass planter. An observation of the nurse staffing information was completed on 01/30/19 at 10:20 AM. The nurse staffing information was found in the front lobby of the facility on an end table. There was a large glass planter sitting directly in front of the information and was not visible without moving the glass planter. An interview was conducted with the Scheduler on 01/30/19 at 10:24 AM. The Scheduler confirmed that each day she completed the nurse staffing information and placed on the end table in the front lobby of the facility. She stated that she had been doing the nurse staffing information for a year and had always placed the information up front on the end table behind the large glass planter. An interview and observation were conducted with the Director of Nursing (DON) on 01/30/19 at 4:29 PM. The nurse staffing information was in the front lobby of the facility on an end table. There was a large glass planter sitting directly in front of the information. The DON stated that she used to post the nurse staffing information on the front glass at the receptionist desk and was told that it "looked tacky" so she had moved it to end table but confirmed that it was not visible to residents and visitors. The DON stated she would relocate the information to a more prominent place in the facility.	F 732	administrator or designee will verify 3 times a week that the staff posting is in a predominant area for 12 weeks. The results of the audit will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance Compliance date 2/26/19	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ____ B. WING ____	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 761	Continued From page 30 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to remove loose unsecured pills from 3 of 3 medication carts (200, 300, and 500) and failed to remove expired medication from 1 of 3 medication carts (500 hall). The findings included: 1a. An observation of the 200-hall medication cart was conducted on 01/31/19 at 10:47 AM. In the second drawer of the medication cart the following pills were found not stored in their	F 761	F761 Label Storage Drugs and Biologicals Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. Element 1 On 1/31/19, the loose pills and expired	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 761	Continued From page 31 original package and loose in the bottom of the drawer: 2 large white round pills, 5 medium white round pills, 1 white capsule, and 2 round brown pills. In the third drawer of the medication cart the following pills were found not stored in their original package and loose in the bottom of the drawer: 1 white/blue capsule, 1 square white pill, 2 half white round pills, 2 round peach pills, 1 oblong peach pill, and 1 large clear fluid filled capsule. An interview was conducted with Nurse #1 on 01/31/19 at 10:50 AM. Nurse #1 confirmed that she was responsible for the 200-hall medication cart. Nurse #1 stated that the pills should not be loose in the medication drawer and she would discard of them right away. b. An observation of the 300-hall medication cart was made on 01/31/19 at 11:11 AM. In the second drawer of the medication cart the following pills were found not stored in their original package and loose in the bottom of the drawer: 1 round light brown pill, 1 large white round pill, 2 small brown round pills, 1 and half large red oblong pills, 1 white capsule, and 1 oblong purple and white pill. An interview was conducted with Nurse #2 on 01/31/19 at 11:15 AM. Nurse #2 confirmed that she was responsible for the 300-hall medication cart. She stated that the pills should not be loose in the medication cart and she would discard of them right away. c. An observation of the 500-hall medication cart was conducted on 01/31/19 at 11:34 AM. The following pills were found not in their original package loose in the bottom of the second	F 761	medications were removed immediately from the 200, 300, and 500 medication carts. No residents were affected by this deficient practice. Element 2 To identify other residents who have the potential to be affected, a 100% medication cart audit was completed on 2/1/19. No further expired medications were found or loose pills. Element 3 To prevent this from recurring, an in-service was completed by the DON on 2/7/19 to the licensed nursing staff as well as the medication aides on ensuring that all medications are secured properly and that all medications are removed from the medication carts that are expired and disposed of properly. An assigned nurse will perform a cart audit daily to ensure that there are no lose pills or expired medications in each med cart. Any negative findings will be corrected immediately. Newly hired licensed staff will be educated on this expectation as part of orientation. Element 4 The monitor and maintain ongoing compliance, the DON or designee will perform an audit of 2 medication carts for 12 weeks. Any negative findings will be corrected immediately. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The DON is responsible for compliance. Compliance date is 2/26/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 761	Continued From page 32 drawer of the medication cart: 1 round blue pill, 1 round small white pill, and 1 yellow capsule. Also, in the second drawer of the medication cart an opened bottle of Aspirin 325 milligrams (mg) was found. The bottle contained no label but had a last name that had been written on top of the bottle. The expiration date of the bottle of Aspirin was 11/2013. There were also 8 tablets of Spironolactone/hydrochlorothiazide 25/25 milligrams (mg) that contained an expiration date of 01/11/19. An interview was conducted with Nurse #3 on 01/31/19 at 11:38 AM. Nurse #3 confirmed that he was responsible for the 500-hall medication cart and stated that the pill should not be loose in the drawer and that he would discard them. Nurse #3 stated that he had not gone through his medication cart today because the night shift nurses took care of that. Nurse #3 also stated that the expired medication should have been removed from the cart and was not sure why it was still on the cart and available for use. An interview was conducted with the Director of Nursing (DON) on 01/31/19 at 12:22 PM. The DON stated that the night shift nurses went through the medication carts at least weekly and she would do spot checks of the carts as well. She added that she had gone through the 200 and 300 hall medication carts on Saturday and did not identify the loose pills. The DON also stated that the pharmacy staff visited the facility and audited one side of the facility each month. She added that they were in the facility the second week in January and audited some of the carts and did not identify any issues. The DON stated that she expected loose pills to be removed from medication carts during the night	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 761	Continued From page 33 shift inspection along with the expired medication and disposed of per facility protocol.	F 761		
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide the appropriate dessert for residents ordered by the physician to have a low concentrated sweets diet for 1 of 1 lunch meal observation and 4 sampled residents (Residents #3, 4, 33 and 56). The findings included: On 01/30/19 at 11:41 AM the lunch meal service was observed. The Dietary Manager (DM) was present for the observations. The DM reported that the facility utilized a liberalized therapeutic diet for diabetic residents. She explained that the liberalized therapeutic diet for diabetic residents was called "Low Concentrated Sweets" (LCS). The DM stated that typically the LCS diet was the same as a regular diet but provided a sugar substitute, diet tea and smaller portioned desserts. During the lunch meal tray line observation, the	F 808	F808 Therapeutic Diets Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. ELEMENT 1 Residents #3, #4, #56, and #33 remain in the facility, and did not have any negative outcome from consuming a full desert portion. ELEMENT 2 All residents on LCS diets have the potential to be affected, however, no resident suffered any negative outcome from consuming the full dessert portion. ELEMENT 3 To prevent this from reoccurring, the RD	2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 808	Continued From page 34 facility's spreadsheet was reviewed and specified the day of 01/30/19 the dessert was a fruit cheesecake bar. The spreadsheet specified the dessert for the LCS diet was ½ of a 2 inch by 3 inch serving of the fruit cheesecake bar. Observations of the tray line on 01/30/19 revealed the dietary aide assigned to plate the dessert was plating a 2 inch by 3 inch serving of the fruit cheesecake bar on trays. The dietary aide reported that all the dessert was the "same." Observations of sampled residents revealed: a. Resident #3 was admitted to the facility on 05/22/13 with diagnoses that included type 2 diabetes mellitus. A physician's order dated 05/15/18 specified the resident was to have a LCS diet with regular texture. The Minimum Data Set (MDS) dated 10/21/18 specified the resident's cognition was moderately impaired and she was ordered to receive a therapeutic diet. On 01/30/19 at 12:28 PM Resident #3 was observed in the dining room eating lunch. Observations of her lunch meal revealed a 2 inch by 3 inch serving of fruit cheesecake bar. b. Resident #4 was readmitted to the facility on 01/14/19 with diagnoses that included type 1 diabetes mellitus. A physician's order dated 01/14/19 specified the resident was to receive a LCS diet. The Minimum Data Set (MDS) dated 01/21/19 specified the resident's cognition was intact and her received a therapeutic diet. On 01/30/19 at 12:33 PM Resident #4 was observed in his room eating lunch. On his meal tray was a 2 inch by 3 inch serving of fruit	F 808	provided re-education to all kitchen staff on following menu spreadsheets for LCS diets on 1/30/19. New hires will be educated on following residents' ordered diets upon orientation. Agency staff will not be used in dietary. ELEMENT 4 To monitor and maintain compliance, the food service director or designee will audit correct portion size of dessert on LCS diets once daily for one week, then twice a week for 11weeks. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. FSD Responsible for Compliance 2/26/19 Compliance Date	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 808	Continued From page 35	F 808		

cheesecake bar. The resident was interviewed and stated he usually got dessert with lunch and ate it; but he wasn't aware it if was the right portion or not.

c. Resident #33 was admitted to the facility on 11/29/18 with diagnoses that included end stage renal disease and type 2 diabetes mellitus. A physician's order dated 12/05/18 specified the resident was to have a LCS diet. The Minimum Data Set (MDS) dated 12/08/18 specified the resident's cognition was intact and he received a therapeutic diet.

On 01/30/19 at 12:30 PM the Resident's meal tray contained a 2 inch by 3 inch serving of fruit cheesecake bar.

d. Resident #56 was admitted to the facility on 02/20/17 with diagnoses that included type 2 diabetes mellitus. A physician's order dated 09/11/18 specified the resident was to have a LCS diet. The Minimum Data Set (MDS) dated 01/16/19 specified the resident's cognition was intact and he received a therapeutic diet.

On 01/30/19 at 12:35 PM observations of the Resident's lunch meal revealed he was served the regular sized portion of dessert.

On 01/30/19 at 12:43 PM the DM was interviewed again and reported that she was new in her role. She stated she was aware the LCS diet was to receive ½ servings of dessert but did not realize the dietary staff had not followed the spreadsheet for the lunch meal on 01/30/19.

On 01/30/19 at 2:10 PM the Registered Dietitian (RD) was interviewed and explained an LCS diet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 808	Continued From page 36 was used to provide a consistent amount of carbohydrates for diabetic residents. She stated that the spreadsheet typically specified the LCS diet was to receive half portions of dessert like cakes and pies. She added that she did not routinely monitor dietary staff for tray accuracy but stated that it was a problem that the therapeutic diets for LCS had not been followed for the lunch meal.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to have hot water accessible to dietary staff for washing their hands in 2 of 2 hand sinks and failed to remove opened, unlabeled food from use in 2 of 2 nourishment	F 812	F812 Kitchen Sanitation Preparation and submission of this Plan of Correction does not constitute admission of or agreement with, it is required by the State and Federal law. It is executed and	2/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 812

Continued From page 37
refrigerators.

The findings included:

1. On 01/28/19 at 12:29 PM an initial tour of the kitchen was made that included using a designated hand sink to wash hands. Observations of the hand sink revealed there was hot and cold water.

On 1/30/19 at 11:27 AM a follow-up visit to the kitchen was made and prior to observations, the hand sink was used. Observations of the hand sink revealed there was no hot water. The Dietary Manager (DM) was present for the observations and used a digital thermometer to measure the hot water. The digital thermometer registered 51 degrees Fahrenheit. The DM reported there had been warm water from the faucet earlier that day.

On 01/30/19 at 11:30 AM the Registered Dietitian (RD) was present for the observation and interviewed about hot water accessibility for washing hands. The RD reported that soap and friction was adequate for sanitizing hands.

On 01/30/19 at 12:15 PM the Maintenance Director was interviewed and reported the facility had to cut off the hot water supply to the facility on 01/29/19 because of unsafe high temperatures. He explained that the kitchen's two hand sinks were affected and did not have hot water available. He stated that the dietary staff were able to wash their hands using cold water because the directions on the soap only specified to use with water.

On 01/30/19 at 2:18 PM the Administrator was

F 812

implemented as a means to continuously improve the quality of care to comply with the state and federal requirements.
ELEMENT 1
Hot water was provided via air pot for hand hygiene for kitchen staff immediately on 1/30/19. The opened unlabeled food in the nourishment room refrigerator was immediately removed on 1/28/19. No residents were noted to have had any negative outcomes from this finding.
ELEMENT 2
To identify other residents that have the potential to be affected, all nourishment room refrigerators were cleaned out. There were no other findings of opened unlabeled items.
As of 1/31/19 the water temperatures have been regulated to be reading appropriate temperatures, therefore dietary staff are able to continue to use the handwashing sink.
ELEMENT 3
To prevent this from reoccurring, on 1/30/19, the Food Service Director, educated kitchen staff on proper water temps and hand washing procedures. Dietary staff will revert to using the hot water in the air pot if the water temperatures should drop below 110 and will notify maintenance immediately. Ongoing random temp monitoring will be an ongoing facility practice.
Staff was educated on 2/7/19 by Administrator on storing personal food in the break room refrigerator and not in the nourishment room.
The nourishment room refrigerators will be monitored for inappropriately stored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 812	Continued From page 38 interviewed and reported the two sinks in the kitchen were without hot water and staff were able to wash their hands the same way staff on the floor could wash their hands by using cold water, soap and friction. The Administrator was unaware the Federal regulations for food production required hot water for washing hands. 2. On 01/28/19 an initial tour of the kitchen was made with the Dietary Manager (DM). She stated she was new in her role. Observations were made of the two nourishment rooms with the DM. On 01/28/19 at 12:37 PM the West wing nourishment room was observed. Inside the refrigerator were two opened, unlabeled cartons of milk and two opened, unlabeled drink bottles. The DM removed the items and reported they were not to be stored without proper labeling and dating. On 01/28/19 at 12:42 PM the East wing nourishment room was observed. Inside the refrigerator was personal food unlabeled and undated and a bag from McDonald's with no date or name to indicate how long the food had been stored. The DM removed the food items and explained that all personal food should be labeled and dated. The DM was interviewed during the observation and explained she expected her staff to remove items stored improperly.	F 812	food when they are being assessed for temperature readings. Any findings will be addressed immediately. ELEMENT 4 To monitor and maintain ongoing compliance, the water temps in the hand sink will be audited daily for one week, twice a week for 11 weeks, by the FSD or designee. Any concerns with the water not being hot will be brought to the attention of the maintenance director immediately. To monitor and maintain compliance, the contents of the nourishment room refrigerator will be audited daily for one week, twice a week for 11 weeks, by the FSD or designee. Any negative findings as a result of these audits will be corrected immediately. The results of the audits will be forwarded to the facility QAPI committee for further review any recommendations. FSD will be responsible for compliance. Date of compliance 2/26/19	