| DEPART | MENT OF HEALTH AN | ID HUMAN SERVICES | | | FOI | RM APPROVED |
|--------------------------|---|--|---------------------|--|----------|----------------------------|
| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | NO. 0938-0391 |
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | | TE SURVEY MPLETED |
| | | 345351 | B. WING | | 0 | C 2/02/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AUTUMN | CARE OF SALUDA | | | 501 ESSEOLA CIRCLE SALUDA, NC 28773 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | E 00 | 0 | | |
| F 000 | was conducted onsite facility on 01/26/21. obtained offsite throu exit date was change was found in complia | | F 00 | 0 | | |
| F 561 SS=E | Control Survey and c conducted onsite 01/2 facility on 01/26/21. A obtained through 02/2 date was changed to found in compliance of control regulations ar CMS and Centers for Prevention (CDC) rec prepare for COVID-11 were investigated and Event ID# BNQ811. Self-Determination | commended practices to 9. A total of 2 allegations d both were substantiated. | F 56 | 1 | | 3/2/21 |
| | §483.10(f) Self-detern The resident has the promote and facilitate through support of re not limited to the righ (1) through (11) of thi §483.10(f)(1) The res activities, schedules of waking times), health | mination. right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f) s section. ident has a right to choose (including sleeping and care and providers of health | | | | |
| LABORATORY | DIRECTOR'S OR PROVIDER/ | SUPPLIER REPRESENTATIVE'S SIGNATURE | | TITLE | | (X6) DATE |
| Electroni | cally Signed | | | | | 02/26/2021 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 03/01/2021

| | | MEDICAID SERVICES | | | | <u>NO. 0938-039</u> |
|---------------|--|---|---------------|--|-------------|----------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | · · · | TE SURVEY MPLETED |
| | | | A. BUILDIN | G | | С |
| | | 345351 | B. WING | | | 2/02/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | 0.0001 | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 2/02/2021 |
| | | | | 501 ESSEOLA CIRCLE | - | |
| AUTUMN | CARE OF SALUDA | | | SALUDA, NC 28773 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF COF | RECTION | (X5) |
| PREFIX TAG | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | | SHOULD BE | COMPLETION |
| F 561 | Continued From page | o 1 | | | | |
| F 301 | Continued From pag | | F 5 | 01 | | |
| | | tent with his or her interests, | | | | |
| | assessments, and pl applicable provisions | | | | | |
| | | | | | | |
| | §483.10(f)(2) The real | sident has a right to make | | | | |
| | | ts of his or her life in the | | | | |
| | facility that are signif | icant to the resident. | | | | |
| | | | | | | |
| | | sident has a right to interact | | | | |
| | | community and participate in both inside and outside the | | | | |
| | facility. | | | | | |
| | | | | | | |
| | §483.10(f)(8) The re | | | | | |
| | | ctivities, including social, | | | | |
| | | unity activities that do not nts of other residents in the | | | | |
| | facility. | | | | | |
| | | T is not met as evidenced | | | | |
| | by: | | | | | |
| | Based on record rev | view and resident, family and | | Residents #3, #13, #6, #14, # | 11, and #12 | |
| | staff interviews, the f | | | were provided a copy of the re | | |
| | residents placed on | | | rights as well as the resident's | | |
| | | otential exposure from direct | | party. The rights were reviewe | | |
| | | positive for COVID-19 the | | the resident and the responsib | | |
| | | to smoke for 6 of 6 residents (Resident #3, #13, #6, #14, | | smoking schedule was created facility with input from the resid | - | |
| | | failure occurred during a | | responsible party. | | |
| | COVID-19 pandemic | | | · · · · · · · · · · · | | |
| | | | | All residents have the potentia | | |
| | Findings included: | | | affected by this deficient pract | | |
| | | | | therefore all current residents | | |
| | | "Independent/Unsupervised | | provided a copy of the residen | - | |
| | | .OA) During Covid-19 03/20, read in part: "Facilities | | a copy was mailed to the resp party. A resident council meet | | |
| | should reassess resi | | | conducted by the facility socia | | |
| | | rvised with LOA or smoking. | | review the rights and determin | | |
| | | to consideration if resident is | | concerns regarding resident ri | - | |
| | able to follow COVIE | | | | - | |

Facility ID: 922956

If continuation sheet Page 2 of 14

| | S FOR MEDICARE & | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | LE CONSTRUCTIO | | OMB NO. (X3) DATE SI | |
|--------------------------|--------------------------|---|---------------------|------------------------|---|-------------------------|---------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | . , | | | COMPLE | |
| | | | A. BOILDIN | | | с | |
| | | 345351 | B. WING | | | | 2/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRES | S, CITY, STATE, ZIP CODE | 02/01 | |
| | | | | 501 ESSEOLA C | IRCLE | | |
| AUTUMN | CARE OF SALUDA | | | SALUDA, NC | 28773 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EAG | ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIA | | (X5) COMPLETIC DATE |
| | • | | - | | DEFICIENCY) | | |
| F 561 | Continued From page | 2 | F 56 | 31 | | | |
| | | sal masking and social | | | t this from recurring, the facili | tv | |
| | | ompting. If a resident is not | | · · | ator or designee will complete | - | |
| | | bllow these requirements | | | on resident rights to all staff t | | |
| | | esignated as requiring | | | is education will be provided | - | |
| | | or smoking. Residents who | | | es and agency staff. A reside | | |
| | • | observation unit are not | | | eeting will be held routinely, a | | |
| | | OA of any kind. Such | | | monthly, to review resident | | |
| | - | offered nicotine patches or | | | any concerns that the counci | 1 | |
| | other smoking cessat | • | | | d resident rights. Any concerr | | |
| | physician's orders." | | | | en through the grievance | | |
| | | | | | nd communicated back to the | | |
| | 1. a. Resident #3 wa | s admitted to the facility on | | | resolution review. | | |
| | | ses that included hemiplegia | | | | | |
| | | e of the body), mild cognitive | | To monitor | r and maintain ongoing | | |
| | impairment and nicot | | | | e, beginning 3/3/21 the | | |
| | | ine dependence. | | | ator or designee will audit 10 | | |
| | | note dated 12/23/20 for | | | per week for 12 weeks to | | |
| | | e following comments under | | | at there are no resident right | | |
| | | nic nicotine dependence, | | | oncerns. These audits will | | |
| | | ted smoker. Not interested | | | sidents in the facility and | | |
| | - | 20: Daily routine revolves | | | esponsible party via phone. | | |
| | | s, remains assisted and | | | lings will be documented on a | an | |
| | | tine patch available when | | | Any negative findings will be | | |
| | | to COVID-19 pandemic | | | immediately. | | |
| | | | | | s of the audits will be forward | | |
| | | m Data Set (MDS) dated | | | lity QAPI committee for furthe | r | |
| | 01/08/21 noted Resid | | | review and | d recommendations. | | |
| | · · · · | on and required limited staff | | | | | |
| | assistance with locon | notion on/off the unit. | | The facility complianc | y Administrator is responsible | for | |
| | A review of Resident | #3's medical record | | | ···. | | |
| | | Point of Contact (POC) test | | Date of co | mpliance is 3/2/21. | | |
| | results for the dates of | . , | | | | | |
| | | 14/21, 1/18/21, 1/21/21, and | | Title of new | rson responsible for implantin | a | |
| | 1/25/21 that were all | | | | able plan of correction: | ' з | |
| | | negative. | | | ate, Administrator | | |
| | During a telephone in | terview on 01/27/21 at 3:42 | | | | | |
| | PM Resident #3's Re | | | | | | |

Facility ID: 922956

If continuation sheet Page 3 of 14

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 03/01/2021 APPROVED). 0938-0391 |
|--------------------------|--|--|---------------------|--------------------------------------|--|-------------------|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345351 | B. WING | | _ | | C 02/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| AUTUMN | CARE OF SALUDA | | | 01 ESSEOLA CIRCLE ALUDA, NC 28773 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 561 | time and looked forwa the day to smoke. The week when she learns conversation with a st had stopped allowing to go outside and smo isolation precautions. was Resident # 3's m allowing her out of the was affecting her qua During a telephone in PM, the Director of Ne Resident #3 had rema precautions since 12/ exposure from direct positive and provided added as long as staf direct care continued COVID-19, isolation p would be discontinued b. Resident #13 was 12/10/19 with diagnos hypertension, history bipolar disorder. The quarterly Minimu 01/05/21 noted Resid and required staff sup on/off the unit. A review of Resident F results for the dates of 1/04/21, 01/07/21, 1/2 | 3 had smoked for a long and to going outside during be RP stated it was last ed through general taff member that the facility residents out of their rooms oke due to being placed on The RP added smoking ain pleasure and by not e room to smoke, she felt it lity of life. terview on 01/27/21 at 1:00 ursing (DON) confirmed ained on isolation 28/20 due to repeated care to Resident #3. She f members who provided to test negative for orecautions for Resident #3 d on 02/04/21. admitted to the facility on ses that included of traumatic brain injury and m Data Set (MDS) dated ent #13 had intact cognition pervision with locomotion | F 561 | | | | |

Facility ID: 922956

If continuation sheet Page 4 of 14

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 03/01/2021 APPROVED . 0938-0391 |
|--------------------------|---|---|---------------------|---|---|-------------------|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345351 | B. WING | | _ | (02/ | C 02/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | S | REET ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| AUTUMN | CARE OF SALUDA | | | 1 ESSEOLA CIRCLE ALUDA, NC 28773 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 561 | During a telephone in PM, Resident #13 cor but had not been able approximately one mo quarantine. Resident a nicotine patch but d refused. Resident #1 choice and missed be smoke, "it's what keep During a telephone in PM, the Administrator had remained on isola 12/28/20 due to repea care staff who had tes care to Resident #13. members who provide test negative for COV for Resident #13 wou 02/04/21. c. Resident #6 was a 02/10/18 with diagnos convulsions, anxiety of depression. The quarterly Minimut 12/17/20 noted Resid and required staff sup on/off the unit. A physician progress Resident #6 noted the the diagnosis of chror "11/16/20 - daily supe interested in quit assis smoking at facility. N | terview on 02/01/21 at 1:24 firmed he was a smoker a to go outside to smoke for onth due to being on #13 stated he was offered idn't like them so he 3 added he wasn't given the aing able to go outside to ps me sane." terview on 02/01/21 at 2:34 c confirmed Resident #13 ation precautions since ated exposure from direct sted positive and provided She added as long as staff ed direct care continued to 7D-19, isolation precautions Id be discontinued on ddmitted to the facility on ses that included disorder and major m Data Set (MDS) dated ent #6 had intact cognition pervision with locomotion note dated 01/13/21 for a following comments under hic nicotine dependence, ervised smoking. Not st. 02/20/20 - has started o desire for quit assist ed about adverse health | F 561 | | | | |

Facility ID: 922956

If continuation sheet Page 5 of 14

| | | D HUMAN SERVICES | | | | | FORM |): 03/01/2021 APPROVED |
|--------------------------|--|--|---------------------|----|-------------------------------|--|-----------|---------------------------------|
| STATEMENT (| S FOR MEDICARE & I | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ´ | | CONSTRUCTION | | (X3) DATE | 0. 0938-0391 SURVEY LETED |
| | | 345351 | B. WING | | | _ | | C 02/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, ST | ATE, ZIP CODE | | 02/2021 |
| | | | | 50 | 1 ESSEOLA CIRCLE | | | |
| AUTUMN | CARE OF SALUDA | | | SA | ALUDA, NC 28773 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 561 | Continued From page | • 5 | F 5 | 61 | | | | |
| | results for the dates of 1/04/21, 01/07/21, 1/1 1/21/21, and 1/25/21 During a telephone in PM, Resident #6 conf and usually went outs 4 times a day but had room to go outside to on isolation precaution sure how long she ha precautions and could explained why she co outside and smoke bu and received a nicotir stated she wanted an | Point of Contact (POC) test f 12/28/20, 1/01/21, 11/21, 1/14/21, 1/18/21, that were all negative. terview on 02/01/21 at 1:18 irmed she was a smoker ide to smoke approximately not been allowed out of the smoke since being placed ns. Resident #6 was not d been on isolation d not recall if anyone had uld not leave her room to go ut did state she was offered | | | | | | |
| | PM, the Administrator remained on isolation due to repeated exposive who had tested positive Resident #6. She address who provide test negative for COV for Resident #6 would 02/04/21. d. Resident #14 was 08/22/19 with diagnoss heart failure and major The comprehensive N | ed direct care continued to ID-19, isolation precautions | | | | | | |

| | H AND HUMAN SERVICES E & MEDICAID SERVICES | | | FOR | D: 03/01/2021 MAPPROVED O. 0938-0391 |
|--|---|---------------------|--------------------------------------|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
| | 345351 | B. WING | | 02 | C 2/02/2021 |
| NAME OF PROVIDER OR SUPPLIEF | 3 | S | TREET ADDRESS, CITY, STATE, | | |
| AUTUMN CARE OF SALUDA | | | 01 ESSEOLA CIRCLE ALUDA, NC 28773 | | |
| PREFIX (EACH DEFIC | RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE DIENCY) | (X5) COMPLETION DATE |
| Iocomotion on theA review of Residerevealed COVID-results for the dat1/04/21, 01/07/211/21/21, and 1/23During a telephoPM, Resident #1and usually wentnot been able todue to being on ofhe was offered aone and if givenget outside to smDuring a telephoPM, the Administhad remained on12/28/20 due to becare staff who hadcare to Residentmembers who pritest negative forfor Resident #1402/04/21.e. Resident #1105/24/19 with diathemiplegia.The quarterly Min12/17/20 noted Fand required stafton/off the unit. | quired supervision with e unit. dent #14's medical record -19 Point of Contact (POC) test tes of 12/29/20, 1/01/21, 1, 1/11/21, 1/14/21, 1/18/21, 5/21 that were all negative. ne interview on 02/01/21 at 1:27 4 confirmed he was a smoker coutside 5 times a day but had smoke in the past "month or two" quarantine. Resident #14 stated nicotine patch but did not want the choice, he would prefer to | F 561 | | | |

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| | S FOR MEDICARE & | | | | | IO. 0938-039 |
|--------------------------|---|---|---------------------|--|----------------------------|----------------------------|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ECONSTRUCTION | | E SURVEY IPLETED |
| | | | | | | С |
| | | 345351 | B. WING | | 0 | 2/02/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, STATE, ZIP COD | θE | |
| AUTUMN | CARE OF SALUDA | | | 501 ESSEOLA CIRCLE SALUDA, NC 28773 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | (X5) COMPLETION DATE |
| F 561 | results for the dates of 1/04/21, 01/07/21, 1/ 1/21/21, and 1/25/21 During a telephone in PM, Resident #11 revo outside to smoke abo been allowed out sind "quarantine." Reside "just a little bit" that he smoke but that "it was recall how long he ha precautions or when the go outside and smoke During a telephone in PM, the Administrator had remained on isola 12/28/20 due to repeat care staff who had test care to Resident #11. members who provide test negative for COV for Resident #11 wou 02/04/21. f. Resident #12 was a 04/26/19 with diagnost infarction (damage to loss of oxygen) and a The quarterly Minimu 10/18/20 noted Reside | Point of Contact (POC) test of 12/28/20, 1/01/21, 11/21, 1/14/21, 1/18/21, that were all negative. Aterview on 02/01/21 at 1:15 yealed he usually went out 5 times a day but hadn't be being placed under nt #11 stated it bothered him e couldn't go outside to s alright." He was unable to d been on isolation the last time he was able to e. Aterview on 02/01/21 at 2:34 r confirmed Resident #11 ation precautions since ated exposure from direct sted positive and provided . She added as long as staff ed direct care continued to /ID-19, isolation precautions Id be discontinued on admitted to the facility on ses that included cerebral tissues in the brain due to | F 561 | | | |

Facility ID: 922956

If continuation sheet Page 8 of 14

| TATEMENT (| OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | PLE CONSTRUCTION | | O. 0938-039 |
|--------------------------|---------------------------------------|---|---------------------|---|-----------------------------------|---------------------------|
| ND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | IG | CON | IPLETED |
| | | 345351 | B. WING | | | C |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP (| | 2/02/2021 |
| | | | | 501 ESSEOLA CIRCLE | | |
| AUTUMN | CARE OF SALUDA | | | SALUDA, NC 28773 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETIO DATE |
| F 561 | Continued From page | e 8 | F 5 | 61 | | |
| | results for the dates of | of 12/28/20, 1/01/21, | | | | |
| | | 11/21, 1/14/21, 1/18/21, that were all negative. | | | | |
| | | terview on 02/01/21 at 1:21 | | | | |
| | | nfirmed he was a smoker to go outside to smoke since | | | | |
| | | antine. Resident #12 stated | | | | |
| | - | hoice just told he could not | | | | |
| | go smoke. Resident further questions. | #12 declined to answer | | | | |
| | | terview on 02/01/21 at 2:34 r confirmed Resident #12 | | | | |
| | | ation precautions since | | | | |
| | | ated exposure from direct sted positive and provided | | | | |
| | | She added as long as staff | | | | |
| | | ed direct care continued to | | | | |
| | _ | /ID-19, isolation precautions Id be discontinued on | | | | |
| | 02/04/21. | | | | | |
| | | n 01/26/21 at 12:29 PM, the | | | | |
| | • • | OON) stated residents who mission based precautions | | | | |
| | | of their room at all, even to | | | | |
| | go outside to smoke. | The DON explained they | | | | |
| | | ician or Nurse Practitioner to | | | | |
| | | e option for a nicotine patch. were informed they could | | | | |
| | resume their smoking | | | | | |
| | transmission based p discontinued. | recautions were | | | | |
| | | terview on 01/27/21 at 1:00 | | | | |
| | - | ed when nursing staff tested 9, the residents on the | | | | |
| | nursing staff's assign | | | | | |

| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 0: 03/01/2021 APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|--|--|-------------------|---|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | TIPLE CONSTRUCTION | _ | (X3) DATE COMP | SURVEY LETED |
| | | 345351 | B. WING | | | (02/0 | 02/2021 |
| NAME OF PF | ROVIDER OR SUPPLIER | | • | STREET ADDRESS, CITY, S | STATE, ZIP CODE | | |
| | CARE OF SALUDA | | | 501 ESSEOLA CIRCLE SALUDA, NC 28773 | | | |
| | | | | | | | a (=) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X (EACH CORR | R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 561 | exposure. The DON re-exposed by nursing for COVID-19 and pro- 14-days of isolation p During a joint telepho and Administrator on Administrator stated b received from their co- their infection control transmission based p out of their rooms unle The Administrator exp considered to be med confirmed residents in allowed to go outside transmission based p | recautions due to potential added when residents were g staff who tested positive ovided direct care, the recautions started over. ne interview with the DON 1/27/21 at 3:17 PM, the based on the guidance orporate office as well as policy, residents placed on recautions were not allowed ess medically necessary. blained smoking was not lically necessary and n the facility were not | F 5 | 561 | | | |
| F 580 SS=D | PM, the Administrator residents on transmis resident only had con caregiver per shift wh further exposure. The allowing residents to g risk of exposure would they would have with assisting them outside Administrator stated t related to transmissio during an outbreak, th decision in order to per facility. Notify of Changes (Inj | ich decreased their risk for e Administrator stated by go outside to smoke their d increase due to contact multiple facility staff e to the smoking area. The hey had followed their policy n based precautions and hey had to make the best rotect the residents of the jury/Decline/Room, etc.) | F 5 | 580 | | | 3/2/21 |

If continuation sheet Page 10 of 14

| | MENT OF HEALTH AN S FOR MEDICARE & I | | | | | | FORM |): 03/01/2021 APPROVED). 0938-0391 |
|--------------------------|---|--|-------------------|-----|-------------------------------|--|-------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>í</i> | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345351 | B. WING | | | _ | | C 02/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | | | 5 | 01 ESSEOLA CIRCLE | | | |
| AUTUMN | CARE OF SALUDA | | | s | ALUDA, NC 28773 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 580 | §483.10(g)(14) Notific (i) A facility must imm consult with the reside consistent with his or representative(s) whee (A) An accident involve results in injury and he physician intervention (B) A significant change mental, or psychosoce deterioration in health status in either life-three clinical complications) (C) A need to alter tree a need to discontinue treatment due to advect commence a new form (D) A decision to transe resident from the facilis §483.15(c)(1)(ii). (ii) When making notified (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must are resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (iv) The facility must resident is available and provide the facility must resident in the facility must resident | ation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident n there is- ring the resident which as the potential for requiring ; ge in the resident's physical, ial status (that is, a , mental, or psychosocial eatening conditions or ; atment significantly (that is, an existing form of erse consequences, or to n of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the ent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically nailing and email) and | F | 580 | | | | |

Facility ID: 922956

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| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--------------------|-----|---|--|---------------------------|
| | | 345351 | B. WING | | | | C / 02/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | CARE OF SALUDA | | 501 ESSEOLA CIRCLE | | 01 ESSEOLA CIRCLE | | |
| | CARE OF SALUDA | | | s | SALUDA, NC 28773 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETIO DATE |
| F 580 | that is a composite di §483.5) must disclose its physical configural locations that compris part, and must specifi room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revi interviews, the facility Responsible Party of 1 of 5 residents revie change (Resident #3) Findings included: Resident #3 was adm 05/30/19 with diagnosi dependence. The quarterly Minimu 01/08/21 assessed R impaired cognition. A physician's progress revealed the following diagnosis of nicotine daily assisted smokel assist. 10/28/20: dail smoking times, remai has nicotine patch av quarantine due to CC restrictions." | osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations ⁻ is not met as evidenced iew, family and staff r failed to notify the a new medication order for wed for notification of). hitted to the facility on ses that included nicotine m Data Set (MDS) dated esident #3 with moderately as note dated 12/23/20 g comments under the dependence: "12/23/20: r, not interested in quit y routine revolves around ins assisted and supervised, ailable when under | F | 580 | Resident #3 responsible party was notified of the resident's current orders and plan of care was reviewed. All residents have the potential to be affected by this deficient practice; therefore, an audit of new orders will be completed by the Director of Nursing o designee by 3/2/21 for the last 7 days. Residents or their responsible party we notified of any new orders. The notifica was documented in the resident's med record. To prevent this from recurring, the facil Director of Nursing or designee will complete education to all nurses on the requirement of notification to residents their responsible party of condition changes, including new orders, by 3/2/ This education will be provided to all ne hires and agency staff. The Director of Nursing or designee will monitor for ne orders at clinical morning meeting and verify the resident or responsible party were notified. | e r ere ition ical ity e or 21. ew w | |
| | quarantine due to CC restrictions." Review of Resident # | VID-19 pandemic | | | orders at clinical morning meeting and verify the resident or responsible party | | |

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PRINTED: 03/01/2021

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345351 B. WING 02/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 ESSEOLA CIRCLE** AUTUMN CARE OF SALUDA SALUDA, NC 28773 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 580 Continued From page 12 F 580 start date of 01/11/21 for: Nicotine Patch 14 compliance, beginning 3/3/21 the Director milligram/24 hour - apply one patch every 24 of Nursing or designee will audit 10 hours as needed for nicotine dependence for 30 resident's orders per week for 12 weeks days. Use when unable to go outside to smoke to validate that any new orders were due to COVID-19 pandemic restrictions. communicated to the resident and/or their responsible party. These findings will be Review of the January 2020 staff progress notes documented on an audit tool. Any for Resident #3 revealed no entry indicating the negative findings will be corrected Responsible Party (RP) was notified of the new immediately. medication order dated 01/11/21. The results of the audits will be forwarded A telephone interview on 01/27/21 at 3:42 PM to the facility QAPI committee for further was conducted with Resident #3's RP. She review and recommendations. stated during a conversation with a facility staff member last week when she learned they had The facility Administrator is responsible for stopped allowing residents from going outside to compliance. smoke if they were under isolation precautions. The RP stated she then spoke with one of the Date of compliance is 3/2/21. facility nurses for an update. The nurse confirmed Resident #3 had not been allowed out Title of person responsible for implementing an acceptable plan of of the room to go outside and smoke. The nurse had also reported the physician had ordered a correction: nicotine patch for Resident #3, who kept pulling Melissa Pate, Administrator the patch off. The RP added she had not been notified that Resident #3 had a physician's order for a nicotine patch and she had specifically requested to be notified of any changes or new medication orders. During a telephone interview on 02/02/21 at 9:13 AM, Nurse #1 stated she usually called the resident's RP to notify them of new medication orders and entered a progress note in the resident's medical record but sometimes got busy and forgot. Nurse #1 confirmed she entered Resident #3's medication order received by the physician for the Nicotine patch on 01/11/21 but was unable to recall if she had notified Resident #3's RP.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 03/01/2021

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | PRINTED: 03/01/2021 FORM APPROVED OMB NO. 0938-0391 | |
|--|--|--|--|-------------------------------|---|---|----------------------------|
| | (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
| | 345351 | B. WING | | _ | C 02/02/2021 | | |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZI | | ATE, ZIP CODE | | | |
| AUTUMN CARE OF SALUDA | | | 501 ESSEOLA CIRCLE SALUDA, NC 28773 | | | | |
| (X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREF TAG | | (EACH CORREC CROSS-REFEREN | EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 580 Continued From page 1 | 80 Continued From page 13 | | F 580 | | | | |
| PM the Director of Nurs nurses were responsibl RP of any new order ar note in the resident's m stated Nurse #1 should #3's RP when the medi | Continued From page 13 During a telephone interview on 01/29/21 at 1:00 PM the Director of Nursing (DON) explained nurses were responsible for notifying a resident's RP of any new order and entering a progress note in the resident's medical record. The DON stated Nurse #1 should have notified Resident #3's RP when the medication order for a nicotine patch was received by the physician on 01/11/21. | | | | | | |

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