	-	ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUT		CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	, ,				PLETED
		345269	B. WING _				C 21/2016
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
				15	505 BRINGLE FERRY ROAD		
AUTUMN	CARE OF SALISBURY			S	ALISBURY, NC 28146		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
					DEFICIENCY)		
F 000	INITIAL COMMENTS		F	000			
		cited as a result of the					
	complaint investigation N1RL11.	on of 7/21/16 Event ID#					
F 282		ICES BY QUALIFIED	F 2	282			8/18/16
SS=D	PERSONS/PER CAR	RE PLAN					
	The second second states						
	must be provided by	d or arranged by the facility					
		resident's written plan of					
	care.	residents whiten plan of					
		is not met as evidenced					
	by:	and staff interview the					
	facility failed to follow	ew and staff interview the interventions for			FOR THE RESIDENT AFFECTED: Resident #60 was evaluated by therapy	,	
	contractures for 1 of 2				staff on 8/12/16. New orders were	, 	
		ad orders for splitting or a			received on 8/15/16 to begin left upper		
	hand roll.	1 0			extremity splint to be worn 6 hours q sh	ift	
	The findings included				as tolerated and hand roll when splint is	6	
		mitted to the facility on sis that included hemiplegia			off for contracture prevention.		
	and hemiparesis follo				FOR THE RESIDENTS WITH		
	cerebrovascular disea				POTENTIAL TO BE AFFECTED:		
		id contracture of left hand.			A contracture audit was completed by the	ne	
	The most recent Mini	mum Data Set (MDS)			staff development coordinator (SDC) or	ו	
	assessment dated 4/2	26/16 revealed Resident #60			8/12/16. Referrals were made to therap	у	
		sistance with the use of to			as indicated.		
	-	daily living and had upper					
		mpairments. Resident #60			SYSTEM CHANGES:	nd	
		S assessment as being videnced by a brief mental			Nursing staff were inserviced by DON a SDC on 8/11/2016 regarding ensuring	шu	
		though Resident #60 was			splints are applied as ordered, following	1	
		ntact according to the			care plans, documentation of refusals,	,	
		sment, the resident was not			skin assessments and skin care related	to	
	interviewed.				splints and contractures and rehab		
	Review of Resident #	60 ' s care plan dated			communication form.		
		SUPPLIER REPRESENTATIVE'S SIGNATUR	 F		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/15/2016

PRINTED: 09/16/2016

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.

Electronically Signed

		MEDICAID SERVICES				8-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	Y
					С	
		345269	B. WING		07/21/201	16
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF SALISBURY			1505 BRINGLE FERRY ROAD		
				SALISBURY, NC 28146		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMP	X5) PLETIO ATE
F 282	Continued From page	e 1	F 28	2		
		ident #60 was a risk for skin	1 20			
	breakdown related to			CNAs were inserviced by the DOM	l and	
	weakness, incontiner	-		SDC regarding reviewing each pa		
	diagnosis of Diabetes	Mellitus (DM), contracture		Kardex and following the plan of c	are,	
		or compartment syndrome.		reporting change in condition by the		
		dent #60 would have no		and Watch form regarding ADLs a	nd	
	-	kin breakdown though next		decreased ROM,		
		her stated Resident #60		application of splints and handrolls documentation in the kiosk and sk		
		ntable signs/symptoms of ne (updated 7/20/16). The		with residents with contractures.	Incare	
	interventions initiated			with residents with contractures.		
	splint/wash cloth to le			A communication form has been in	nitiated	
	Observe skin for irritation/breakdown. Monitor for			between therapy and nursing to be		
	signs and symptoms of compartment syndrome			completed by therapy in the event		
	indicated on 7/20/16.			contracture or risk of a developing		
	Review of Resident #	•		contracture. Therapy staff were		
		entified as ADL 's. The ADL		inserviced by rehab manager on 8	/12/16	
		vash cloth to left hand as in for irritation/breakdown.		on the communication form.		
	Observation on 7/18/	16 at 11:27am revealed		Those residents not on therapy ca	seload	
	Resident #60 being a	ssisted out of an activity by		will be evaluated at least quarterly		
		assistant (NA). Resident		to decreased range of motion and		
		not have on a left hand		contracture by case manager nurs		
	splint or a hand roll.	40.40.50		RAI GO400 Functional Limitation		
	Observation on 7/19/			Range of Motion steps for assess	ment will	
		ing in bed. She is observed it or hand roll to her left		be utilized.		
		vas observed as held in a		The 'Stop and Watch' tool form is		
		denced by 4 digits being		completed by nursing staff when t	here is a	
	held inward toward R			change of condition related to dec		
		16 at 9:03am revealed		ROM/ADL of resident.		
		ing in bed. Resident #60				
		have a left hand splint or a				
		on the resident 's right on		QA/MONITORING:		
	-	contracted hand was on the		The DON/ADON and SDC will aud		
	left.	$an \frac{7}{20}/16 at 0.10am$		residents with orders for splints we		
		on 7/20/16 at 9:10am 0 had hand splint that she		3 weeks then monthly for 3 month ensure residents with orders for	5 10	
	revealed resident #0	o nau nanu spiint that she				

Facility ID: 922955

If continuation sheet Page 2 of 12

	DF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		D. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				
						С
		345269	B. WING			/21/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CARE OF SALISBURY			1505 BRINGLE FERRY ROAD		
AUTOMIN				SALISBURY, NC 28146		
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 282	Continued From page	e 2	F 282	2		
		other intervention in place				
	other than the use of	the hand splint. She stated		A one time audit of care plans for		
		to identify resident 's needs.		residents with splints and decrea		
	Interview with NA#2			will be done by MDS staff and ca	re plans	
		60 had a brace that when put feed. She indicated the		will be updated as indicated.		
		n off while the resident was		MDS Coordinator/case manager	will audit	
		ed there was no other		3 resident care plans with splints		
	intervention other that	in Resident #60 ' s hand		monthly for 3 months to ensure		
	-	taff were to use the kardex		contractures are care planned ad	equately	
	when identifying a re-			to reflect devices ordered.		
		on 7/20/16 at 9:22am Resident #60 splint in the		Any grass of identified concerns		
		gets out of bed. She further		Any areas of identified concerns addressed at the time and any co		
		onally put a wash cloth in the		concerns will be addressed in fac		
	residents hand as we			meetings.	5	
		t ' s needs by reviewing the				
	residents Kadex.					
		aff development coordinator				
		n reveled she oriented facility click care system (PCC).				
	-	tion in regards to navigating				
		where to get information in				
	-	resident needs. The staff				
	-	ator further revealed she				
		ne use of the Kardex. The				
	care.	per the Residents plan of				
		OS Coordinator on 7/21/16 on				
		update resident care plans				
		She revealed the updates to				
	the resident care plan					
		well. She indicated that the				
	as written.	ere to follow the care plan				
		sistant Director of Nursing				
		it 9:15am revealed updates				
		d over to the cardex that				
		 The DON indicated that 				

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	E SURVEY PLETED
		345269	B. WING				C /21/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF SALISBURY				505 BRINGLE FERRY ROAD SALISBURY, NC 28146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282 F 317 SS=D	when the NA's pull u they could see the res special instructions. #60 did not like the us remove it on her own. should monitor the res back in her hand. Sh should have been doo refusal to wear the ha revealed she did not s documented and refue It was her expectation plan of care and commencessary department necessary department necessary intervention 483.25(e)(1) NO RED UNAVOIDABLE Based on the compre- resident, the facility m who enters the facility m who enters the facility m who enters the facility m sunavoidable. This REQUIREMENT by: Based on observation interviews the facility development of a com- who had a right hand Findings Included: Resident #79 was adu 1/12/2012 with a diag Alzheimer's Disease	p the resident on the keiose sidents demographics and The ADON stated Resident se of the hand roll and would She identified that staff sident and put the hand roll e further indicated that staff cumented the resident 's nd roll. The ADON see any refusals sal had not been reported. In that staff follow the written municate refusals so the t could implement ns. UCTION IN ROM UNLESS hensive assessment of a nust ensure that a resident without a limited range of rience reduction in range of ident's clinical condition eduction in range of motion is not met as evidenced ns, record review and staff failed to identify the tracture in 1 of 3 residents contracture (#79). mitted to the facility on noses that included , Abnormal Weight Loss,		317	FOR THE RESIDENT AFFECTED: Resident #79 was referred to therapy of 7/21/16. New orders were received for therapy on 7/21/16 and the care plan w updated as indicated. FOR THE RESIDENTS WITH THE POTENTIAL TO BE AFFECTED:	/as	8/18/16
	1/12/2012 with a diag	noses that included , Abnormal Weight Loss,				he	

Event ID: N1RL11

Facility ID: 922955

If continuation sheet Page 4 of 12

PRINTED: 09/16/2016

		MEDICAID SERVICES					<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· /	E SURVEY PLETED
							С
		345269	B. WING			07	/21/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
				150	05 BRINGLE FERRY ROAD		
AUTOMIN	CARE OF SALISBURY			SA	ALISBURY, NC 28146		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 317	Continued From page	a 4	F 3 ²	17			
1 017	1.5	ne most recent quarterly	F J	"	SDC on 8/12/16. Referrals to therapy		
		IDS) assessment dated			were made as indicated and care plans	5	
		esident #79 was totally			were updated as indicated and care plans	-	
		or all activities of daily living					
		airments in range of motion			SYSTEM CHANGE:		
		mities and had received no			Nursing staff were inserviced by DON a	and	
		torative treatment during the			SDC on 8/11/2016 regarding ensuring		
	last assessment perio				splints are applied as ordered, following	g	
		79 cognition was extremely			care plans, documentation of refusals,		
	impaired.	lan datad E/0/2016 rayaalad			skin assessments and skin care related	d to	
	-	an dated 5/9/2016 revealed e of motion or contracture			splints and contractures and rehab communication form.		
	prevention.	e of motion of contracture			communication form.		
					CNAs were inserviced by the DON and	ł	
	Review of the nursing	g notes an assessment titled			SDC regarding reviewing each patient		
	" nursing head to toe			Kardex and following the plan of care,			
		at resident had full range of			reporting change in condition by the St	ор	
	motion to all extremit	ies.			and Watch form regarding ADLs and		
					decreased ROM, application of splints		
		nal therapy evaluation dated			and handrolls and documentation in the	е	
		Resident #79 was referred to			kiosk and skin care with residents with		
		posture and a decline in			contractures.		
		increased staff assistance. dent #79 ' s right upper			A communication form has been initiate	he	
		0% ROM with a hypertonic			between therapy and nursing to be	54	
		paired gross and fine motor			completed by therapy in the event of		
	control.				contracture or risk of a developing		
					contracture. Therapy staff were		
		an dated 5/9/2016 revealed			inserviced by rehab manager on 8/12/1	16	
		e of motion or contracture			on the communication form.		
	prevention.				-		
					Those residents not on therapy case lo		
	" nursing head to toe	g notes an assessment titled			will be evaluated at least quarterly related to decreased range of motion and risk		
		at resident had full range of			to decreased range of motion and risk contracture by case manager nurse. The		
	motion to all extremit	-			RAI GO400 Functional Limitation in		
					Range of Motion steps for assessment	will	
	An observation of Re	sident #79 on 7/18/2016 at			be utilized.		
		e resident was lying in bed					

Facility ID: 922955

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		<u>IO. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
					С	
		345269	B. WING		07/21/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF SALISBURY			1505 BRINGLE FERRY ROAD SALISBURY, NC 28146		
(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 SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 317	Continued From page	e 5	F 317	,		
	with both eyes closed was curled up in a fis An observation of Re 9:56 am revealed the with both eyes closed	d. The resident ' s right hand t position. sident # 79 on 7/20/2016 at resident was lying in bed d. The last 3 fingers of the		The 'Stop and Watch' tool form is completed by nursing staff when change of condition related to de ROM/ADL of resident.	there is a	
	residents right hand were curled inward toward her palm; the thumb and second finger were touching and partially curled inward toward her palm. The resident was asked if she could open her fingers but she was unable to follow directions.		QA/MONITORING: The DON/ADON/SDC will audit r 6 residents weekly for 3 weeks th monthly for 3 months for decreas ROM/contracture development.	nen sed		
	An interview with Nur pm revealed that the contracture to the righ			A one time audit of care plans for residents with splints and decrea will be done by MDS staff and ca will be updated as indicated.	sed ROM	
	revealed that she not having any contractur ' s right hand was dra	se #1 on 7/20/16 at 3:18 pm aware of Resident #79 res. She stated Resident #79 wn up some, but believed I open her right hand and opened.		The MDS/case manager will aud resident care plans with splints/d monthly for 3 months to ensure contractures are care planned ac to reflect devices ordered.	evices	
	of Rehab and the occ 07/21/2016 at 8:31 ar bed with eyes closed. Resident #79 to try ar resident did not open instructions. The ther gradually opened the right hand. As they w fingers Resident #79 hurts". Observation of revealed the last 3 fin	ident #79 with the Director cupational therapist on m. The resident was lying in . The therapists asked nd open the right hand. The her hand or follow apists then stroked and fingers on Resident #79 ' s ere working to open the grimaced and stated "it of the resident ' s right hand ngers were stiff and bent and he inner right hand was dry		Any areas of identified concerns addressed at the time and any co concerns will be addressed in fac meetings.	ontinued	

Facility ID: 922955

If continuation sheet Page 6 of 12

	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 09/16/2016 M APPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	PLE CONSTRUCTION G	(X3) DAT	E SURVEY PLETED
		345269	B. WING		07	C / 21/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ε	
AUTUMN	CARE OF SALISBURY			1505 BRINGLE FERRY ROAD SALISBURY, NC 28146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 317	because the resident staff and was not active also stated the resider splint to prevent the ri- progressing. An interview with the 07/21/2016 at 8:55 ar #79 had not received the last 2 years. An interview with nurse am revealed that reside contracture to her right was not aware of any the right hand. An interview with nurse 07/21/2016 at 9:12 ar provided bed baths ar #79. She stated that residents right hand b palm of the residents open so she could was She also stated that so changes in Resident as change nurse or thera An interview with the a (ADON) on 07/21/2016 her expectation was t and nurses should has range of motion for re- and made a referral to	the last occupational arch 18, 2016; especially was totally dependent on vely using her hand. They nt would benefit from a ght hand contracture from restorative aide on n revealed that Resident any restorative therapy in se #2 on 07/21/2016 at 9:01 dent #79 did have a nt hand. She stated that she splint or device ordered for sing assistant #4 on n revealed that she has nd showers for Resident she tried to clean the by putting her finger in the hand to get the fingers to ash the inside of her hand. she had not reported any #79 's right hand to her py. Assistant Director of Nursing 6 at 10:09 am revealed that hat the nursing assistants ve identified the decline in sident #79 's right hand o the therapy department.	F 3'	17		
F 318 SS=D		SE/PREVENT DECREASE	F 3 ⁻	18		8/18/16

Facility ID: 922955

If continuation sheet Page 7 of 12

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345269	B. WING		C 07/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				1505 BRINGLE FERRY ROAD	
AUTUMN	CARE OF SALISBURY			SALISBURY, NC 28146	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 318	Continued From page	7	F 31	8	
	resident, the facility m with a limited range o	and services to increase or to prevent further			
	by: Based on observatio interview the facility fa orders and therapy re sampled residents (R hand contracture. The findings included Resident #60 was add 8/21/15 with a diagno and hemiparesis follo cerebrovascular disea non-dominate side an The most recent Mini assessment dated 4/2 required extensive as activities of daily living lower extremity impai coded on the MDS as cognitively intact as e status (BIM ' s) score #60 was coded as co the quarterly MDS as not interviewed. Review of Resident # 4/29/16 revealed Res breakdown related to weakness, incontinent	mitted to the facility on sis that included hemiplegia wing unspecified ase affecting left d contracture of left hand. mum Data Set (MDS) 26/16 revealed Resident #60 sistance to complete g (ADL) and had upper and rments. Resident #60 was sessment as being videnced by a brief mental of 13. Although Resident gnitively intact according to sessment, the resident was 60 ' s care plan dated ident #60 was a risk for skin decreased mobility,		 FOR THE RESIDENT AFFECTED: Resident #60 was evaluated by ther staff on 8/12/16. New orders were received on 8/15/16 to begin left upp extremity splint to be worn 6 hours of as tolerated and hand roll when splin off for contracture prevention. FOR THE RESIDENTS WITH POTENTIAL TO BE AFFECTED: A contracture audit was completed to SDC on 8/12/16. Referrals to therap were made as indicated and care pl were updated as indicated. SYSTEM CHANGE: Nursing staff were inserviced by DO SDC on 8/11/16 regarding ensuring are applied as ordered, following ca plans, documentation of refusals, sk assessments and skin care related to splints and contractures and rehab communication form. CNAs were inserviced by the DON as SDC regarding reviewing each patie Kardex and following the plan of car 	per g shift nt is by the by ans N and splints re tin to and ent's

Facility ID: 922955

If continuation sheet Page 8 of 12

PRINTED: 09/16/2016

		MEDICAID SERVICES				OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	((X3) DATE SURVEY COMPLETED
	oontheomory		A. BUILDING			
		345269	B. WING			С
		345269	B. WING			07/21/2016
NAME OF PR	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE	
	CARE OF SALISBURY			1505 BRINGLE FER		
				SALISBURY, NC	28146	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH (VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 318	Continued From page	e 8	F 31	8		
		or compartment syndrome.			ange in condition by the Sto	a
		dent #60 would have no			orm regarding ADLs and	1°
		kin breakdown though next			OM, application of splints	
	review. The goal furt	her stated Resident #60			s and documentation in the	
		ntable signs or symptoms of		kiosk and ski	n care with residents with	
		me (updated 7/20/16). The		contractures.		
	interventions initiated					
	splint/wash cloth to le				ation form has been initiated	d
		tion or breakdown. Monitor			rapy and nursing to be	
	for signs and symptom syndrome indicated of	-			y therapy in the event of or risk of developing a	
		60 's occupational therapy			Therapy staff were	
		lated 7/7/16 stated staff			rehab manager on 8/12/16	3
		lon and doff appropriate		-	unication form.	
		extremity (LUE) and monitor				
	skin condition for effe			Those reside	ents not on therapy caseloa	d
	management and joir	nt protection. The diagnosis		will be evalua	ated at least quarterly relate	ed
	identified Resident #6	60 had a contracture of the			I range of motion and risk o	
		arge plan stated slim grip II			by case manager nurse. The	e
	splint LUE 4 hour we				Functional Limitation in	
		60 's physician order		0	tion steps for assessment v	will
		on 7/7/16 stated Resident		be utilized.		
		shcloth hand roll for LUE		The 'Stop on	d Watch' tool form is	
	pain.	every shift for complaints of			y nursing staff when there is	sa
		60 ' s physician order			indition related to ROM/AD	
		on 7/8/16 stated Resident		of resident.		-
		slim Grips II splint 4 hours to				
		every day and evening shift.		QA/MONITO	RING:	
		16 at 11:27am revealed		The DON/AD	OON and SDC will audit 3	
		ssisted out of an activity by			h orders for splints weekly f	for
	•	assistant (NA). Resident			n monthly for 3 months to	
		not have on a left hand			ents with orders for	
	splint or a hand roll.			splints/device	es are in place as ordered.	
		mpted with Resident #60 on				
		he resident was unable to denced by not answering			udit of care plans for those h splints and decreased RC	
	DE INTERVIEWER AS EVI	Dediced by DOI answering	1	residents with	o solitois and decreased R(11/1
	questions that were a				by MDS staff and care plan	

Facility ID: 922955

If continuation sheet Page 9 of 12

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
					С	
		345269	B. WING			//21/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF SALISBURY			1505 BRINGLE FERRY ROAD SALISBURY, NC 28146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 318	Continued From page	9	F 31	8		
	Observation on 7/19/7 Resident #60 to be ly observed to not have her left hand. Her left in a balled position as held inward toward R Observation on 7/19/7 named resident lying did not have on a spli hand. Her left hand w balled position as evid held inward toward R Observation on 7/20/7 Resident #60 to be ly was observed to not f hand roll. Her left han a balled position as evid held inward toward R Interview with (nursing 7/20/16 at 9:10am rev hand splint that she h further revealed she w intervention in place of hand splint. She stat identify resident ' s ne Interview with NA#2 of revealed Resident #60 on when Resident #60 indicated the brace w resident was in bed. no other intervention hand splint. NA#2 stat Kardex when identifyi Interview with NA#3 of revealed she applied	16 at 8:50am reveled ing in bed. She was on a splint or hand roll in t hand was observed as held s evidenced by 5 digits being esident #60 ' s palm. 16 at 2:45pm revealed the in bed. The named resident nt or a hand roll in her left vas observed as held in a denced by 5 digits being esident #60 ' s palm. 16 at 9:03am revealed ing in bed. Resident #60 have a left hand splint or a nd was observed as held in videnced by 5 digits being esident #60 ' s palm. g assistant) NA # 1 on vealed Resident #60 had ad on during the day. She was unaware of any other other than the use of the ted she used the Kardex to eeds. on 7/20/16 at 9:18am 0 had a brace that was put 0 was out of bed. She as to be taken off while the NA#2 indicated there was other than Resident #60 ' s ted staff were to use the ng a resident ' s needs.		MDS Coordinator/case manag 3 resident care plans with splir monthly for 3 months toensure contractures are care planned to reflect devices ordered. Any areas of identified concern addressed at the time and any concerns will be addressed in meetings.	nts/devices adequately ns will be continued	

Facility ID: 922955

If continuation sheet Page 10 of 12

						IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
			A. BUILDING	3		
		345269	B. WING		C	
		545265				7/21/2016
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF SALISBURY			1505 BRINGLE FERRY ROAD		
				SALISBURY, NC 28146		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 318	Continued From page	- 10				
F 310		9 10	F 31	18		
	residents Kadex.					
		aff development coordinator				
		reveled she oriented facility				
		click care system (PCC).				
	-	tion in regards to navigating				
		where to get information in				
	-	resident needs. The staff				
		ator further revealed she				
		the use of the Kardex. The				
		per the resident 's plan of				
	care.	piotont Director of Nursing				
		sistant Director of Nursing				
		t 9:15am revealed updates				
		d pull over to the Kardex				
	-	e DON indicated that when				
		resident on the keiose they ts demographics and				
		The ADON stated Resident se of the hand roll and would				
		. She identified that staff				
		sident and put the hand roll				
		e further indicated that staff cumented the resident 's				
	-	blint or the hand roll. The did not see any refusals				
		cated refusals had not been				
		#60. The ADON stated it				
		that staff follow the written municate refusals so the				
	necessary department					
	necessary intervention	-				
	•	habilitation Director on				
		dentified Resident #60 as				
	having a left hand co					
	-	s review of Resident #60 's				
		ary dated 7/7/16 indicated				
		ovided a Left hand orthotic				
		gement. The Rehab director				
		nement The Renan nitector				

If continuation sheet Page 11 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/16/2016 1 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345269	B. WING		_	07/3	C 21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•11	
Δυτυμν	CARE OF SALISBURY		1	505 BRINGLE FERRY ROA	AD		
				SALISBURY, NC 28146			
(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	BELAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 318	interventions put into Kardex. The Rehabil her expectation that s for contracture manage instances in which a r wear or would not tole Rehab Director stated resident to therapy in not used or refused s	place via carafe plan and itation Director stated it was staff follow the interventions gement and commu8incate resident would refuse to erate a splinting device. The d nursing would refer a the instance a splint was o additional measures could ontracture management or	F 318				

Facility ID: 922955

If continuation sheet Page 12 of 12