	-	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		345351	B. WING			0	C 9/11/2018
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		,11,2010
					501 ESSEOLA CIRCLE		
AUTUMN	CARE OF SALUDA				SALUDA, NC 28773		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT)N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL		COMPLETION DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	RIATE	27112
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F	65	6		10/4/18
	§483.21(b) Comprehe	ensive Care Plans					
	§483.21(b)(1) The fac	cility must develop and					
		nensive person-centered					
		sident, consistent with the					
		th at §483.10(c)(2) and					
	§483.10(c)(3), that inc						
	-	ames to meet a resident's					
		mental and psychosocial					
	needs that are identifi	ied in the comprehensive					
		nprehensive care plan must					
	describe the following						
		are to be furnished to attain					
		ent's highest practicable					
		psychosocial well-being as					
		24, §483.25 or §483.40; and					
		would otherwise be required					
		25 or §483.40 but are not					
	•	esident's exercise of rights					
		ling the right to refuse					
	treatment under §483						
		ervices or specialized					
		the nursing facility will					
	provide as a result of						
		a facility disagrees with the					
		RR, it must indicate its					
	rationale in the reside						
		h the resident and the					
	resident's representat						
	(A) The resident's goa						
	desired outcomes.	ference and notential for					
		eference and potential for					
	future discharge. Fac						
		s desire to return to the					
		ssed and any referrals to					
	-	s and/or other appropriate					
	entities, for this purpo						
		n the comprehensive care					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	Ξ		TITLE		(X6) DATE

Electronically Signed

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.

10/03/2018

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			OMB NO	M APPROVE 0. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í	IPLE CONSTRUCTION		PLETED
		345351	B. WING			C / 11/2018
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
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 PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 656	requirements set forth section. This REQUIREMENT by: Based on observatio interviews, the facility planned interventions to keep a resident cle dependent residents activities of daily living The findings included Resident #11 was add 02/16/18 with hemiple following a cerebral v flaccid hemiplegia of traumatic brain injury A review of Resident Minimum Data Set (M revealed the resident impaired for daily dec also revealed the resi assistance of two per always incontinent of A review of Resident 09/05/18 revealed the for being at risk for se CVA, dementia and p resident to maintain h through the next revie in part, bathing and h dressing and groomin	in accordance with the h in paragraph (c) of this is not met as evidenced ins, record reviews, and staff failed to implement care a to provide incontinent care an and dry for 1 of 2 (Resident # 11) reviewed for g (ADL). I: mitted to the facility on egia and hemiparesis rascular accident (CVA), the right side, dysphagia, (TBI), dementia and others. #11's most recent quarterly MDS) dated 07/20/18 was severely cognitively cision making. The MDS ident required extensive sons for toileting and was	F	 F656 Develop/Implement (Care Plan CRF(s): 483.21(The facility must develop and comprehensive care plan for resident, consistent with the rights set for at 483.10 (c)(2 (c)(3) that includes measure objectives and timeframes in meet a resident's medical, in mental and psychosocial net identified in the comprehen assessment Criteria 1 Based on observative reviews, and staff interview failed to implement care platinterventions to provide inco- keep a resident clean and co- dependent residents review activities of daily living (ADI) Criteria 2- The procedure for implementing the plan of co- F656 A list of residents who require assistance in ADL will be co- the most recent MDS quartu- September 28, 2018. 	b) (1) nd implement a pr each e resident's 2) and 483.10 eable in which to nursing and eeds that are sive ations, record rs, the facility anned ontinent care to dry for 1 of 2 ved for L) pr prrection for ire total pmpiled from	

Facility ID: 922956

If continuation sheet Page 2 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 09/11/2018 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 656 Continued From page 2 F 656 care, and toileting with assistance of 2. on those residents who require total assistance in ADL to ensure the care An observation on 09/10/18 at 1:58 PM was plans accurately reflect the resident's care made of Nurse #1 instructing the scheduler and needs by October 4, 2018 NA #1 to put Resident #11 to bed. Resident #11's transfer to bed and incontinence care was All staff will be educated on providing care observed in his room. As the resident was lifted for the ADL dependent resident as outline out of his Geri chair there was a strong odor of in the plan of care by October 4, 2018 urine coming from the resident and the cushion in the resident's chair was noted to be wet. The Criteria 3- The monitoring procedure to resident's sweatpants were removed, and ensure that the plan of correction is Nursing Assistant (NA) #1 held them up and there effective and that the deficiency remains was a large oval wet spot on the left side back of corrected and/or in compliance with the the pants where urine had seeped through his regulatory requirements include the pants. NA #1 opened the brief and it was following; saturated with urine from front to back and the lining was completely wet and balled up in the The DON or designee will complete a middle from the saturation of urine. The resident care plan audit of two ADL dependent had also had a small soft bowel movement in the residents twice a week for 4 weeks, then brief. NA #1 cleaned Resident #11 on the front once a week for 4 weeks then monthly using aseptic technique, turned him and cleaned times 3 months. him on the back side using aseptic technique. NA #1 removed the dirty brief, wrapped it, and threw The DON or designee will complete a it in the trash can. The resident's bottom was rounding audit on two ADL dependent slightly red, so she applied cream to it and residents twice a week for 4 weeks, then secured the new brief around him. once a week for 4 weeks then monthly times 3 months. An interview on 09/10/18 at 2:25 PM revealed NA #1 was not assigned to Resident #11 that day but Results will be reported to monthly QAPI was helping with the resident. NA #1 stated the meeting resident was on the early riser list and stated he had been up since she reported to work at 7:00 Date of Completion AM. 10/4/18 An interview on 09/10/18 at 2:35 PM with NA #2 revealed she had been assigned to Resident #11 for the day. She stated he had been up when she reported to work at 7:00 AM. NA #2 stated she had checked the resident's line on his brief at

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

Facility ID: 922956

If continuation sheet Page 3 of 10

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345351	B. WING				C / 11/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	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 SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 656	out of the room and p dining room in prepar stated she had check by taking him into the the strip on his brief a at that time as well. N changed the resident strip was still yellow a changed since 3rd sh the day. An interview on 09/11 #1 had not been assig had assisted in his ca was not a heavy wette his pants yesterday, if had been changed. N changed residents ab were incontinent. An interview on 09/11 #2 had been assigned 09/10/18 but did not h today. NA #2 stated 1 heavy wetter but was checked every 2 hour She stated she check 11:00 AM in the show lining was yellow so h stated Resident #11 v #2 was on duty from 3 scheduler changed hi An observation was n of Resident #11's trar incontinence care. As of the Geri chair there	ellow, so she had taken him laced him in front of the ation for breakfast. NA #2 ed him again at 11:00 AM shower room and looking at and stated it was still yellow NA #2 stated she had not all shift because his brief and stated he had not been ift got him up in his chair for /18 at 1:18 PM revealed NA gned to Resident #11 but are. She stated the resident er and stated by the looks of t had been a while since he NA #1 stated she usually yout every 2 hours if they /18 at 1:28 PM revealed NA d to Resident #11 on have him on her assignment Resident #11 was not a incontinent and should be are and changed when wet. the the resident yesterday at a incontinent and should be are not changed. NA #2 vas not changed while NA 7:00 AM until NA #1 and the m at around 2:00 PM.	F	656			

Facility ID: 922956

If continuation sheet Page 4 of 10

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 10/05/2018 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_		C 11/2018
NAME OF PF	ROVIDER OR SUPPLIER		- T	STREET ADDRESS, CITY, S	TATE, 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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 677 SS=D	NA #3 opened his brie front part of the brief a was dry. NA #3 clean a new brief and secur positioned for comfort placed within his reac An interview on 09/11 scheduler revealed R wetter and stated he w room every 2 hours a She stated he should changed at 10:00 AM was not very wet toda had been changed at An interview on 09/11 #1 revealed she was Resident #11 was che yesterday but stated h and was not a heavy incontinent residents changed every 2 hours An interview on 09/11 Charge Nurse revealed dependent residents f and if wet, to be chan plan. An interview on 09/11 Administrator revealed the residents were ch hours whether they w	were removed and were dry. ef and there was urine in the and the back of the brief hed the resident and applied red it. The resident was a and his call light was that 2:02 PM with the esident #11 was not a heavy was usually taken to his nd checked and changed. have been checked and yesterday and stated he ay at 1:46 PM because he 10:00 AM before lunch. /18 at 2:22 PM with Nurse not aware of how much ecked and changed he typically did not drink a lot wetter. The nurse stated are typically checked and rs. /18 at 4:11 PM with the ed she expected all to be checked every 2 hours ged according to their care	F 65	56			10/4/18

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CENTERS	FOR MEDICARE &	MEDICAID SERVICES				OMB NO	APPROVE 0. 0938-039
TATEMENT OF ND PLAN OF (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345351	B. WING			C 09/11/2018	
NAME OF PRO	OVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN C	ARE OF SALUDA				ESSEOLA CIRCLE LUDA, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio interviews, the facility incontinence care to H dry for 1 of 2 resident for activities of daily Ii dependent residents. The findings included Resident #11 was adi 02/16/18 with hemiple following a cerebral v flaccid hemiplegia of traumatic brain injury A review of Resident Minimum Data Set (N revealed the resident impaired for daily dec also revealed the resi assistance of two per always incontinent of A review of Resident 09/05/18 revealed the for being at risk for se CVA, dementia and p resident to maintain h through the next revie included allow for res with assistance of 2 w	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced ns, record reviews, and staff failed to provide keep a resident clean and is (Resident #11) reviewed iving (ADL) care provided for clean and hemiparesis ascular accident (CVA), right side, dysphagia, (TBI), dementia and others. #11's most recent quarterly MDS) dated 07/20/18 was severely cognitively claion making. The MDS ident required extensive sons for toileting and was	F		F677 ADL Care Provided to Dependeresidents CFR(s): 483.24(a) (2) A resident who was unable to carry ou activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and hygiene Criteria 1 The plan of correcting cited deficiency of F677 and the processes lead to the citation; Based on observations, record reviews, and sta interviews, the facility failed to provide incontinence care to keep a resident of and dry for 1 of 2 residents reviewed for dependent residents. Criteria 2- The procedure for implementing the plan of correction fo F677 A list of residents who require total assistance in ADL will be compiled fro the most recent MDS quarterly data b September 28, 2018. All staff will be educated on care for th ADL dependent resident by October 4 2018	ut oral that ff clean for r m y	

Facility ID: 922956

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0	PROVE 938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SUR COMPLET	
		345351	B. WING		C 09/11/2	2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
				501 ESSEOLA CIRCLE		
AUTUMN	CARE OF SALUDA			SALUDA, NC 28773		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE CO	(X5) OMPLETIO DATE
F 677	Continued From pag	e 6	F 67	77		
	assistance of 2, bed dressing and groomi eating with assistance during daily care, end and assist if necessa advance, keep perso pain meds as ordere efforts/accomplishme self and continue to e incontinent care as n assistance with self- report to nursing if re toileting with assistant An observation on 09 Resident #11 reveale outside the dining roo attempted to talk but resident was dressed	mobility with assistance of 2, ng with assistance of 2, e of 1, encourage activity courage to attend activities rry, explain all procedures in onal items in same location, d, praise all ents resident make to assist encourage, provide ecessary, provide needed care daily and as needed, sident declines care, and	F 6	 tools to be utilized in the process to ensure the Al dependent residents is b October 1, 2018 The DON will identify an members that will be par monitoring process by C The DON will begin the process effective October Criteria 3- The monitorin ensure that the plan of c effective and that the de corrected and/or in compregulatory requirements following; 	DL care for being provided by d educate staff rt of the betober 4, 2018 monitoring er 1, 2018 ing procedure to correction is ficiency remains poliance with the	
	An observation on 08 made of Nurse #1 ins NA #1 to put Resider #11's transfer to bed observed in his room out of his Geri chair to urine coming from th the resident's chair w resident's sweatpant Nursing Assistant (N was a large oval wet the pants where uring pants. NA #1 opene saturated with urine to lining was completely middle from the satur	9/10/18 at 1:58 PM was structing the scheduler and th #11 to bed. Resident and incontinence care was the resident was lifted there was a strong odor of the resident and the cushion in vas noted to be wet. The s were removed, and A) #1 held them up and there spot on the left side back of the had seeped through his		 The DON or designee w daily documentation aud provided for 2 ADL depentimes a week for 4 week times a week for 4 week times 3 months. The DON or designee w daily rounding audit on 2 residents 5 times a week then three times a week monthly times 3 months. Results will be reported meeting Criteria 4- The person re- implementing the plan or 	lit of ADL care endent residents 5 is, then three is then monthly ill complete a 2 ADL dependent k for 4 weeks, for 4 weeks then to monthly QAPI esponsible for	

Facility ID: 922956

	S FOR MEDICARE &					NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED
			A. BOILDING			С
		345351	B. WING		0	9/11/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
	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 C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 677	Continued From page	e 7	F 67	77		
		ue, turned him and cleaned		The DON is responsible f	for implementing	
	him on the back side	using aseptic technique. NA		and monitoring the correct		
		brief, wrapped it, and threw		Data of compliance is Oc	tobor 1 2019	
	slightly red, so she ap	e resident's bottom was		Date of compliance is Oc	aober 4, 2018	
	secured the new brief	-				
	An interview on 00/10)/18 at 2:25 PM revealed NA				
		to Resident #11 that day but				
		resident. The scheduler				
		etting the resident to bed				
	-	sted with discarding the dirty #1 stated the resident was on				
		had been up since early				
	-	ift had gotten him up and put				
		She stated he had been up				
	since she reported to	WORK at 7.00 AM.				
)/18 at 2:35 PM with NA #2				
		en assigned to Resident #11				
	-	ed he had been up when she 00 AM. NA #2 stated she				
		dent's line on his brief at				
		ellow, so she had taken him				
		laced him in front of the ration for breakfast. NA #2				
		ed him again at 11:00 AM				
		shower room and looking at				
	-	and stated it was still yellow				
		NA #2 stated she had not all shift because his brief				
	-	and stated he had not been				
		ift got him up in his chair for				
	the day.					
	An interview on 09/11	/18 at 1:18 PM revealed NA				
		gned to Resident #11 but				
	had assisted in his ca was not a heavy wett	are. She stated the resident				

Facility ID: 922956

If continuation sheet Page 8 of 10

	-	D HUMAN SERVICES					FORM): 10/05/2018 // APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	LETED
		345351	B. WING			_		C 11/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				5	01 ESSEOLA CIRCLE			
AUTUMIN	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 CORRE CROSS-REFERE	BEAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	had been changed. N changed residents ab were incontinent. An interview on 09/11 #2 had been assigned 09/10/18 but did not h today. She again stat the Geri chair when s 7:00 AM. NA #2 state heavy wetter but was checked every 2 hour She stated she check 11:00 AM in the show lining was yellow and blue color so he was Resident #11 was not on duty from 7:00 AM scheduler changed hi An observation was n of Resident #11's tran incontinence care. As of the Geri chair there and the cushion in the The resident's pants w NA #3 opened his brie front part of the brief a was dry. NA #3 clear aseptic technique, an be intact with no brok new brief and secured positioned for comfort placed within his reac	t had been a while since he NA #1 stated she usually out every 2 hours if they /18 at 1:28 PM revealed NA d to Resident #11 on have him on her assignment ted Resident #11 was up in he had reported to work at ed Resident #11 was not a incontinent and should be s and changed when wet. ed the resident yesterday at er room and the brief 's if wet it turned a greenish not changed. NA #2 stated changed while NA #2 was until NA #2 and the m at around 2:00 PM. hade on 09/11/18 at 1:46 PM isfer to bed and is the resident was lifted out e was not an odor of urine e resident's chair was dry. were removed and were dry. ef and there was urine in the and the back of the brief hed the resident using d his bottom was noted to en skin. NA #3 applied a d it. The resident was and his call light was	F	677				
	scheduler revealed sh							

Facility ID: 922956

If continuation sheet Page 9 of 10

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &						FORM): 10/05/2018 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE COMP	SURVEY LETED
	345351	B. WING			_		C 11/2018
NAME OF PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN CARE OF SALUDA				01 ESSEOLA CIRCLE ALUDA, NC 28773			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Resident #11 had we yesterday in 3 hours Resident #11 was no he was usually taker and checked and ch have been checked and yesterday and stated because he had been before lunch.An interview on 09/1 #1 revealed she had on 09/10/18 and that #1 stated she was no Resident #11 was ch yesterday but stated and was not a heavy yesterday had been because they had 2 real busy.An interview on 09/1 Charge Nurse revea Resident #11 to satu clothing onto his cha She stated she expet to be checked every changed.An interview on 09/1 Administrator reveal	d it was not possible that et his brief that much . The scheduler stated of a heavy wetter and stated in to his room every 2 hours anged. She stated he should and changed at 10:00 AM d he was not very wet today in changed at 10:00 AM 1/18 at 2:22 PM with Nurse been training another nurse thad been her focus. Nurse of aware of how much necked and changed he typically did not drink a lot wetter. The nurse stated a terrible day for the NAs call outs and the NAs were 1/18 at 4:11 PM with the led she would not expect urate his brief through his hir from 11:00 AM to 2:00 PM. ected all dependent residents 2 hours and if wet, to be 1/18 at 5:15 PM with the ed it was his understanding hecked and changed every 2	F	677				

If continuation sheet Page 10 of 10

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		ATE SURVEY OMPLETED	
		345351	B. WING		R-C		
		343351		STREET ADDRESS, CITY, STATE, ZIP CODE	09/11/2018		
NAME OF PI	ROVIDER OR SUPPLIER				=		
AUTUMN	CARE OF SALUDA			501 ESSEOLA CIRCLE SALUDA, NC 28773			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	I	PROVIDER'S PLAN OF CO	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE	COMPLETION	
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)		{F 6	77}		10/24/18	
	out activities of dail services to maintail personal and oral h This REQUIREMEN by: Based on observa interviews, the facili incontinence care to dry for 1 of 2 reside for activities of daily dependent resident The findings includ Resident #11 was a 02/16/18 with hemi following a cerebra flaccid hemiplegia of traumatic brain inju A review of Reside impaired for daily d also revealed the reside impaired for daily d also revealed the reside 09/05/18 revealed	NT is not met as evidenced tions, record reviews, and staff lity failed to provide o keep a resident clean and ents (Resident #11) reviewed y living (ADL) care provided for ts.		 F677 ADL Care Provided to D residents CFR(s): 483.24(a) (2 A resident who was unable to activities of daily living receive necessary services to maintain nutrition, grooming, and person hygiene Criteria 1 The plan of correctind deficiency of F677 and the pro- lead to the citation; Based on observations, record reviews, interviews, the facility failed to incontinence care to keep a re- and dry for 1 of 2 residents re- activities of (ADL) care provide dependent residents. Criteria 2- The procedure for implementing the plan of correct F677 A list of residents who require assistance in ADL will be com the most recent MDS quarter 	2) carry out es the n good anal and oral ng cited pocesses that and staff provide esident clean viewed for ed for ection for total piled from		

Electronically Signed

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.

09/28/2018

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0RM APPROVE NO. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		345351	B. WING _			R-C 09/11/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		09/11/2010
				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 PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETIO DATE
{F 677}	Continued From page	a 1	(E. 6)	77)		
1 0115	1.0		{F 6	<i>[1</i>]		
		wer/bath per schedule per			acc and audit	
	-	, bathing and hygiene with		The DON will develop a proc tools to be utilized in the mor		
		mobility with assistance of 2,		process to ensure the ADL c	0	
		ng with assistance of 2, e of 1, encourage activity		dependent residents is being		
				October 4, 2018	provided by	
		courage to attend activities ry, explain all procedures in		October 4, 2018		
		nal items in same location,		The DON will identify and ed	uppto staff	
þ	pain meds as ordered			members that will be part of		
	-	ents resident make to assist		monitoring process by Octob		
	self and continue to e			monitoring process by Octob	24, 2010	
		ecessary, provide needed		The DON will begin the moni	itoring	
		are daily and as needed,		process effective October 4,	-	
		sident declines care, and		process enective October 4,	2010	
	toileting with assistan			Criteria 3- The monitoring pro	ocedure to	
				ensure that the plan of correct		
		0/10/18 at 11:00 AM of		effective and that the deficier		
		d him sitting in his Geri chair		corrected and/or in complian		
		om. The resident smiled and		regulatory requirements inclu		
		was not understood. The		following;		
	resident was dressed			lonowing,		
	sweatpants with bunn			The DON or designee will co	molete a	
		., 20010 011 0011 1001.		daily documentation audit of		
	An observation on 09)/10/18 at 1:58 PM was		provided for 2 ADL depender		
		structing the scheduler and		times a week for 4 weeks, th		
		at #11 to bed. Resident		times a week for 4 weeks the		
		and incontinence care was		times 3 months.		
		. As the resident was lifted		The DON or designee will co	mplete a	
		here was a strong odor of		daily rounding audit on 2 AD		
		e resident and the cushion in		residents 5 times a week for	•	
	-	as noted to be wet. The		then three times a week for 4		
	resident's sweatpants			monthly times 3 months.		
		A) #1 held them up and there				
	- ·	spot on the left side back of		Results will be reported to m	onthly QAPI	
		e had seeped through his		meeting	- ,	
	pants. NA #1 opened	· •				
		rom front to back and the		Criteria 4- The person respo	nsible for	
		wet and balled up in the		implementing the plan of cor		
		ation of urine. The resident				

Facility ID: 922956

If continuation sheet Page 2 of 5

STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	<u>). 0938-039</u> E SURVEY PLETED
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING	G			R-C
		345351	B. WING				/11/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
{F 677}	Continued From page	2	{F 677	7}			
	had also had a small brief. NA #1 cleaned	soft bowel movement in the Resident #11 on the front		,	The DON is responsible for implement and monitoring the corrective action.	ting	
	using aseptic technique, turned him and cleaned him on the back side using aseptic technique. NA #1 removed the dirty brief, wrapped it, and threw it in the trash can. The resident's bottom was slightly red, so she applied cream to it and secured the new brief around him.				The date of compliance is October 24, 2018		
	#1 was not assigned was helping with the assisted NA #1 with g	0/18 at 2:25 PM revealed NA to Resident #11 that day but resident. The scheduler getting the resident to bed sted with discarding the dirty			POC Amended F656 Tag 10/1/2018 F656 Develop/Implement Comprehens Care Plan CRF(s): 483.21(b) (1)	sive	
	trash and linen. NA # the early riser list and morning when 3rd shi	*1 stated the resident was on I had been up since early ift had gotten him up and put She stated he had been up			The facility must develop and implement comprehensive care plan for each resident, consistent with the resident's rights set for at 483.10 (c)(2) and 483. (c)(3) that includes measureable objectives and timeframes in which to	;	
	revealed she had bee for the day. She state reported to work at 7:	0/18 at 2:35 PM with NA #2 en assigned to Resident #11 ed he had been up when she 00 AM. NA #2 stated she dent's line on his brief at			meet a resident's medical, nursing and mental and psychosocial needs that a identified in the comprehensive assessment		
	7:45 AM and it was ye out of the room and p dining room in prepar stated she had check by taking him into the the strip on his brief a at that time as well.	ellow, so she had taken him placed him in front of the ration for breakfast. NA #2 red him again at 11:00 AM r shower room and looking at and stated it was still yellow NA #2 stated she had not all shift because his brief			Criteria 1 Based on observations, recorreviews, and staff interviews, the facilit failed to implement care planned interventions to provide incontinent care paresident clean and dry for 1 of dependent residents reviewed for activities of daily living (ADL)	ty re to	
	strip was still yellow a	and stated he had not been ift got him up in his chair for			Criteria 2- The procedure for implementing the plan of correction for F656	r	
		/18 at 1:18 PM revealed NA gned to Resident #11 but			A list of residents who require total assistance in ADL will be compiled fro	m	

Facility ID: 922956

If continuation sheet Page 3 of 5

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY		
					IPLETED		
						R-C	
345351		B. WING		09	09/11/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
				501 ESSEOLA CIRCLE			
AUTUMN CARE OF SALUDA				SALUDA, NC 28773			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE , CROSS-REFERENCED DEFICI	TO THE APPROPRIATE	DATE	
{F 677}	Continued From page 3		{F 67	7}			
	had assisted in his care. She stated the resident			the most recent MDS qu	arterly data by		
	was not a heavy wett	ter and stated by the looks of		September 28, 2018.	, <u>,</u>		
		it had been a while since he					
		NA #1 stated she usually		An audit of care plans w			
	-	pout every 2 hours if they		on those residents who	•		
	were incontinent.			assistance in ADL to en plans accurately reflect			
	An interview on 00/12	1/18 at 1:28 PM revealed NA		needs by October 24, 2			
	#2 had been assigne				010		
		have him on her assignment		All staff will be educated	l on providing care		
		ited Resident #11 was up in		for the ADL dependent r			
	the Geri chair when s	she had reported to work at		in the plan of care by O	ctober 24, 2018		
		ed Resident #11 was not a					
	-	incontinent and should be		Criteria 3- The monitorir			
		rs and changed when wet.		ensure that the plan of c			
		ked the resident yesterday at		effective and that the de	-		
		ver room and the brief's I if wet it turned a greenish		corrected and/or in com regulatory requirements	-		
		not changed. NA #2 stated		following;			
		t changed while NA #2 was		lonowing,			
	on duty from 7:00 AM	-		The DON or designee w	vill complete a		
	-	im at around 2:00 PM.		care plan audit of two Al	DL dependent		
				residents twice a week f	or 4 weeks, then		
		made on 09/11/18 at 1:46 PM		once a week for 4 week	s then monthly		
	of Resident #11's trai			times 3 months.			
		s the resident was lifted out			·III		
	of the Geri chair there was not an odor of urine and the cushion in the resident's chair was dry.			The DON or designee w rounding audit on two A	•		
		were removed and were dry.		residents twice a week f			
		ef and there was urine in the		once a week for 4 week			
	front part of the brief and the back of the brief was dry. NA #3 cleaned the resident using			times 3 months.	, , , , , , , , , , , , , , , , , , ,		
	aseptic technique, and his bottom was noted to			Results will be reported	to monthly QAPI		
		ken skin. NA #3 applied a		meeting			
		d it. The resident was					
	positioned for comfor placed within his read	t and his call light was		The date of compliance 2018	is October 24,		
				2010			
		1/18 at 2:02 PM with the					

Facility ID: 922956

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DEPART	FORM APPROVED OMB NO. 0938-0391									
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345351	B. WING			R-C 09/11/2018				
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE						
AUTUMN CARE OF SALUDA					501 ESSEOLA CIRCLE SALUDA, NC 28773					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE				
{F 677}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 scheduler revealed she helped on both sides of the building yesterday due to 2 NA call outs for day shift. She stated it was not possible that Resident #11 had wet his brief that much yesterday in 3 hours. The scheduler stated Resident #11 was not a heavy wetter and stated he was usually taken to his room every 2 hours and checked and changed. She stated he should have been checked and changed at 10:00 AM yesterday and stated he was not very wet today because he had been changed at 10:00 AM before lunch. An interview on 09/11/18 at 2:22 PM with Nurse #1 revealed she had been her focus. Nurse #1 stated she was not aware of how much Resident #11 was checked and changed yesterday but stated he typically did not drink a lot and was not a heavy wetter. The nurse stated yesterday had been a terrible day for the NAs because they had 2 call outs and the NAs were real busy. An interview on 09/11/18 at 4:11 PM with the Charge Nurse revealed she would not expect Resident #11 to saturate his brief through his clothing onto his chair from 11:00 AM to 2:00 PM. She stated she expected all dependent residents to be checked every 2 hours and if wet, to be changed. An interview on 09/11/18 at 5:15 PM with the Administrator revealed it was his understanding the residents were checked and changed every 2 hours whether they were wet or dry.		{F 6	677	}					

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