		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE	
		345269	B. WING _			11/	08/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF SALISBURY				05 BRINGLE FERRY ROAD ALISBURY, 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 SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623 SS=B	CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility trans resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and manne facility must send a cor representative of the Long-Term Care Omb (ii) Record the reason discharge in the reside accordance with para and (iii) Include in the notif paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, discharge required un made by the facility a resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's he allow a more immedia under paragraph (c)(7) (D) An immediate tran required by the resident	before transfer. fers or discharges a hust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The boy of the notice to a Office of the State budsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or hder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when viduals in the facility would r paragraph (c)(1)(i)(C) of widuals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;	F	523			12/6/18
		SUPPLIER REPRESENTATIVE'S SIGNATUR	·F		TITLE		(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

12/06/2018

PRINTED: 12/18/2018

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** 

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	· · ·	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	<b>IPLETED</b>
		345269	B. WING		1'	1/08/2018
NAME OF PI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 623	Continued From page	e 1	F 623			
(E) A resident has not resided days.						
	notice specified in pa must include the follo (i) The reason for tra (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such reques to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omt (vi) For nursing facilit and developmental d disabilities, the mailin telephone number of the protection and ad developmental disabilities of the Developmental C of the Developmental disabilities of the distabilities of the	nsfer or discharge; of transfer or discharge; nich the resident is rged; e resident's appeal rights, address (mailing and email), er of the entity which tts; and information on how orm and assistance in and submitting the appeal es (mailing and email) and the Office of the State budsman; y residents with intellectual isabilities or related ig and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402,				
cc (v di er ac ac	disorder or related dis email address and te agency responsible for advocacy of individua	als with a mental disorder Protection and Advocacy				

Facility ID: 922955

If continuation sheet Page 2 of 32

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED		
		345269	B. WING		11/08/2018		
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTIVE ACTION SH       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SH		
F 623	Continued From pag	e 2	F 623	3			
		he notice changes prior to	1 020				
		or discharge, the facility					
		pients of the notice as soon					
		he updated information					
	becomes available.						
	§483.15(c)(8) Notice	in advance of facility closure					
		closure, the individual who is					
t v	the administrator of t	he facility must provide					
	written notification pr	ior to the impending closure					
	to the State Survey A	gency, the Office of the					
	State Long-Term Car	e Ombudsman, residents of					
		esident representatives, as					
		ne transfer and adequate					
		dents, as required at §					
	483.70(I).						
		F is not met as evidenced					
	by:						
		view and staff and family		THE PREPARATION AND SUBM			
		failed to provide a written		OF THIS PLAN OF CORRECTION			
	U U	ch included the reason for		NOT CONSTITUTE AN ADMISSIO			
	discharge to the resid			AGREEMENT BY THE PROVIDE			
	-	of 4 sampled residents who		THE TRUTH OF THE FACTS ALL			
		he hospital (Resident #1,		OR OF THE CONCLUDION STAT	-		
	Resident #11, Reside	ent #12, and Resident #71).		THE STATEMENET OF DEFIENC	. THIS		
		dont #110 medical recent		PKAN OF CORRECTIOEN IS			
		dent #1's medical record		PREPARED AND SUBMITTED SO			
		to the facility on 7/26/18		BECAUSE OF REQUIREMENTS STATE AND FEDERAL LAW.	UNDER		
		akness, heart disease, and blood clots to his upper		STATE AND FEDERAL LAW.			
		and blood clots to his upper		1. CORRECTIVE ACTION FOR T	HOSE		
		t dated 8/2/18 revealed he		RESIDENTS FOUND TO HAVE B			
		vely impaired and required		AFFECTED:			
		sistance with turning in bed,		1a. Resident #1's daughter was w	ith		
	transferring in and ou	-		resident when resident was sent to			
	toileting.			hospital; documentation was not n			
				chart. Late entry note was placed			
	1		1		-		
	Nurses note dated 1 <sup>2</sup>	1/5/18 at 3:15 pm written by		chart and the daughter was called	on		

Facility ID: 922955

If continuation sheet Page 3 of 32

## 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 345269 B. WING 11/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1505 BRINGLE FERRY ROAD** AUTUMN CARE OF SALISBURY SALISBURY, NC 28146 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) 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 623 Continued From page 3 F 623 saturation was below 90% consistently, the being sent to hospital on 11/5/2018 due to low partial pressure of oxygen (PO2) was physician was notified, and the resident was sent to the emergency room. The note did not less than 90%. document if the family member was notified of the 1b. Resident 11's granddaughter was not discharge to the hospital. notified when sent to the hospital and The Emergency Department Note dated 11/5/18 documentation was not noted. Late entry revealed Resident #5 was admitted to the note placed in resident's chart that hospital with Pneumonia of Right Lung and granddaughter was notified on 12/4/2018 Congestive Heart Failure. at 5:30pm-regarding resident being sent to the hospital on 9/21/2018 with An interview with Nurse #4 on 11/8/18 at 9:27 am tachycardia, fever and urinary tract revealed Resident #1's oxygen level had dropped infection. even though he was on continuous oxygen on 11/5/18 and he was sent back to the emergency 1c. Resident #12's son was not notified on room for evaluation and was admitted to the 9/11/2018 that resident was being sent to hospital. She stated she called the family hospital for increased shortness of breath, member when the resident was discharged to the low PO2 saturations at 88% with oxygen hospital but she did not notify the resident or and abnormal lung sounds. Late entry family member in writing of the reason for note was placed in resident's chart on 12/4/2018 that the son was notified at discharge. 5:32pm regarding sending resident to hospital; son replied that he was notified An Interview with the Director of Nursing on and made aware of situation. 11/8/18 at 11:35 am revealed she did not have written notification of the reason for discharge for Resident #1 on 11/5/18. 1d. Resident #71's son and grandson were with resident when resident was at A phone interview 11/8/18 at 1:30 pm with the cardiologist appointment and was Resident #1's family member revealed she had aware resident was being sent to the hospital. Facility medical doctor (MD) was not received a written explanation of the reason Resident #1 was sent to the hospital on 11/5/18. not notified. Late entry note was placed in An interview with the Administrator on 11/8/18 at resident's chart that resident was being 2:15 pm revealed his expectation was the admitted to the hospital from the resident and/or family member would be notified cardiologist's office on 8/17/2018 and of the reason for a resident being transferred at grandson and son were notified via the time of the transfer. telephone at 5:42pm on 12/4/2018. MD notified on 12/5/2018 that resident was admitted to the hospital from the 2. Resident #11 was admitted to the facility on cardiologist office.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922955

PRINTED: 12/18/2018

## 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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345269 B. WING 11/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1505 BRINGLE FERRY ROAD** AUTUMN CARE OF SALISBURY SALISBURY, NC 28146 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) 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 623 Continued From page 4 F 623 8/9/2017 with diagnoses that included dysphagia, unspecified convulsions and essential For each resident and RP the transfer and hypertension. discharge notices sent were in a manner in which they could easily understand A review of the Minimum Data Set (MDS) using CMS guidelines and facility policy. assessment dated 8/17/2018 revealed Resident #11 was rarely understood, had short and 2. CORRECTIVE ACTION long-term memory problems, recognized staff ACCOMPLISHED FOR THOSE names and faces and knew she was in a nursing **RESIDENTS HAVING POTENTIAL TO** home. Additionally, the MDS revealed Resident BE AFFECTED: #11 had severely impaired cognitive skills. 2a. The Director of Nursing A review of hospital records revealed Resident (DON)/designee will audit all medical #11 was hospitalized on 9/21/2018 with records for changes in condition of tachycardia, fever and urinary tract infection. residents including transfers to the hospital in the last 30 days and ensure A review of a nurse's note dated 9/21/2018 at that MD and resident's responsible party 3:37 PM revealed Resident #11 was sent to the (RP) were notified in a manner easily emergency room for evaluation and treatment. understood using CMS guidelines and Further review did not reveal any documentation facility policy information. that the resident or the resident's representative received prior notification of the transfer. 3. MEASURES AND SYSTEMATIC CHANGES TO ENSURE DEFICIENT An interview on 11/8/2018 at 2:34 PM with Nurse PRACTICE WILL NOT RECUR: #1 revealed she wrote the nurse's note on the date of transfer to the hospital. Nurse #1 3a. All licensed staff will be educated on Responsible Party (RP) being notified per disclosed that she did not provide prior notification of the transfer to the resident or her transfer/discharge letter regarding any granddaughter. change in condition including hospitalizations or transfers to hospital An interview on 11/8/2018 at 4:17 PM with the from ancillary appointments. This will be Administrator revealed he expected staff to documented in the individual's medical provide notification to the resident and or the record by Social Worker/designee This resident's representative prior to transfer out of will include notification of the resident's the facility. medical doctor. 3. A review of Resident #12's medical record 3b. During Clinical Morning Meeting, the revealed she was originally admitted to the facility DON/designee will review changes on 3/6/17 and was most recently admitted on including emergency room visits, 9/17/18. Resident #12's diagnoses included: hospitalizations and incidents to verify

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

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PRINTED: 12/18/2018

	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTE	PLE CONSTRUCTION	(V2) T	DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3		OMPLETED
		345269	B. WING			11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 623	Continued From page	5	F 62	23		
	disease, heart failure, dementia. A review of Resident = Data Set (MDS) revea with an Assessment F 8/19/18. Review of th following: The resider been cognitively intac coded as having had assessment period. T having had required e or more people for all (ADLs) except for eat having been independ Review of Resident # revealed a nursing no 12:39 AM. The note of had an oxygen satura supplemental oxygen documented the resid have been short of br had abnormal lung so also documented as h resident was complain review of the progress note dated 9/11/18 do been sent out to the h the hospital with a dia	The resident was coded as extensive assistance of one Activities of Daily Living ing where she was coded as dent with supervision. 12's progress notes te dated 9/11/18 and timed documented the resident tion percentage of 87% with		<ul> <li>documentation of notified of receiving written Transfiletter if resident is dischfacility.</li> <li>3c. All new hired nurser regarding notifying the with ensuring that the F Transfer/Discharge letter</li> <li>4. FACILITY PLANS TO PERFORMANCE TO M SOLUTIONS ARE SUS 4a. Monitoring will be d week X 4 weeks; then once</li> <li>4b. Results of audits wi Quality Assurance Perf Improvement (QAPI) co for 3 months for review needed.</li> <li>The Administrator is res Plan of Correction</li> </ul>	events along with fer and Discharge harged from the s will be educated RP and MD along RP receives the er. D MONITOR ITS MAKE SURE STAINED: one 5 times per 3 times per week a week for 4 weks. Ill be taken to the ormance pommittee monthly and revision as	
	was notified of the dis Review of Resident o	tation if the family member charge to the hospital. f Resident #12's Readmit dated 9/18/18 revealed the				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 12/18/2018 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY
		345269	B. WING		_	11/0	08/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
AUTUMN	CARE OF SALISBURY			1505 BRINGLE FERRY RO 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 CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Failure (CHF) exacerd An interview was com Worker (SW) on 11/7/ stated she did not pro notice to the family m An interview was com Director (AD) on 11/7/ stated she did not pro notice to the family m The AD stated it was members of residents was the family member the facility if the resider An interview was com 11/7/18 at approximat sated Resident #12 w because the resident was short of breath. had called the resider had not notified the fa the time of discharge. a packet with the resider had not notified the fa the time of Resident the family member st through a phone call w discharge and to discharge.	en) and a Congestive Heart bation. ducted with the Social '18 at 10:01 AM. The SW wide a written discharge ember of Resident #12. ducted with the Admissions '18 at 2:34 PM. The SW wide written discharge ember of Resident #12. made clear to family at the time of admission it er's responsibility to contact ent was hospitalized. ducted with Nurse #7 on tely 3:00 PM. The nurse 'as sent out to the hospital had become swollen and The nurse further stated she nt's family to notify them but willy member in writing at The nurse stated she sent dent which had the physician's orders, and the s conducted with the family #12 on 11/7/18 at 3:44 PM. tated he had been notified when the resident was pital back in September, but eceived written notification the reason for the	F 623				
	An interview with the	Administrator on 11/8/18 at					

Facility ID: 922955

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	): 12/18/2018 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	-	(X3) DATE	
		345269	B. WING			11/0	08/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
AUTUMN	CARE OF SALISBURY			505 BRINGLE FERRY RO ALISBURY, NC 28146			
(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 ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	<ul> <li>2:15 pm revealed his resident and/or family of the reason for a resident the time of the transfer</li> <li>4. A review of Resider revealed she was orig on 8/2/18 and was more 8/31/18. Resident #7 Generalized weakness beat, heart disease, d swallowing, chronic kit congestive heart failur</li> <li>A review of Resident #7 Generalized weakness beat, heart disease, d swallowing, chronic kit congestive heart failur</li> <li>A review of Resident #7 10/18/18. Review of the following: The resident and moderately impait was not coded as have the assessment period as having required ex more people for all Act (ADLs).</li> <li>Review of Resident #7 revealed a nursing no 5:40 PM. The note by resident had been see appointment and was Room (ER) at the local Ser which documented states at the set of the section of the section</li></ul>	expectation was the member would be notified sident being transferred at er. ent #71's medical record ginally admitted to the facility ost recently admitted on 1's diagnoses included: as, anxiety, abnormal heart liabetes, difficulty idney disease, and re (CHF). #71's most recent Minimum aled a quarterly assessment Reference Date (ARD) of the assessment revealed ident was coded as having red cognition. The resident ving had behaviors during d. The resident was coded tensive assistance of one or ctivities of Daily Living 71's progress notes the dated 8/17/18 and timed y Nurse #1 documented the en at a cardiologist triaged to the Emergency al hospital.	F 623				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/18/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345269	B. WING			11/	/08/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	<ul> <li>6:38 PM. The note by resident had been addivith an acute on chro Failure (CHF) exacered did not provide evider family member was n the hospital.</li> <li>Further review of Residin not reveal a disch physician's orders to a hospital.</li> <li>A review was completed hospital discharge summary the treatment during hospital discharge summary the treatment during hospital discharge summary the treatment during hospital shortness of breath an achronic congestive heat the time of admissi shortness of breath an An interview was contworker (SW) on 11/8/stated she did not talk Resident #71 regarding hospital.</li> <li>An interview was contracted wheelchait transmitter and the time of admissi shortness of breath an a scheduled 8/17/18. The nurse scheduled 8/17/18. The nurse scheduled wheelchait transmitter and to have been facility wheelchait transmitter and the scheduled wheelchait tran</li></ul>	71's progress notes be dated 8/17/18 and timed y Nurse #1 documented the mitted to the local hospital nic Congestive Heart bation. Review of the note nee of documentation if the otified of the discharge to sident #71's medical record arge assessment or discharge the resident to the ted of Resident #71's mmary dated 8/31/18. The he resident had received bitalization for the following act infection, acute on eart failure, and chronic documented main complaint on to the hospital was nd right leg pain. ducted with the Social /18 at 11:53 AM. The SW < to a family member of ng her discharge to the ducted with Nurse #1 on Nurse #1 stated Resident cardiologist appointment on tated the resident would en transported either by the	F	623			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/18/2018 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				(X3) DATE	
		345269	B. WING				11/	08/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE		
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 PREF TAG	IX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B		(X5) COMPLETION DATE
F 623	Friday, 8/17/18. The contact the resident's aware the resident ha hospital because she would have had to ha the cardiologist appoi she did not forward at resident or the resided discharge from the fa- stated the facility Soc Admissions Coordina responsible for follow family on Monday bed discharged on a Frida An interview was com 11/8/18 at 12:01 PM. #71's family would ha her doctor appointme not allowed to go to d unaccompanied. The contacted the resident resident had having b room or the resident f the hospital. The num normal discharge to the emergency room a pa- along with the resider contained a physician ER, bed hold information, the resident or family An interview was com Nurse (DON) on 11/	liologist appointment on nurse stated she did not family when she was made id been admitted to the said the resident's family ve been with the resident at ntment. The nurse stated ny written notification to the nt's family regarding the cility. The nurse further ial Worker (SW) or the tor would have been ing up with the resident or cause the resident was ay. ducted with Nurse # 4 on Nurse #4 stated Resident ve been with the resident at nt because residents were octor appointments e nurse stated she had not t's family regarding the een sent to the emergency having had been admitted to se stated usually with a he hospital or the acket would have been sent th. The packet would have l's order for being sent to the tion, and a face sheet. s instance regarding ould have been no packet, or notification provided to	F	623	3			

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	RVFY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLET	
		345269	B. WING		11/08/	2018
NAME OF PI	ROVIDER OR SUPPLIER	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF SALISBURY			505 BRINGLE FERRY ROAD ALISBURY, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE C	(X5) OMPLETIO DATE
F 623	families about discha	no would notify resident's	F 623			
	Worker (SW) on 11/8	/18 at 12:15 PM. The SW ntact Resident #71's family				
	Director (AD) on 11/8 stated she did not pro notice to the family m The AD stated she m resident's family on M	londay, 8/20/18, if the family e resident's belongings but				
F 625 SS=B	2:15 pm revealed his resident and/or family of the reason for a re- the time of the transfe	r member would be notified sident being transferred at er. blicy Before/Upon Trnsfr	F 625		12	2/6/18
	§483.15(d) Notice of	bed-hold policy and return-				
	nursing facility transfe the resident goes on nursing facility must p the resident or reside specifies- (i) The duration of the any, during which the	provide written information to				

Facility ID: 922955

If continuation sheet Page 11 of 32

		MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY IPLETED
		345269	B. WING		11	/08/2018
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 PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 625	Continued From page	e 11	F 62	25		
	plan, under § 447.40 (iii) The nursing facilities bed-hold periods, whe paragraph (e)(1) of the resident to return; and (iv) The information set of this section. §483.15(d)(2) Bed-hot the time of transfer of hospitalization or the facility must provide the resident representation described in paragram This REQUIREMENT by: Based on record rev- interviews the facility their representative and	specified in paragraph (e)(1) old notice upon transfer. At		1. CORRECTIVE ACTION RESIDENTS FOUND TO AFFECTED BY DEFICIEN 1a. Resident #1's RP rece	HAVE BEEN	
	reviewed for discharg #1, Resident #11, Re #71). 1. A review of Resi revealed he admitted with diagnoses of we respiratory disease, a	ge from the facility (Resident esident #12, and Resident dent #1's medical record I to the facility on 7/26/18 eakness, heart disease, and blood clots to his upper		policy and a copy of the di letter on 12/5/2018, which with individual for 11/5/201 was discharged to the hos 1b. Resident #11's respon received a bed hold policy the discharge/transfer letter	scharge/transfer was discussed 18 when resident pital sible party (RP) and a copy of er on 12/5/2018,	
	Data Set assessmen was severely cognitiv	et recent Admission Minimum t dated 8/2/18 revealed he vely impaired and required sistance with turning in bed, ut of bed, eating, and		<ul> <li>which was discussed with 9/21/2018 when resident w to the hospital.</li> <li>1c. Resident #12's RP rec hold policy and a copy of t transfer letter on 12/5/2012</li> </ul>	was discharged eived a bed he discharged	
	Nurses note dated 11 Nurse #4 revealed R	1/5/18 at 3:15 pm written by esident #1's oxygen		discussed with the individu when resident was discha	ual for 8/9/2018	

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		MEDICAID SERVICES					0.0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COMP	SURVEY
		345269	B. WING _			11/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF SALISBURY				505 BRINGLE FERRY ROAD ALISBURY, NC 28146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 625	Continued From page	a 12	Fe	625			
	saturation was below	90% consistently, the d, and the resident was sent		520	hospital from the Cardiologist appointment.		
	The Emergency Depa revealed Resident #1 hospital with Pneumo Congestive Heart Fai	artment Note dated 11/5/18 was admitted to the onia of Right Lung and			1d. Resident #71's RP received a bed hold policy and a copy of the discharge/transfer letter on 12/5/2018 which was discussed with the individua for the 8/17/2018 discharge to the hospital.	al	
	responsible for calling	e Admission Coordinator is g the family member after a d to let them know about the			2. HOW CORRECTIVE ACTION WILL ACCOMPLISHED FOR RESIDENTS HAVING POTENTIAL TO BE AFFECT BY SAME DEFICIENT PRACTICE:		
	Admissions Coordina the family when a res hospital. She also sta record of calling famil	n an interview with the itor revealed she contacts ident is discharged to the ated she does not keep a lies to notify them of the Bed esident is discharged. The			2a. The Director of Nursing (DON)/designee will re-educate all licensed staff and Admissions Coordina on the bed hold policy and the discharge/transfer letter.	ator	
	Admission Coordinate copy of the Bed Hold packet to the hospital discharged.	or stated the nurses send a Policy in the discharge I when a resident is			2b. Admissions Coordinator/Designee audit all current residents in facility to ensure that RPs have been given and have been educated on the Bed Hold policy and the transfer/discharge letter		
	revealed Resident #1 even though he was 11/5/18 and he was s room for evaluation a	se #4 on 11/8/18 at 9:27 am 's oxygen level had dropped on continuous oxygen on eent back to the emergency nd was admitted to the			3.MEASURES TO BE PUT IN PLACE/SYSTEMIC CHANGES TO ENSURE DEFICIENT PRACTICE WIL NOT RECUR:	L	
	that is sent with disch hospital included a co She stated she called	ated the discharge packet harged residents to the opy of the Bed Hold Policy. I the family member when harged to the facility but did			3a. DON/designee will re-educate all clinical nursing staff on Bed Hold policy and discharge/transfer letter and eleme of what is needed for any resident sent	ents	
		f the Bed Hold Policy or			out of facility to hospital and/or informa that should be sent to a Specialty Physician with documentation in the		

Facility ID: 922955

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		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		345269	B. WING			1/08/2018
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	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 625	Continued From pag	e 13	F 62	25		
	An interview with the	Director of Nursing on evealed the facility notified		resident's medical record.		
	residents when they	are admitted to the facility of and a copy of the bed hold		3b. DON/designee will re- clinical nursing staff on do		
	policy is sent in the h			the items required to be se		
		rged to the hospital by the		resident when leaving the	•	
	nurse.			include but not limited to to doctor (MD)/RP notificatio		
	A phone interview wi	th Resident #1's family				
		at 1:30 pm revealed she had		3c. Admissions Coordinate		
		n explanation of the facility's		re-educated on discussion		
	-	n Resident #1 was sent to		Hold policy upon admissio		
	the hospital on 11/5/	18.		given to that individual and Discharge/Transfer letter.	b regarding the	
	An interview with the	Administrator on 11/8/18 at		Discharge/ Hansier letter.		
		s expectation was the		4. FACILITY PLANS TO M	IONITOR ITS	
		y member would be notified		PERFORMANCE TO MAN		
	of the Bed Hold Polic discharged to the ho	cy when the resident is spital.		SOLUTIONS ARE SUSTA	INED:	
	-			4a. DON/designee will au	dit clinical	
				records of residents that h		
		admitted to the facility on		to the hospital and/or MD		
		ses that included dysphagia,		and will be audited and dis		
	unspecified convulsion hypertension.	ons and essential		Clinical Morning Meeting & weeks; then 3X/week for 4		
	nypertension.			once a week for 4 weeks.		
	A review of the Minin	num Data Set (MDS)		include Situation, Backgro		
		/17/2018 revealed Resident		Assessment and Recomm		
		rstood, had short and		(SBAR), admission record		
	• • •	roblems, recognized staff		transfer/discharge report i		
		d knew she was in a nursing		Care (PCC), Medication A		
	•	he MDS revealed Resident paired cognitive skills.		Record (MAR), Treatment Record (TAR), Care Plan,		
	#11 Hau severely Imp	Saned Cognitive SKIIIS.		Order/Notification, Pertine		
	A review of hospital r	ecords revealed Resident		Do Not Resuscitate (DNR		
	#11 was hospitalized			and placing bed hold/leave		
	•	nd urinary tract infection.		policy and Notice of Disch		
				Social Worker's mailbox.		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/18/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345269	B. WING			11/	/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	505 BRINGLE FERRY ROAD		
AUTUMIN	CARE OF SALISBURY			S	ALISBURY, NC 28146		
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 625	Continued From page	e 14	F	625			
	3:37 PM revealed Re emergency room for Further review did no	esident #11 was sent to the evaluation and treatment. It reveal any documentation he resident's representative		020	4b. Results of audits will be taken to Quality Assurance Performance Improvement committee meeting mon X 3 months for review and revision as needed.	thly	
	Social Worker (SW) r department was requ	ired to send a packet with erred out. The SW further ncluded information			4c. All newly hired clinical nursing staf be educated on the Bed Hold Policy, Discharge/Transfer letter, documentat in the medical record and discharges the the hospital and/or specialty physician The Administrator is responsible for the Plan of Correction	ion to	
	Admissions Coordina resident's representa with facility regarding reported the resident would call the facility hospital and they will bed. She further repor- record of the calls dis	In 11/7/2018 at 2:34 PM the ator (AC) revealed the tive/family is to follow up the bed hold. The AC 's representative/family if the resident was in the state they can't hold the orted that she did not keep a scussing the bed hold. evealed the bed hold t by nursing.					
	#1 revealed she wrot date of transfer to the disclosed that she did to the resident or the related to a bed hold. revealed she thought	d not provide any information resident's representative Additionally, Nurse #1					
	Administrator reveale provide bed hold noti	2018 at 4:17 PM with the ed he expected staff to fication to resident's and or e party prior to transfer.			sility ID: 922955		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 12/18/2018 FORM APPROVED MB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		3) DATE SURVEY COMPLETED
		345269	B. WING			11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
			1	505 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 (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 625	Continued From page	2 15	F 625			
	revealed she was orig on 3/6/17 and was mo 9/17/18. Resident #1 Generalized weakness disease, heart failure, dementia. A review of Resident # Data Set (MDS) reveat with an Assessment F 8/19/18. Review of th following: The resider been cognitively intact coded as having had assessment period. Thaving had required efformed or more people for all (ADLs) except for eatt having been independ Review of Resident # revealed a nursing no 12:39 AM. The note of had an oxygen satural supplemental oxygen documented the reside	The resident was coded as extensive assistance of one Activities of Daily Living ing where she was coded as dent with supervision. 12's progress notes the dated 9/11/18 and timed documented the resident tion percentage of 87% with				
	also documented as h resident was complain	ounds. The resident was naving had swelling and the ning of nausea. Further s notes revealed another				
	note dated 9/11/18 do been sent out to the h the hospital with a dia heart failure. Review	ocumenting the resident had hospital and was admitted to ignosis of acute congestive of the notes did not provide tation if the family member				

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	-	D HUMAN SERVICES				FORM	: 12/18/2018 APPROVED
STATEMENT (	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		(X3) DATE COMPI	
		345269	B. WING			11/0	08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		
	CARE OF SALISBURY			1505 BRINGLE FERRY ROAD			
AUTOWIN	CARE OF SALISBURT			SALISBURY, NC 28146			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	16	F 62	5			
	History and Physical or resident was docume the facility after having hypoxia (lack of oxyge Failure (CHF) exacerd An interview was cone Worker (SW) on 11/7/ stated she did not pro- the resident or the far #12. The SW stated to (AD) was the person of or the resident's famil SW stated the nursing to send a packet with discharge and the pace policy. An interview was come Director (AD) on 11/7/ stated she did not pro- the resident or family The AD stated it was members of residents was the family member the facility if the reside AD stated she did not had called to discuss further stated the bed nursing sent out with she did not know if the or the resident's famil resident was being dis	ducted with the Social 18 at 10:01 AM. The SW vide bed hold information to nily member of Resident the Admissions Director who would call the resident y about the bed hold. The g department was required the resident at the time of cket included the bed hold ducted with the Admissions (18 at 2:34 PM. The SW vide bed hold information to member of Resident #12. made clear to family at the time of admission it er's responsibility to contact ent was hospitalized. The keep a record of who she the bed hold policy. The AD hold policy was something the resident. The AD stated e nurse asked the resident y about a bed hold when the					
		ely 3:00 PM. The nurse as sent out to the hospital					

Facility ID: 922955

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	-	D HUMAN SERVICES				FORM	2: 12/18/2018 1 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			-	(X3) DATE COMP	
		345269	B. WING			11/0	08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
AUTUMN	CARE OF SALISBURY			1505 BRINGLE FERRY RC 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 CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	was short of breath. had called the resider had not discussed be resident at the time of stated she sent a pac had the resident's fac and the bed hold polic A phone interview wa member for Resident The family member st through a phone call w discharged to the hos he had not received in informed about a bed An interview with the 2:15 pm revealed his resident and/or family of the bed hold policy discharged to the hos evealed she was orig on 8/2/18 and was mo 8/31/18. Resident #7 Generalized weakness beat, heart disease, d swallowing, chronic ki congestive heart failu A review of Resident # Data Set (MDS) reveat with an Assessment F 10/18/18. Review of the following: The res had moderately impai	had become swollen and The nurse further stated she ht's family to notify them but d hold with the family or the f discharge. The nurse ket with the resident which e sheet, physician's orders, cy. s conducted with the family #12 on 11/7/18 at 3:44 PM. tated he had been notified when the resident was pital back in September, but nformation nor was he hold or bed hold policy. Administrator on 11/8/18 at expectation was the member would be notified when a resident was being pital. ent #71's medical record ginally admitted to the facility post recently admitted on 1's diagnoses included: as, anxiety, abnormal heart liabetes, difficulty idney disease, and	F 62	5			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/18/2018 APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE	
		345269	B. WING			11/0	08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
AUTUMN	CARE OF SALISBURY			1505 BRINGLE FERRY RO 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 CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	as having required ex more people for all Ac (ADLs). Review of Resident # revealed a nursing no 5:40 PM. The note by resident had been see appointment and was Room (ER) at the loca note did not provide et the family member was hold policy. Review of Resident # revealed a Social Ser which documented sta sent to the hospital af due to health status. provide evidence of d member was notified policy. Review of Resident # revealed a nursing no 6:38 PM. The note by resident had been add with an acute on chro Failure (CHF) exacerd did not provide evider family member was no hold policy.	d. The resident was coded tensive assistance of one or ctivities of Daily Living 71's progress notes the dated 8/17/18 and timed y Nurse #1 documented the en at a cardiologist triaged to the Emergency al hospital. Review of the evidence of documentation if as notified regarding the bed 71's progress notes vices note dated 8/20/18 aff reported resident was ter a doctor appointment Review of the note did not ocumentation if the family regarding the bed hold 71's progress notes te dated 8/17/18 and timed y Nurse #1 documented the mitted to the local hospital nic Congestive Heart bation. Review of the note nee of documentation if the otified regarding the bed	F 625				

Facility ID: 922955

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				FORM	D: 12/18/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	
	345269	B. WING		11/	08/2018
NAME OF PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	· · · ·	
AUTUMN CARE OF SALISBURY			1505 BRINGLE FERRY ROAD		
AUTUMIN CARE OF SALISBURT			SALISBURY, NC 28146		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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
<ul> <li>hospital discharge summary treatment during hos diagnoses: urinary tr chronic congestive h kidney disease. The at the time of admiss shortness of breath a</li> <li>An interview was con Worker (SW) on 11/8 stated she did not ta family regarding a be the hospital.</li> <li>An interview was con 11/8/18 at 11:55 AM. #71 had a scheduled 8/17/18. The nurse have had to have be facility wheelchair tra contracted wheelchai nurse stated the resi hospital directly from on Friday, 8/17/18. contact the resident aware the resident h hospital because she would have had to h the cardiologist appo she did not forward b resident or the reside discharge from the fa stated the facility So Admissions Coordina responsible for follow</li> </ul>	eted of Resident #71's ummary dated 8/31/18. The the resident had received spitalization for the following act infection, acute on leart failure, and chronic e documented main complaint sion to the hospital was and right leg pain. Inducted with the Social 8/18 at 11:53 AM. The SW lk to Resident #71 nor her ed hold after her discharge to Inducted with Nurse #1 on . Nurse #1 stated Resident d cardiologist appointment on stated the resident would en transported either by the ansportation van or a lir transportation van. The dent was admitted to the a cardiologist appointment The nurse stated she did not is family when she was made ad been admitted to the e said the resident's family ave been with the resident at both the resident stated ped hold information to the ent's family regarding the acility. The nurse further cial Worker (SW) or the ator would have been ving up with the resident or eccuse the resident was	F 62	5		

Facility ID: 922955

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CENTERS FOR MEDICARE & MEDICA	AID SERVICES				FORM	): 12/18/2018 // APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PRC	DVIDER/SUPPLIER/CLIA	· /	E CONSTRUCTION		(X3) DATE	
	345269	B. WING		_	11/	08/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN CARE OF SALISBURY			1505 BRINGLE FERRY ROA SALISBURY, NC 28146	AD		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625 Continued From page 20		F 62	5			
An interview was conducted w 11/8/18 at 12:01 PM. Nurse # #71's family would have been her doctor appointment becau not allowed to go to doctor ap unaccompanied. The nurse s contacted the resident's famili resident had having been sen room, the resident having had the hospital, or bed hold infor stated usually with a normal of hospital or the emergency roo have been sent along with the packet would have contained for being sent to the ER, bed and a face sheet. Nurse #4 s instance regarding Resident # have been no packet, no bed notification provided to the res nursing. An interview was conducted w Nursing (DON) on 11/8/18 at DON stated the Admission Co usually the person who would families about the bed hold. A second interview was condu- Worker (SW) on 11/8/18 at 12 stated she was not the one w contacted a resident or a resid- bed hold and she had not cor nor her family regarding a bed An interview was conducted w Director (AD) on 11/8/18 at 12 stated she did not recall discu- policy with Resident #71's families about the second and she had not cor	#4 stated Resident with the resident at use residents were opointments stated she had not y regarding the at to the emergency d been admitted to mation. The nurse discharge to the om a packet would e resident. The a physician's order hold information, stated in this #71 there would hold information, or sident or family from with the Director of 12:10 PM. The bordinator was d notify resident's ucted with the Social 2:15 PM. The SW ho normally dent's family about a ntacted Resident #71 d hold. with the Admissions 2:31 PM. The AD ussing the bed hold					

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 12/18/2018 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE	
		345269	B. WING		11/	/08/2018
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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625 F 684 SS=D	discharge to the hosp the family came in to resident's belongings them, but that would h because the resident hospital on Friday. Th have documented she family about the bed h them. An interview with the <i>A</i> 2:15 pm revealed his resident and/or family of the bed hold policy discharged to the hos Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fun applies to all treatmer facility residents. Base assessment of a reside that residents receive accordance with profe practice, the compreh care plan, and the res This REQUIREMENT by: Based on record revi interview the facility fa order for 1 of 4 reside for hospitalization. Re hospital on 11/2/18 wi nothing by mouth. He	ital. The AD further stated if pick up some of the she may have talked to have been on Monday was discharged to the ne SW stated she would not a had talked to the resident's hold if she had talked with Administrator on 11/8/18 at expectation was the member would be notified when a resident was being pital. are ndamental principle that ht and care provided to ed on the comprehensive lent, the facility must ensure treatment and care in essional standards of lensive person-centered	F 63		ΓED: led y to	12/6/18

Event ID: 5V9Y11

Facility ID: 922955

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## 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 345269 B. WING 11/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1505 BRINGLE FERRY ROAD** AUTUMN CARE OF SALISBURY SALISBURY, NC 28146 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 684 Continued From page 22 F 684 A review of Resident #1's medical record 1b. Certified Nursing Assistant was revealed he admitted to the facility on 7/26/18 re-educated on confirming diets for any with diagnoses of pneumonitis due to inhalation resident that receives a tray and is noted of food, heart disease, respiratory disease, and to be NPO secondary to having tube blood clots to his upper extremities. His most feeding. recent Admission Minimum Data Set assessment 2. HOW CORRECTIVE ACTION WILL BE dated 8/2/18 revealed he was severely cognitively impaired and required extensive to total ACCOMPLISHED FOR THOSE assistance with turning in bed, transferring in and **RESIDENTS HAVING POTENTIAL TO** out of bed, eating, and toileting. The assessment BE AFFECTED BY SAME DEFICIENT further revealed Resident #1 had difficulty PRACTICE: swallowing and received enteral feedings that provided 51% or more of his caloric intake. 2a. 100% of current resident's diet orders were audited on 12/5/2018 and Nurse's Note dated 10/28/18 at 4:45 pm revealed corrections made for specific diets and/or Resident #1 was discharged to the hospital after changes per medical doctor (MD) orders being found unresponsive with oxygen saturation of 54% on 3 liters of oxygen by nasal canula. 3. MEASURES PUT INTO PLACE OR Admission Note dated 11/2/18 at 3:55 pm SYSTEMIC CHANGES TO ENSURE revealed Resident #1 returned to the facility from THAT THE DEFICIENT PRACTICE WILL the hospital with diagnoses of respiratory failure, NOT RECUR: heart failure, and pneumonia. 3a. All new residents admitted and The Physician's Orders for 11/2/18 included an readmitted will be audited per the order for nothing by mouth and enteral feedings Admission/Readmission audit check every shift for nutrition. sheet to ensure that all orders have been approved per the MD. A review of Resident #1's care plan dated 11/2/18 revealed he required administration of feeding 3b. Orientation will be provided to all new employees during orientation regarding and hydration via feeding tube. following MD orders. The Dietary Order & Communication form dated 11/2/18 for readmission stated the resident was to 4. FACILITY PLANS FOR MONITORING have nothing by mouth. ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED: A Nursing Note dated 11/3/18 at 3:57 pm written by Nurse #4 stated it was reported to the nurse 4a. The Director of Nursing Resident #1 drank 120 cc of orange juice this am. (DON)/designee will audit all new The note further revealed the Physician's admissions regarding MD orders 5X/week

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

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		COMPLETED
		345269	B. WING		11/08/2018
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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIO
F 684	Assistant was notified x-ray and to report an breath. Review of chest x-ray x-ray suggested the r heart failure. Nurses note dated 11 Nurse #4 revealed Re saturation was below physician was notified to the emergency Depa revealed Resident #5 hospital with Pneumo Congestive Heart Fail An interview with Nur revealed Resident #1 even though he was s room for evaluation a hospital. An interview with the at 1:30 pm revealed s	d and gave orders for a chest by fever or shortness of d dated 11/3/18 stated the resident had congestive 1/5/18 at 3:15 pm written by esident #1's oxygen 90% consistently, the d, and the resident was sent om. artment Note dated 11/5/18 5 was admitted to the onia of Right Lung and	F 68	<ul> <li>for 4 weeks; then 3X/week for 4 w then 1X/week for 4 weeks.</li> <li>4b. Results of the audits will be re by the Quality Assurance Perform Committee committee monthly for months for review and revision as needed.</li> <li>The Administrator is responsible f Plan of Correction</li> </ul>	eviewed hance r 3
	visited on Sunday and The Family Member s sent back to the hosp An interview with Nur revealed she was the when Resident #1 red not ordered. She sta	the tray. She stated she d Resident #1 was lethargic. stated on 11/5/18 he was bital with pneumonia. The se #5 on 11/8/18 at 2:15 pm the Charge Nurse on 11/3/18 ceived a meal tray that was ted she did not see the tray, her Resident #1 drank 240			

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	-	D HUMAN SERVICES				FORM	): 12/18/2018 1 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345269	B. WING			11/0	08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
AUTUMN	CARE OF SALISBURY			1505 BRINGLE FERRY RO 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 CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	stated Nurse #6 was day. Nurse #5 stated Physician's Assistant chest x-ray. A phone interview with 2:27 pm revealed she Resident #1 had rece 11/3/18 and had dran Nurse #6 stated she Resident #1 had alwa nothing by mouth. Sh Charge Nurse, Nurse notified the physician dietary of Resident #1 mouth. An interview with Nurse 2:40 pm revealed she breakfast on 11/3/18 had a new order to ea delivered. Nurse Aide the tray Resident #1 v drank the orange juice Resident #1 did not h coughing after drinkin notified Nurse #6 afte Resident #1 drank ora An interview with the 11/8/18 at 2:56 pm re her Resident #1 had hat the tray. She sta that the physician's di and Resident #1 shou	the from the tray. Nurse #5 Resident #1's Nurse that she had called the and received an order for a h Nurse #6 on 11/8/18 at the was notified by NA #1 that ived a breakfast tray on k orange juice from the tray. Was concerned because hys had had an order for the stated she notified the #5, and the Charge Nurse and the family and notified h's orders for nothing by se Aide #1 on 11/8/18 at thad passed trays at and thought Resident #1 at food since a tray was the #1 stated she picked up was given at 9:30 am and he the from the tray. She stated ave any choking or g the orange juice and she r picking up the tray	F 68	4			

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345269	B. WING		11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
UTUMN	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	C PROVIDER'S PLAN OF C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 684	drank orange juice on be hard to know if the to do with Resident # stated his expectation	e was not aware Resident #1 11/3/18. He stated it would corange juice had anything 1 having aspiration. He would be the physician's wed and Resident #1 would	F 6	.84	
F 689 SS=D	CFR(s): 483.25(d)(1)( §483.25(d) Accidents The facility must ensu §483.25(d)(1) The res		F 6	89	12/6/18
	supervision and assis accidents. This REQUIREMENT by: Based on observation facility failed to secure entering the laundry r potentially hazardous The findings included An observation condu revealed the entrance from the 400 hall, a re locked. Upon enterin were no staff member room there were two machines running, tw and hazardous chemi	oom which contained chemicals and equipment. : ucted on 11/6/18 at 3:24 PM e door to the laundry room esident hallway, was not g the laundry room there rs observed in the laundry commercial sized washing o commercial sized dryers, ical storage. Further a door to an employee		<ol> <li>CORRECTIVE ACTION RESIDENTS FOUND TO AFFECTED:</li> <li>1a. Laundry aide was re-eleaving laundry door propp not in laundry room. Laun received disciplinary action</li> <li>HOW CORRECTIVE AC ACCOMPLISHED FOR TH RESIDENT HAVING POTI AFFFECTED BY SAME D PRACTICE:</li> <li>2a. Laundry room will be la times when employee(s) a</li> </ol>	HAVE BEEN ducated on bed open when dry aide n on 11/8/18. CTION WILL BE HOSE ENTIAL TO BE EFICIENT

Event ID: 5V9Y11

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 09	38-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345269	B. WING		11/08/2	018
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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COI	(X5) MPLETIO DATE
F 689	Continued From page	e 26	F 68	9		
	from the laundry room it was unlocked and t access from the 400 also unlocked. Obse door to the laundry ro locked and would not room to the laundry ro on the door in the din door must be kept clo when not in use," and Administrator. At lea observed in the 400 f observation. An observation condu AM revealed the entr room across from the resident accessible d a 5 gallon bucket whi "corrosive" with the h Upon entrance to the staff members observ Further observation r the laundry room from hallway, was not lock the laundry room reve commercial sized wa commercial sized dry chemical being stored from the laundry roor	n to the soiled linen revealed he door which provided hall to the laundry room was rvation of a 4th entrance oom revealed the door was a allow entry from the dining oom. There was a posting ing room which read, "This based and locked at all times d was signed by the st one resident was hall at the time of the ucted on 11/7/18 at 10:33 ance door to the laundry e employee entrance, a oor, was propped open with ch was visibly marked azard sign for corrosive. I laundry room there were no ved in the laundry room. evealed the entrance door to in the 400 hall, a resident ted. Further observation of		<ul> <li>been re-educated on keeping all la doors locked to ensure that no rescan enter laundry room where cheand heavy duty machinery is bein utilized.</li> <li>3. MEASURES PUT IN PLACE/SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILLO NOT RECUR:</li> <li>3a. Administrator/designee re-edustaff on November 8, 2018 ensuriall laundry doors are locked at all that no laundry door may be proppiopen at anytime especially doors automatic closures. Only employed to have access to the laundry rood</li> <li>3b. Push button key pad locks have placed on laundry room doors. Inswere provided by the Staff Develor Coordinator for all facility employed 12/5/2018 on the process and used new key pad locks and that the lar room door must remain closed an when employees are not in the room</li> <li>4. FACILITY PLANS FOR MONIT ITS PERFORMANCE TO MAKE STHAT SOLUTIONS ARE SUSTAIL</li> </ul>	sident emicals g D D ucated ng that times, bed with tes are m. ve been services pment tes on e of the undry d locked om. ORING SURE	
	also unlocked. Obse door to the laundry ro locked and would not	hall to the laundry room was rvation of a 4th entrance oom revealed the door was allow entry from the dining oom. There was a posting		4a. Maintenance Director/designe audit laundry room doors for 5x/w weeks; then 3X/week for 4 weeks 1X/week for 4 weeks.	eek for 4	
	on the door in the din	ing room which read, "This osed and locked at all times		All new employees will be inservic this new procedure during orienta The Administrator is responsible for	tion.	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/18/2018 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
345269		345269	B. WING		11/08/2018		
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	CARE OF SALISBURY			1505 BRINGLE FERRY ROAD			
AUTOWIN				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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	laundry room. The L/ clothing rack. The L/ the door open becaus with the wheeled cloth 5 gallon bucket she h open with was full and destaining concentrat least one resident wa the time of the observe An observation condu AM revealed the entra room from the 400 ha not locked. Upon ent were no staff member room there were two machines running, tw and hazardous chemi observation revealed entrance hallway was gallon bucket. The 5 marked "corrosive" wi corrosive. Observatio the bucker revealed the destaining concentrat from the laundry room it was unlocked and the access from the 400 ha also unlocked. Observation to the laundry room it was unlocked and the access from the 400 ha also unlocked. Observation door to the laundry room it was unlocked and the access from the 400 ha also unlocked. Observation door to the laundry room it was unlocked and the access from the 400 ha also unlocked. Observation door nust be kept clow	the observation the is observed to return to the A was pushing a wheeled A stated she needed to prop be she was coming back hing rack. The LA stated the ad used to prop the door d contained chlorine e, a kind of liquid bleach. At s observed in the 400 hall at ration. acted on 11/8/18 at 10:03 ance door to the laundry II, a resident hallway, was ering the laundry room there rs observed in the laundry commercial sized washing o commercial sized dryers, ical storage. Further a door to an employee propped open with a 5 gallon bucket was visibly ith the hazard sign for on of the listed contents of he bucket contained chlorine e. Observation of the door n to the soiled linen revealed he door which provided hall to the laundry room was rvation of a 4th entrance om revealed the door was allow entry from the dining pom. There was a posting ing room which read, "This sed and locked at all times was signed by the	F 68				
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR L Administrator. During Laundry Aide (LA) wa laundry room. The LA clothing rack. The LA the door open becaus with the wheeled cloth 5 gallon bucket she h open with was full and destaining concentrat least one resident wa the time of the observa- An observation condu AM revealed the entra room from the 400 ha not locked. Upon ent were no staff member room there were two machines running, tw and hazardous chemi observation revealed entrance hallway was gallon bucket. The 5 marked "corrosive" wi corrosive. Observatio the bucker revealed the destaining concentrat from the laundry room it was unlocked and the access from the 400 ha door to the laundry room it was unlocked and the access from the 400 ha also unlocked. Observation not he door in the dini door must be kept clow when not in use," and	A MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMP	

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	-	D HUMAN SERVICES					FORM	): 12/18/2018 MAPPROVED
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE	0. 0938-0391 SURVEY LETED
345		345269	B. WING				11/08/2018	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
AUTUMN CARE OF SALISBURY					505 BRINGLE FERRY ROA	D		
				3	ALISBURY, NC 28146			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	28	F	689				
F 689	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 a Nursing Assistant (NA) #2 entered the laundry room then exited the laundry room. The LA came into the laundry room through the soiled linen room entrance door. The LA stated she had been out delivering personal clothes to the residents. The LA stated she had been to the 400 hall, the 200 hall, the 800 hall, and the 600 hall. The LA stated it took her about 25 minutes to deliver personal clothes to the residents on her round and she delivers the clothes after breakfast between 9:00 AM and 10:00 AM, once a shift, and her shift was from 7:00 AM till either 2:30 PM or 3:00 PM. The LA stated she would usually leave the washer and dryer equipment running when she left the laundry room when she was delivering clothes. The LA stated the only door she had to lock was the entrance door to the laundry room from the dining room. The LA stated there was no one assigned to monitor or observe the entrances to the laundry room when she was delivering clothes. The LA further stated the entrance doors to the laundry from the 400 hall, through the soiled linen room, and the entrance by the employee entrance stayed unlocked. The LA stated the main entrance to the laundry room from the 400 hall remained unlocked all of the time, which allowed third shift to be able to access the laundry room. At least one resident was observed in the 400 hall at the time of the observation. At least one resident was observed in the 400 hall at the time of the observation. An interview was conducted with NA #2 on 11/8/18 at 10:20 AM. The NA stated the laundry room entrance, either the one by the employee entrance or the 400 hall entrance, were usually		F	689				
		there was a door between mployee hall, that door was						

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 12/18/2018 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		MULTIPLE CONSTRUCTION		(X3) DATE	
345269		345269	B. WING			11/08/2018		
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CC	DE		
AUTUMN	CARE OF SALISBURY				505 BRINGLE FERRY ROAD SALISBURY, NC 28146			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI		(X5) COMPLETION DATE
F 689 F 732 SS=C	the door from the dinii was kept locked. The would go into the laurn not in the laundry room not locked. The NA's laundry room to be un laundry room during s LA was delivering clot During an interview co Administrator on 11/8. Administrator stated if laundry room, which co chemicals and equipm or locked and secured Posted Nurse Staffing CFR(s): 483.35(g)(1)- §483.35(g) Nurse Sta §483.35(g)(1) Data re must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number a by the following categ unlicensed nursing sta resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must po	did not lock. The NA stated ing room to the laundry room is NA stated sometimes she adry room and the LA was in and the laundry room was tated she had observed the alocked without the LA in the second shift also when the hing. Inducted with the (18 at 10:31 AM, the is was his expectation for the contained potentially harmful hent, to either be monitored d. Information (4) ffing Information. quirements. The facility g information on a daily and the actual hours worked ories of licensed and aff directly responsible for the is. nurses or licensed defined under State law). des.		689				12/6/18

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/18/2018 1 APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345269		B. WING			11/08/2018		
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1505 BRINGLE FERRY ROAD				
AUTUMN CARE OF SALISBURY				S	ALISBURY, NC 28146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732	32 Continued From page 30		F	732			
	<ul> <li>daily basis at the beginning of each shift.</li> <li>(ii) Data must be posted as follows:</li> <li>(A) Clear and readable format.</li> <li>(B) In a prominent place readily accessible to residents and visitors.</li> <li>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</li> </ul>						
	posted daily nurse sta 18 months, or as requising greater. This REQUIREMENT by: Based on observation interviews, the facility	cility must maintain the offing data for a minimum of nired by State law, whichever is not met as evidenced ns, record review and staff failed to correctly update			1. CORRECTIVE ACTION FOR THOS RESIDENTS FOUND TO HAVE BEEN		
	staffing records review Findings included: The facility 's daily sta 11/5/2018 at 9:49 AM completed for all shifts nurses and nursing as the form and total hou	ting records for 15 of 15 ved. aff posting was observed on . The posted staffing was s with the total number of asistants documented on ars were calculated for each were made for changes in			<ul> <li>AFFECTED:</li> <li>1a. Staffing posting was corrected immediately to reflect the actual staff working.</li> <li>2.CORRECTIVE ACTION FOR OTHEF RESIDENTS HAVING THE POTENTIA TO BE AFFECTED:</li> <li>2a. No residents are affected by this practice at this time</li> </ul>		
	10:36 AM. The posted all shifts with the total nursing assistants do	s observed on 11/6/2018 at d staffing was completed for number of nurses and cumented on the form and lated for each shift. No			3. MEASURES PUT INTO PLACE/SYSTEMIC CHANGES TO ENSURE DEFICIENT PRACTICES DO NOT OCCUR:	)	

Facility ID: 922955

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## 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 345269 B. WING 11/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1505 BRINGLE FERRY ROAD** AUTUMN CARE OF SALISBURY SALISBURY, NC 28146 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 732 Continued From page 31 F 732 adjustments were made for changes in staffing. 3a. Interim Regional Director of Clinical Services (IRDCS) re-educated the A total of 15 daily staff posting records dated from Director of Nursing (DON) and charge 9/1/2018 until 10/14/2018 were reviewed. All nurse on the proper guidelines on posting posted nurse staffing did not match the employee daily nursing hours on November 7, 2018. schedule and no adjustments were made to the posted staffing to reflect staff call-outs or changes 3b. The Staff Development Coordinator in staffing. (SDC)/designee will re-educate all charge nurses on the proper process of posting An interview was conducted with the Director of daily nursing staffing on November 6, Nursing (DON) on 11/7/2018 at 10:48 AM. The 2018 DON reported the Assistant DON completed the posted nursing staffing forms, but she was 3c. New form has been initiated to meet unavailable for interview. The DON went on to requirements as specified by Data explain the posted nursing staffing sheets were Regulations. completed by the charge nurses when the Assistant DON was not available, and Human 4.FACILITY PLANS FOR MONITORING Resources would correct the forms to reflect ITS PERFORMANCE TO MAKE SURE call-outs or staffing changes the next day. The THAT THE SOLUTIONS ARE DON went on to explain she was not aware the SUSTAINED: staffing should be updated for each shift to reflect call-outs, staffing changes or adjustments. 4a. DON/designee will audit Posting Daily Nursing Staff form daily for 4 weeks; then The Administrator was interviewed on 11/8/2018 3X/week; then weekly X 4 weeks. at 2:58 PM and he stated it was his expectation each nursing shift would update the posted nurse 4b. Results of audits will be taken to staffing with accurate staffing information and **Quality Assurance Performance** adjust the hours due to call-outs or other Improvement meeting monthly X3 months schedule changes. for review and revision as needed. The Administrator is responsible for this Plan of Correction.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 12/18/2018