DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FO	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				ATE SURVEY
		345351	B. WING				C 05/16/2024
NAME OF PI	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		0,10,2024
	CARE OF SALUDA			5	01 ESSEOLA CIRCLE		
				S	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	to conduct a complain 05/08/24. The survey on 05/16/24 to validat and exited on 05/16/2 was changed to 05/16 The following intakes NC00214829 and NC NC00216543 resulted Two (2) of the 3 comp deficiency. Past noncompliance CFR 483.10 at tag F5 (J) CFR 483.12 at tag F6 (J) CFR 483.25 at tag F6 (J)	:00216543. Intake d in immediate jeopardy. blaint allegations resulted in					
	(J)	726 at a scope and severity , and F689 constituted					
	Substandard Quality						
	Immediate Jeopardy removed on 05/04/24	began on 04/24/24 and was					
	A partial extended su	-					
F 580 SS=J		jury/Decline/Room, etc.))(i)-(iv)(15)	F	580			
	§483.10(g)(14) Notific (i) A facility must imm	cation of Changes. ediately inform the resident;					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE
Electroni	cally Signed						06/03/2024

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

PRINTED: 06/10/2024

	MENT OF HEALTH AN					FORM	0: 06/10/2024 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_	05/ [,]	_ 16/2024
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
AUTUMN	CARE OF SALUDA			01 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-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	consult with the reside consistent with his or representative(s) whe (A) An accident involve results in injury and he physician intervention (B) A significant change mental, or psychosocid deterioration in health status in either life-thr clinical complications) (C) A need to alter tree a need to discontinue treatment due to advect commence a new forr (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in resides State law or regulation (e)(10) of this section. (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15)	ent's physician; and notify, her authority, the resident ing the resident which as the potential for requiring ; ge in the resident's physical, ial status (that is, a , mental, or psychosocial eatening conditions or); atment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ms as specified in paragraph ecord and periodically nailing and email) and	F 580				

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	TERS FOR MEDICARE & MEDICAID SERVICES		0.00.00			O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			С
		345351	B. WING		05	5/16/2024
AME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2024
				501 ESSEOLA CIRCLE		
UTUMN	CARE OF SALUDA			SALUDA, NC 28773		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	Continued From pag	o 2	ГБО			
F 300			F 58			
	•	istinct part (as defined in e in its admission agreement				
		tion, including the various				
	1 2 0	se the composite distinct				
		y the policies that apply to				
		en its different locations				
	under §483.15(c)(9).					
		Γ is not met as evidenced				
	by: Based on record review, staff, Nurse Practitioner (NP), and Medical Doctor (MD) interviews, the			Dest personnlispes, pe plen	of	
				Past noncompliance: no plan correction required.	01	
		the physician of a fall when		correction required.		
	they reported a chan					
		ely cognitively impaired				
	resident on blood thin					
	physician was not no	tified when there was a delay				
		ely without delay) x-ray order				
	•	sident with a decrease in				
		er left hip and pain. The				
		s ordered on 4/25/24 at tained until 4/26/24 that				
		cture of the left hip at the				
		on (the area near the hip				
		esident #1 underwent surgery				
	to repair the left hip f	racture. On 5/1/24 Resident				
		om the hospital to hospice				
		1 expired on 5/2/2024. This				
		1 of 3 residents reviewed for				
	notification of change	e (Resident #1).				
	Findings included:					
		nitted to the facility on				
	12/11/22 with a diagr	nosis that included				
	Alzheimer's disease.					
	The quarterly Minimu	ım Data Set (MDS) dated				
	03/25/24 assessed R					

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		MEDICAID SERVICES					NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		STRUCTION	`` '	TE SURVEY
			A. BUILDIN	IG			
		245254	B. WING				С
		345351				()5/16/2024
NAME OF PH	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF SALUDA				SEOLA CIRCLE		
				SALUE	DA, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	• 3	F 5	80			
1 000			F J	00			
	Record review of the	Change in Condition					
	-	vas assessed due to a					
	change in condition.						
	-	ormal limits. Resident #1					
	received anticoagular	nt medication and had no					
	changes in mental or	functional status. Resident					
	#1 displayed signs/sy	mptoms of pain and an					
		or a STAT (immediate) x-ray					
	of the left hip for decr	ease range of motion and					
	pain.						
	Record review of the	physician's orders revealed					
	in part:						
	Stat X-ray for left hip	for decreased range of					
	motion and pain date	d 4/25/24 at 12:48 PM.					
	Record review of a pr	rogress note dated 4/26/24					
	at 10:56 AM written b	y the DON revealed in part:					
		IA #1 took Resident #1 to the					
		g Resident #1 to the toilet					
	when her foot came of						
		1stated that she lowered the					
		Agency NA #1 called for NA dent #1. On 4/25/24 staff NA					
		ent #1 to her chair and noted					
		to hold her foot up while					
		repositioning and making					
		#2 immediately notified the					
	•	as wrong with Resident #1.					
	NP ordered a STAT x	-ray of the left hip related to					
		nd pain. Final results of					
		on 4/26/24. Results noted an					
	acute fracture of the I	-					
		on. NP notified of results					
		transfer Resident #1 to the					
		tion and treatment. Resident					
	#1 nag remained at h	er baseline. The Guardian	1	1			1

Facility ID: 922956

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/10/2024 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING			_		C 16/2024
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF SALUDA				01 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		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	hospital. A phone interview on #1 (agency) revealed Resident #1 for a sho stated that she placed stand lift and as she (#1 to the toilet, Reside She then transferred I with the sit to stand lift and she lowered Resi the sling from the sit to Once Resident #1 wa #1 stated she stepped called for help from N not called a Nurse to because Resident #1 after the shower she to yelling but did not tell slipping and lowering A phone interview on #2 revealed that on 4, resident's room when hall and asked her to When NA #2 entered Resident #1 sitting on NA #2 stated that she assess Resident #1 b Resident #1 slid dowr #2) had not thought o stated that if she thou harder, she would hav immediately. NA #2 r	#1 was currently at the 5/7/24 at 10:52 AM with NA that she was assigned to wer only on 4/24/24. NA #1 4 Resident #1 in the sit to NA #1) transferred Resident ent #1 was yelling in shock. Resident #1 off the toilet t, Resident #1's foot slipped, ident #1 to the floor using o stand mechanical lift. s lowered to the floor, NA d out into the hallway and A #2. NA #1 stated she had assess Resident #1 had not fallen. NA #1 stated told Nurse #1 about the her about Resident #1's foot her to the ground. 5/7/24 at 12:22 PM with NA /24/24 she was in another NA #1 came out into the come into the shower room. the shower room, she saw ther bottom on the floor. did not get a nurse to ecause she was told to the floor and she (NA f that as a fall. NA #2 ght Resident #1 had fallen ve gotten a nurse evealed that she had a falls being defined as any ving downward, dropping or	F	580				
	falling) to the floor by	ving downward, dropping or a resident. She stated that her nurse and had her						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/10/2024 APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345351	B. WING			_		C 16/2024	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
				5(01 ESSEOLA CIRCLE				
AUTUMN	CARE OF SALUDA			S	ALUDA, NC 28773				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From page assess Resident #1 b #2 stated that she did incident in the shower she had not associate shower room incident An interview on 5/7/22 revealed that neither 1 to her and spoken abo A phone interview on Nurse #2 revealed he assigned nurse on 4/2 NA #2 had mentioned Resident #1's fall. Nu interactions with Resid displayed no signs or #2 stated that his nex he got report from the identify) that they wer be completed for Res state if he was aware and was delayed or th physician regarding th A phone interview on Nurse #3 revealed sh She stated that Resid seemed fine in the mo around noon when N/ put her in her wheelch noticed a decrease in #1's leg and informed Resident #1 and orde stated that when she come during her shift, because it was not un	 5 efore she was moved. NA not tell the NP about the the previous day because ad the foot drag with the . 3 at 12:06 PM with Nurse #1 NA #1 nor NA #2 had come out Resident #1 on 4/24/24. 5/8/24 at 10:32 AM with was Resident #1's 24/24 and neither NA #1 nor anything to him about urse #2 stated that during his dent #1 on 4/24/24 she symptoms of pain. Nurse t shift was on 4/26/24 and e off going nurse (unable to e waiting on a hip x-ray to ident#1. The nurse did not the x-ray order was STAT hat he contacted the e delayed x-ray. 5/7/24 at 12:54 PM with e was working on 4/25/24. ent #1 was talking and orning. Nurse #3 stated that A#2 got Resident #1 up and hair, NA #2 reported she range of motion in Resident the NP. The NP assessed red a STAT x-ray. Nurse #3 did not see the x-ray staff she did not notify anyone nusual for the x-ray company 		580					
	come during her shift,	she did not notify anyone usual for the x-ray company							

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			()(0)			IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	E SURVEY
			A. BUILDING	G		
		345351	B. WING			С
		345351	B. WING			5/16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL)E	
AUTUMN	CARE OF SALUDA			501 ESSEOLA CIRCLE		
	1			SALUDA, NC 28773		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From page	<u>e 6</u>	F 58	80		
1 000	_		F Jo	80		
		4 at 10:27 AM with the NP when she was coming down				
		topped her and told her				
		g with Resident #1's leg.				
		2 told her when she (NA #2)				
		Resident #1 she yelled, and				
		n (NA #2) attempted to push				
	her in the wheelchair	When she assessed				
	Resident #1, she yell	ed and guarded her left leg				
		She ordered a STAT hip x-ray				
		and decreased range of				
		ere was a delay from the				
		ne NP was not notified of the				
	-	fied her on 4/26/24 of the				
		a fracture to the left hip and				
		lity to send Resident #1 to hat had she known there				
		ray she would have sent				
		e ER sooner. The NP stated				
		Id her about the fall when				
		esident #1's pain on 4/25/24.				
		led that had she known				
		fall she would have sent				
	Resident #1 directly t	to the ER. The NP could not				
	say for certain that th	e delay in care would have				
	changed the outcome	e for Resident #1. She stated				
		ed the STAT x-ray, she				
		pleted in the evening of				
		ad left for the day. She				
		if there was a delay in				
		-ray she expected to be				
	was taking antiplatele	via phone call. Resident #1				
	was taking antipiatele					
	An interview on 5/7/2	4 at 4:07 PM with the				
		DON) revealed that on				
		ad taken Resident #1 into				
		at #1 slid down with the help				
	1					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · ·	E SURVEY PLETED
			A. BUILDI	ING	G		
		345351	B. WING				C
		345351	D. WING			05	/16/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF SALUDA				501 ESSEOLA CIRCLE		
					SALUDA, NC 28773		1
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 580	Continued From page	e 7	Í F	58	80		
		shower room and NA #2		00			
		was ok. She stated that NA					
#1 and NA #2 moved Resident #1 back into her wheelchair without having a Nurse assess her.							
		hower room and neither NA					
	#1 nor NA #2 told any	yone. On 4/25/24 NA #2 was					
		to Resident #1 then she got					
	Resident #1 up into h	er wheelchair to take her to					
	the small dining room	n and as NA #2 started to					
	push Resident #1 out						
	wheelchair she notice						
		usted Resident #1's foot and					
		problem. NA #2 got the NP					
		ess Resident #1. The NP					
		1 and ordered a STAT hip					
		ain and decreased ROM. ng about the fall on 4/24/24					
	at this point to anyone	•					
		DON was reviewing the					
		ous day and she inquired					
		for Resident #1. The Unit					
	-	r there were no results and					
	-	. As the Unit Manager was					
		x-ray unit company had					
		to take the x-ray for Resident					
		were given to the NP and					
		ow how this happened. The					
		was looking into what					
		ive orders to send Resident					
	#1 out to the ER for fu						
		investigation on 4/26/24					
		iewed NA #2, NA #2 then					
	-	Resident #1's fall in the					
		/24. The DON further					
		T orders should be fulfilled					
		they had not been the Nurse					
	-	N or the Provider and the					
		t been completed and the					
	RP that there had bee	en a change in condition					

Facility ID: 922956

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/10/2024 MAPPROVED). 0938-0391
STATEMENT (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER 345351		. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, 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-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	8	F 580				
	Medical Director revenotified first and then The MD stated that the for unknown pain and He stated that NA #1 informed the facility a have wanted Residen moved. The MD state the delay in notification outcome. He stated to to inform him about the order. The MD stated have sent Resident # since they were cominibut that was a decision not the staff. Residen medication. An interview on 5/8/24 Administrator reveale communicate to the F was a delay in a STAT The Administrator was Jeopardy on 5/8/24 at The facility provided to accomplished for thos been affected by the output to the The facility failed to me	she called him immediately. In P then ordered an x-ray decreased range of motion. and NA #2 should have bout the fall, and he would it #1 assessed before being ed that he did not feel that on had altered Resident #1's hat he expected the facility he delay in the STAT x-ray that he probably would not 1 to the ER for a hip x-ray on for the Provider to make t #1 was taking antiplatelet 4 at 1:49 PM with the d he expected staff to Provider and the RP if there T order. s notified of Immediate t 4:41 PM. he following corrective al of Immediate Jeopardy e of 5/4/24.					

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	-	D HUMAN SERVICES					FORM): 06/10/2024 MAPPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		345351	B. WING			_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER		- 1	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				5	01 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA			S	ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	x-ray order on 4/25/24 failed to notify a Nurse #1 fell on 4/24/24 and moving Resident #1 or informed the NP on 4, having issues with he did not notify the NP or performed an assess bruising or swelling w x-ray and changed so times daily for pain. F on 4/25/24 and notifie would not be able to or 4/26/24. Floor nurse stat x-ray. Director of re-educated floor nurse notification of MD for X-ray results revealed 4/26/24. Facility notifi received orders to ser on 4/26/24 for evaluate 2. Address how the far residents having the p the same deficient pra Director of Nursing an education on 4/26/24 licensed nurses and C on notification to MD/ or falls and accidents, designee completed of 5/3/24 with all license staff on notification to x-rays orders. Intervie determine if any issue	ere was a delay in a stat 4. C.N.A. #1 and C.N.A #2 e/MD or NP when Resident failed to notify before off the floor. C.N.A. #2 /25/24 that Resident #1 was r foot dragging. C.N.A #2 of the fall on 4/24/24. NP ment on Resident #1, no as noted. NP ordered stat heduled Tylenol to three Radiology contacted facility d the floor nurse that they obtain the stat x-ray until did not notify NP of delay in 7 Nursing and/or designee se on 5/3/24 on proper any delay in stat orders. 4 acute fracture of left hip on ied Nurse Practitioner and nd resident to the hospital tion and treatment. acility will identify other botential to be affected by actice. nd/or designee completed and on 5/3/24 with all CNA's including agency staff NP and RP of all incidents . Director of Nursing and/or education on 4/26/24 and d nurses including agency MD/NP on delay of stat ews were conducted with ents on 4/29/24, 5/2/24 and ws were conducted to	F	580				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 06/10/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING			_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF SALUDA				01 ESSEOLA CIRCLE ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	checks on all resident were completed to en injury from an unrepor findings were noted. Nursing checked for a and there were none. 3. Address what mea or systemic changes in deficient practice will in The Director of Nursin 4/26/24 educated 100 nurses including agen incidents and acciden and change in condition practitioner. New hire educated with the ont 5/2/24 through 5/3/24 their designee educat staff including agency accidents and inciden of Nursing and/or theil licensed nurses includo orders and procedure notification to physicial orders or other chang residents. 4. Indicate how the far performance to make sustained. The facility made the QAPI committee mee our investigation into the	managers completed skin s on 4/26/24. Skin checks sure there were no signs of rted fall, no negative On 4/26/24 Director of any other stat x-ray orders asures will be put into place made to ensure that the not recur. ag and/or their designee on % C.N.A.'s and licensed acy staff on reporting of ts and reporting protocols on to physician or nurse as to the facility are boarding procedures. On Director of Nursing and/or ed all C.N.A.'s and licensed staff on reporting of ts. On 4/26/24 the Director r designee educated all ding agency nurses on stat s. This education included an or NP on a delay of stat es of condition for the acility plans to monitor its sure that solutions are decision to have an ad hoc ting on 5/3/24 as a result of the incident. It was the	F	580				

Facility ID: 922956

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/10/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING			_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF SALUDA				01 ESSEOLA CIRCLE ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	obtain copies of new a NP. Director of Nursi audit results daily for for x-rays are completed notified of this process Director of Nursing and audit change of condit daily for 12 weeks to of incidents/accidents completed. Director of Nursing and daily huddles with liced beginning and end of in condition or incident throughout the shift in notifications have beet that MD/NP have beet Results of the audits of the QAPI committee of Nursing and/or their of as needed for three of Corrective action will The facility alleged a	12 weeks. nd/or their designee will and stat x-ray orders from ng and/or their designee will 12 weeks to ensure order ted as ordered. NP was s on 5/3/24. nd/or their designee will tion and incident reports ensure physician notification and falls has been nd/or designee will have ensed nurses and C.N.A.'s at shift to discuss any change that may have occurred order to ensure proper en made. This is to ensure n notified of any incidents. will be presented monthly to meeting by the Director of lesignee for review/revision nonths. be completed: May 4, 2024 IJ removal date of 5/4/24.	F	580		DEFICIENCY)		
	5/16/24 and verified th acceptable corrective evidenced by facility of interviews. Review of dated 4/26/24, 5/2/24	plan was validated on he facility implemented an action plan on 5/04/24 as documentation and staff the in-service sign-in sheets , and 5/3/24 revealed all received education staff						

Facility ID: 922956

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	D: 06/10/2024 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345351	B. WING _			C 05/16/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF SALUDA			501	1 ESSEOLA CIRCLE		
AUTUWIN	CARE OF SALUDA			SA	ALUDA, NC 28773		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 580 F 600 SS=J	notification of incident reporting protocols an physician or nurse pra- facility staff revealed te education regarding the reporting protocol and to do when a resident of the fall. Review of the dated 4/26/24 through completed as outlined plan with no concerns Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the in neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemit treat the resident's me §483.12(a)(1) Not use physical abuse, corpor involuntary seclusion; This REQUIREMENT by: Based on observation Nurse Practitioner, an interviews, the facility right to be free from n disregarded Resident	is and accidents and d change in condition to actitioner. Interviews with they received in-service the facility's incident d were able to verbalize what t had a fall and who to notify the facility's monitoring tools of 5/16/24 revealed they were d in the corrective action is identified. Neglect m Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or f is not met as evidenced n, record review, and staff, d Medical Doctor failed to protect a resident's eglect when staff #1's plan of care and nt without the use of a total	F 5		Past noncompliance: no plan of correction required.		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/10/2024 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		-	(X3) DATE COMP	SURVEY LETED
		345351	B. WING				C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		- I	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 ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	to the floor. The follow Nurse Practitioner wa #1 due to her left foot x-ray results revealed hip. On 4/28/24 Resit to repair the left hip fr #1 was discharged fro care and Resident #1 Findings included: This tag is crossed re Based on observation Nurse Practitioner, ar interviews, the facility resident from the toile one staff member use mechanical lift instead resulting in the reside 3 sampled residents r (Resident #1). On 4/2 transferred Resident is to stand mechanical lii indicated the resident mechanical lift, Resid NA #1 had to lower R #1 requested help fro assisted Resident #1 mechanical lift. Trans using the total mecha from two people. On 4 the Nurse Practitioner foot dragged the floor asked for her to asses	er Resident #1 was assisted wing day (4/25/24) the s asked to assess Resident dragging on the floor and an acute fracture of the left dent #1 underwent surgery acture. On 5/1/24 Resident on the hospital to hospice expired on 5/2/2024. ferred to F 689. a, record review, and staff, ad Medical Doctor failed to safely transfer a t to the shower chair when	F 60	0			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 06/10/2024 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_	05/ [.]	_ 16/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
			5	01 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA		s	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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	(immediate) x-rays or STAT x-ray results for acute fracture of the k Nursing (DON) notifie Resident #1 to be ser further evaluation and Resident #1 underwe hip fracture. On 5/1/2 discharged from the h Resident #1 expired of The Administrator was Jeopardy on 5/8/24 at The facility provided t action plan with a con 1. Address how corre accomplished for thos been affected by the of The facility failed to tr manner which resulte Resident #1 was supp using a total lift and w with a sit to stand whe # 1 requested help fro C.N.A.'s transferred th her chair without the of X-ray was obtained of fracture of left hip, fac Practitioner and order resident to the hospita treatment. Immediate Unknown Origin was Director of Nursing co C.N.A. #2 which confi	sident #1 and ordered STAT a 4/25/2024. On 4/26/24 c Resident #1 revealed an eff hip. The Director of ed the NP who ordered at out to the hospital for d treatment. On 4/28/24 nt surgery to repair the left 24 Resident #1 was hospital to hospice care and on 5/2/2024. s notified of Immediate t 4:41 PM. he following corrective npletion date of 5/4/24. ective action will be se residents found to have deficient practice. ansfer resident #1 in a safe d in a left hip fracture. posed to be transferred /as transferred by C.N.A #1 en the fall occurred. C.N.A. om C.N.A. # 2. Both he resident from the floor to use of the proper lift. n 4/26/24 which revealed	F 600				

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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 ___ С 345351 B. WING 05/16/2024 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 600 Continued From page 15 F 600 C.N.A #1 in returning resident to chair. CNA #1 is no longer permitted to work at the facility, CNA #2 has been terminated. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing and/or designee completed interviews with communicative residents on 4/26/24, 5/2/24 and 5/3/24 regarding care and services provided to identify any other injury of unknown origin. No other issues were identified. Unit managers completed skin check on all residents on 4/26/24 to ensure there were no signs or symptoms of injury noted, no negative findings were noted. Current lift status was obtained from the therapy department. Unit managers cross-referenced the lift status to the Kardex and Care Plans. 3. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing and/or their designee on 4/29/24 educated 100% C.N.A.'s and licensed nurses on safe transfers, reporting of incidents and accidents and reporting protocols. Agency staff will be educated prior to the first shift working on proper lifts, facility policies, and reporting all incidents and changes in condition. New hires to the facility are educated with the onboarding procedures. On 5/2/24 through 5/3/24 Director of Nursing and/or their designee educated all C.N.A.s and licensed staff on lift competencies and transfers and proper use of the lift, with return demonstration by the licensed staff and C.N.A.'s, reporting of accidents and incidents, following the Kardex for proper transfers and change in condition. On 5/2/24

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922956

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PRINTED: 06/10/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/10/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING			_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
AUTUMN	CARE OF SALUDA				01 ESSEOLA CIRCLE ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	designee educated al neglect, definition of a policy for reporting. S has no tolerance for a in immediate terminat and/or their designee abuse/neglect policy, consequences of abu staff will be educated Nursing and/or their d 4. Indicate how the fa performance to make sustained. The facility made the QAPI committee mee our investigation into decision of the QAPI of monitoring of this defi 5/6/24 for a period of To monitor ongoing co Nursing and/or their d observations of five (6 weeks to ensure residu utilizing lifts are received Unit Mangers will select the next 12 weeks that compare therapy lift s plan and Kardex to er	rector of Nursing and/or their I facility staff on abuse and abuse/neglect and facility staff educated that facility abuse/neglect and will result ion. Director of Nursing educated agency staff on reporting and se/neglect on 5/3/24. New upon hire by the Director of lesignee. cility plans to monitor it sure that solutions are decision to have an ad hoc ting on 5/3/24 as a result of the incident. It was the committee to begin cient practice beginning on 12 weeks. ompliance the Director of lesignee will complete 5) residents per week for 12 dents requiring assist ving the proper transfer. ect 5 residents weekly over at currently use a lift and tatus to the current care nsure accuracy. their designee will audit five bers weekly times 12 they understand the ect and the reporting se/neglect.	F	600				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 06/10/2024 MAPPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			· /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345351	B. WING			_		 16/2024	
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
	CARE OF SALUDA			5	501 ESSEOLA CIRCLE				
Actonin			SALUDA, NC 28773						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	responsible parties per ensure that no abuse, Results of the audits of the QAPI committee r Nursing and/or their d as needed for three m Completion date: May The facility alleged a l The Corrective Action 5/16/24 and conclude implemented an acce on 5/4/24. Interviews agency staff, revealed education and training transfers that included assistance for all tran- identifying a resident's and lift identifying tag training. Additionally, facility staff were educ abuse/neglect policy, consequences of abu interviewed all verbali performing a mechan receiving re-education regarding the facilities Review of the monitor transfers that began of weekly for the next 12 outlined in the correct concerns identified.	 v 5 alert residents and 5 er week for 12 weeks to 'neglect is occurring. will be presented monthly to neeting by the Director of esignee for review/revision nonths. v 4, 2024 J removal date of 5/4/24. plan was validated on d the facility had ptable corrective action plan with nursing staff, including d the facility had provided g on use of mechanical lift d requiring two-person sfers, using the proper lift, s lift status on the Kardex, on the door, and gait belt agency staff along with all cated on the facilities reporting and se/neglect on 5/3/24. Staff zed they were observed 		600		JEFICIENCY)			
F 684 SS=J	Quality of Care CFR(s): 483.25		F	684					

Event ID: PSLW11

Facility ID: 922956

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY			
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	· · · ·	MPLETED			
						С			
		345351	B. WING			5/16/2024			
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO					
				501 ESSEOLA CIRCLE					
AUTUMN	CARE OF SALUDA			SALUDA, NC 28773	SALUDA, NC 28773				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE			
F 684	Continued From page	e 18	F 68	.4					
	§ 483.25 Quality of ca								
		ndamental principle that nt and care provided to							
		ed on the comprehensive							
	•	dent, the facility must ensure							
		treatment and care in							
	accordance with profe	essional standards of							
		nensive person-centered							
	care plan, and the res	sidents' choices.							
		is not met as evidenced							
	by:								
		iew and Medical Doctor		Past noncompliance: no pla	an of				
	(MD), Nurse Practitio			correction required.					
	-	failed to assess Resident							
		fall and prior to getting her ally, the facility failed to							
		ediate) order for x-ray was							
		delayed care. On 4/24/24							
		ransferred Resident #1 from							
	her bed to the sit to s	tand lift and transported							
	Resident #1 to the sh	ower room. During a							
		r room from the toilet to the							
		ent #1's foot slipped and NA							
		dent #1 to the floor. NA #1 from NA #2. NA #1 and NA							
		Nurse that Resident #1 had							
	fallen. An assessmen								
		e prior to Resident #1 being							
		ne NP placed a STAT order							
		00 PM. The facility was							
		as a delay in the STAT x-ray							
		e NP. The results of the							
	-	on 4/26/24 at 11:38 AM when							
		ig (DON) notified the NP of							
		ent Resident #1 to the							
	_	condition report indicated pain and the final x-ray							
	noted a fracture of Re								

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/10/2024 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345351	B. WING			_		C 16/2024
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, ST	ATE, 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		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	disease, mild protein- infarction (a disruption severe vascular deme unsteadiness on feet, mobility, reduced mot coordination. An Activity of Daily Liv revised 03/08/24, reve ADL self-care perform mobility, weakness, p (scarring of the tempo polymyalgia rheumatic disorder that causes r Included was an intern #1 required a total me two-person assistance The quarterly Minimum 03/25/24 assessed Re impairment in cognitic the upper and lower e required total dependent with bed mobility (roll transfers, and tub/sho took antiplatelet and h and had no previous f A phone interview on #1 (agency) revealed	cted 1 of 3 residents. hitted to the facility on ses that included Alzheimer's calorie malnutrition, cerebral n of blood flow to the brain), entia, history of falling, abnormalities of gait and bility, and lack of ving (ADL) care plan, last ealed Resident #1 had an hance deficit related to ain, temporal sclerosis bral lobe of the brain), ca (an inflammatory muscle pain and stiffness). vention that noted Resident echanical lift with a sling and e for all transfers. m Data Set (MDS) dated esident #1 with severe on and had no impairment of extremities. Resident #1 ence on staff assistance left and right), toilet ower transfers. Resident #1 hypoglycemic medications	F	684		DEFICIENCY)		
	worked at the facility f	-						

Facility ID: 922956

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &					FORM	: 06/10/2024 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
	345351	B. WING		_	05/ [,]	; 16/2024
NAME OF PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN CARE OF SALUDA			01 ESSEOLA CIRCLE ALUDA, NC 28773			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Resident #1's room. Resident #1 from he proceeded to the sh Resident #1 on the Resident #1 off the Resident #1 off the Resident #1's foot s Resident #1 to the f sit to stand mechan was lowered to the stepped out into the from NA #2. NA #2 explained what hap replied that Residen sometimes. NA #1 a 2-person physical a the floor to her when not called a Nurse to because NA #1 did to the floor qualified shower she told Nur did not tell her about and lowering her to A phone interview o #2 revealed that on resident's room whe hall and asked her t When she entered t Resident #1 sitting of She asked NA #1 w stated that Resident mechanical lift. She was alright and NA Resident #1, grabbe their arms under Re into a wheelchair ar room. NA #2 stated	hanical lift and went to NA #1 stated she transferred er bed with the sit to stand lift ower room where she placed toilet. She then transferred toilet with the sit to stand lift, lipped, and she lowered loor using the sling from the ical lift. Once Resident #1 floor, NA #1 stated she hallway and called for help came to help NA #1. NA #1 pened to NA #2 and NA #2 it #1 yelled like that and NA #2 then performed a ssist to get Resident #1 up off elchair. NA #1 stated she had to assess Resident #1 not think lowering Resident #1 as a fall. She stated after the rse #1 about the yelling but t Resident #1's foot slipping	F 684				

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	-	D HUMAN SERVICES					FORM	06/10/2024 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE COMP	LETED
		345351	B. WING			_	(05/	C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•••	
				50	01 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA			S	ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	#2) had not thought of that if she thought Re- she would have gotte #2 revealed that she H falls being defined as moving downward, dr by a resident. She sta told her nurse and hav before she was move not tell the NP about f the previous day beca the foot drag with the A phone interview on Nurse #2 revealed he assigned nurse on 4/2 NA #2 had mentioned Resident #1's fall. He interactions with Resi displayed no signs or room and later on in r stated that his next sh got report from the off waiting on a hip x-ray Resident #1. When th received on 04/26/24 #1 had a hip fracture, emergency room (ER An interview on 5/7/22 revealed that she was related to Resident #1 stated that she worke not Resident #1's ass revealed that neither h to her and spoke to he	n to the floor and she (NA f that as a fall. She stated sident #1 had fallen harder, n a nurse immediately. NA had received education on any descent (action of opping or falling) to the floor ated that she should have d her assess Resident #1 d. She stated that she did the incident in the shower ause she had not associated shower room incident. 5/8/24 at 10:32 AM with was Resident #1's 24/24 and neither NA #1 nor anything to him about e stated that during his dent #1 on 4/24/24 she symptoms of pain in the day esident #1's room. He hift was on 4/26/24 and he f going nurse that they were to be completed for he x-ray results were and revealed that Resident she was sent out to the). 3 12:06 PM with Nurse #1 s not involved in the incident I's fall on 04/24/24. She d on 4/24/24, but she was igned nurse. She further NA #1 nor NA #2 had come er about Resident #1.	F	684				
	A phone interview on	5/7/24 at 12:54 PM with						

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	-	D HUMAN SERVICES					FORM): 06/10/2024 MAPPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	LETED
		345351	B. WING			_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF SALUDA				01 ESSEOLA CIRCLE			
	1			S	ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Nurse #3 revealed sh 4/24/24 the day of the the day after the incid first thing in the morni Resident #1's room at back. Resident #1's v She stated that Resid seemed fine. She sta NA #2 got Resident # wheelchair, NA #2 rep decrease in range of and informed the NP. assessed Resident # stated she received n morning of 4/25/24 of shower room the prev Resident #1 had not of symptoms of pain like grimacing, or guarding see the x-ray staff cor Record review of the document by Nurse # in part: Resident #1 w change in condition. obtained and within n received anticoagular changes in mental or #1 displayed signs/sy order was received fo of the left hip for decre pain. An interview on 5/7/24 revealed on 4/25/24 v the hallway, NA #2 sta something was wrong She stated that NA #2	e was not working on e incident but was working ent on 4/25/24. She stated ng (4/25/24) she went into nd she was lying flat on her ital signs and they were fine. ent #1 was talking, and she tted that around noon when 1 up and put her in her borted she noticed a motion in Resident #1's leg The NP immediately 1 and ordered an x-ray. She o mention in shift report the Resident #1's fall in the rious day. She stated that displayed any signs or e yelling, moaning, g. She stated she did not me during her shift. Change in Condition 3 dated 04/25/24 revealed vas assessed due to a	F	684				

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	S FOR MEDICARE &						NO. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		TRUCTION		ATE SURVEY		
010101	CONTRECTION		A. BUILDIN	NG					
		0.15054				С			
		345351	B. WING			05/16/2024			
IAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CO	JDE			
	CARE OF SALUDA			501 ESS	SEOLA CIRCLE				
				SALUD	DA, NC 28773				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF				
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	<	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLETIO DATE		
F 684	Continued From page	23	F 6	684					
	her leg dragged wher	n (NA #2) attempted to push							
	0 00	When she assessed							
		ed and guarded her left leg							
		he stated that Resident #1							
	was normally up in he	er wheelchair with a very							
	calm personality, and	she was not herself that							
	day. The NP observe	ed no bruising when she did							
	a skin check. She or	dered a STAT hip x-ray to							
	the left hip for pain ar	nd decreased range of							
	motion (ROM) but the	ere was a delay from the							
	x-ray company and th	ne NP was not notified of the							
	delay. The DON noti	fied her on 4/26/24 of the							
	x-ray results showing	a fracture to the left hip and							
		ity to send Resident #1 to							
	the ER. She stated the	nat had she known there							
		ay she would have sent							
		e ER sooner. She stated							
	that NA #2 helped NA								
		all in the shower. The NP							
		l not told her about the fall							
		to Resident #1's pain on							
		revealed that had she							
		nt #1's fall she would have							
		ctly to the ER. The NP could							
	•	at the delay in care would							
		tcome for Resident #1. She							
		ation with falls was very							
		nd this seemed like an that deviates from what is							
		expected). She stated that							
		e STAT x-ray, she expected							
		the evening of 04/25/24 after							
		ay. She further revealed that							
		obtaining the STAT x-ray							
	-	formed of the delay via							
		ed that when a STAT order							
	was placed for exam	ple in the morning, it should							

If continuation sheet Page 24 of 56

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/10/2024 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING			_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
A				5	01 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA			S	ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	in part: "Stat X-ray for left motion and pain dated "Tylenol Oral Table (Acetaminophen), give times a day for pain s Record review of the 14/26/24 at 11:28 AM refracture of left hip. Record review of the 1 record (MAR) for April acetaminophen was of per the physician's ord discharge to the hosp Review of Resident # 4/24/24 through 4/26/ documented as 0. Record review of the 2 2024 through April 20 assessments were connoted. An interview on 5/7/24 revealed that on 4/24/24 Resident #1 into the sed down with the help N/ agency. NA #1 called room and NA #2 askes She stated that NA #1 Resident #1 back into having a nurse assess shower room and neit anyone. On 4/25/24	 physician's orders revealed hip for decreased range of d 4/25/24 at 12:48 PM. et 325 milligrams (MG) e 650 mg by mouth three tarted on 4/25/2024. radiology report dated revealed there was an acute medication administration l 2024 revealed that the documented as administered der until Resident #1's ital. 1's daily pain scale from 24 revealed her pain was shower sheets from March 24 revealed skin ompleted with no concerns 4 at 4:07 PM with the DON 4/24 NA #1 that had taken shower. Resident #1 slid A #1 who was from an d NA #2 into the shower ed if Resident #1 was okay. 	F	584				

Facility ID: 922956

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	OF DEFICIENCIES	MEDICAID SERVICES	(Y2) MI !! T		STRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, í				MPLETED
			A. BOILDI				С
		345351	B. WING			0	5/16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				501 ES	SEOLA CIRCLE		
AUTUMN	CARE OF SALUDA			SALU	DA, NC 28773		
(X4) ID	SUMMARY ST	ID		PROVIDER'S PLAN OF COF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)		COMPLETIO DATE
F 684	Continued From page	e 25	F6	84			
	into her wheelchair to	o take her to the small dining					
	room and as NA #2 s	started to push Resident #1					
		r wheelchair she noticed					
		agging. NA #2 adjusted					
p		ld noticed there was a the NP and asked her to					
		The NP assessed Resident					
		AT hip x-ray for increased					
		ROM. NA #2 said nothing					
	about the fall on 4/24	/24 at this point to anyone.					
		rning meeting the DON was					
	-	from the previous day and					
		e x-ray order for Resident er told her there were no					
		d look into it. As the Unit					
	Manager was looking						
		at the facility to take the					
	x-ray for Resident #1	The x-ray results were					
	0	he NP wanted to know how					
		The DON stated that she					
	-	t happened, the NP gave					
		ent #1 out to the ER for d treatment. The DON then					
		on with the Administrator and					
		an for an injury of unknown					
		vestigation on 4/26/24, NA					
	#2 told the DON about	ut Resident #1's fall in the					
		/24. The DON notified the					
		ator and implemented risk					
		ealed that all STAT orders					
		hin 2 hours and if they had hould notify the DON or the					
		er had not been completed.					
	Record review of a p	rogress note dated 4/26/24					
		by the DON revealed in part:					
		IA #1 took Resident #1 to the					
		ng Resident #1 to the toilet					
	when her foot came of	our the sit to stand	1	1			1

If continuation sheet Page 26 of 56

DEPARTMENT OF HEALTH AN						FORM	06/10/2024 APPROVED
CENTERS FOR MEDICARE & N STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
	345351	B. WING _			_	(05/	C 16/2024
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
			50	1 ESSEOLA CIRCLE			
AUTUMN CARE OF SALUDA			S/	ALUDA, NC 28773			
PREFIX (EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
the resident to the floor NA #2 to assist with R NA #2 transferred Res noted resident was un while being wheeled. making another attem notified the NP that so Resident #1. NP order hip related to decrease results of x-ray were m noted an acute fractur intertrochanteric regio and order received to ER for further evaluati #1 had remained at he was currently at the ho An interview on 5/8/24 Medical Director revea notified first and then s He stated that the NP unknown pain and ded He stated that NA #1 a informed the facility at have wanted Resident moved. He stated that delay in care had alter He stated that he expen- him about the delay in stated that he probabl Resident #1 to the ER were coming the follow a decision for the Prov He further stated that completing it the day i hours. He stated if a re	I stated that she lowered or. Agency NA #1 called for esident #1. On 4/25/24 staff sident #1 to her chair and hable to hold her foot up After repositioning and pt, NA #2 immediately omething was wrong with ered a STAT x-ray of the left ed mobility and pain. Final eccived on 4/26/24. Results to of the left hip at the n. NP notified of results transfer Resident #1 to the ion and treatment. Resident er baseline. Resident #1 ospital. A at 10:00 AM with the aled that the NP was she called him immediately. then ordered an x-ray for creased range of motion. and NA #2 should have bout the fall, and he would t #1 assessed before being at he did not feel that the red Resident #1's outcome. ected the facility to inform in the STAT x-ray order. He y would not have sent c for a hip x-ray since they wing morning, but that was vider to make not the staff.	F 6	;84				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 06/10/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345351	B. WING			05/	C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				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 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 684	Continued From page	27	F 68	34			
	on 4/25/24. On 4/26// revealed that Resider that was when they had happened. The I investigated the incide NA #2 revealed Reside The NP ordered Reside hospital for further events stated this was a very they pride themselves communication. They Friday 4/26/24. He state communicate to the F in a STAT order and F Medical Director for a STAT orders. The Administrator was Jeopardy on 5/8/24 at provided the following a completion date of \$ 1. Address how correst accomplished for those been affected by the of The facility failed to have nurse after the fall and floor. The facility failed improper transfer the reported the resident dragging. On 4/25/24 notified by C.N.A. #2 her left foot. Nurse P assessment on reside	d that an x-ray was ordered 24 the results of an x-ray at #1 had a leg fracture and ad discovered something DON and himself ent. During the first interview lent #1 had a fall on 4/24/24. dent #1 to be sent out to the aluation and treatment. He r unusual incident because s on thorough started staff education that ated he expected staff to Provider if there was a delay be would have to defer to the n appropriate time frame for s notified of Immediate t 4:41 PM. The facility corrective action plan with 5/4/24. ective action will be se residents found to have deficient practice. ave resident assessed by a d prior to getting her off the					

Facility ID: 922956

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	-	D HUMAN SERVICES				FORM): 06/10/2024 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345351	B. WING		_	05/ ⁻	C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				501 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA			SALUDA, NC 28773			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					(X5) COMPLETION DATE	
F 684	pain. Radiology conta notified the floor nurse to obtain the stat x-ray did not notify NP of de Nursing and/or design on 5/3/24 on proper n delay in stat orders. > fracture of left hip on 4 Nurse Practitioner and resident to the hospita and treatment. Imm Injury of Unknown Ori Director of Nursing co C.N.A. #2 which revea and a conclusion on h C.N.A. #2 confirmed to floor in the shower roo C.N.A #1 in returning cannot return to the fa terminated from the fa residents having the p the same deficient pra Director of Nursing an interviews with comm 5/2/24 and 5/3/24 reg provided to identify an other injury of unknow were identified by resi assessments were co Unit Managers on 4/2 ensure there were no injuries related to incid No negative findings of	order to three times daily for acted facility on 4/25/24 and a that they would not be able y until 4/26/24. Floor nurse elay in stat x-ray. Director of nee re-educated floor nurse otification to MD for any K-ray results revealed acute 4/26/24. Facility notified d received orders to send al on 4/26/24 for evaluation ediate investigation for gin was initiated on 4/26/24. Inducted an interview with aled the incident on 4/24/24 now the fracture occurred. hat resident was on the om and C.N.A #2 assisted resident to chair. C.N.A #1 acility, CNA #2 has been acility.	F 684				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/10/2024 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING				C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	29	F 684				
		nsures will be put into place made to ensure that the not recur.					
	completed education licensed nurses on 4/ transfers, reporting of and reporting protoco This includes having a resident after all falls staff will be educated proper lifts, facility po- incidents and change the facility are educat procedures. On 5/2/2 Director of Nursing ar educated all C.N.A.s reporting of incidents definition of a fall. Ag prior to taking an assi Director of Nursing ar completed 100% edu- on stat orders. This notification to MD/NP	29/24 which included, safe incidents and accidents, ls and change in condition. a licensed nurse assess a and/or incidents. Agency prior to first shift working on licies, and reporting all in condition. New hires to ed with the onboarding 24 through 5/3/24 the nd/or their designee and licensed staff on and accidents and the pency staff were educated gnment. On 4/26/24 the nd/or their designee cation of all licensed nurses education included if stat order has been ses are educated on STAT					
		acility plans to monitor its sure that solutions are					
	QAPI committee mee our investigation into decision of the QAPI	cient practice beginning on					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/10/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				01 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA			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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	30	F 684				
	obtain copies of new a from NP. Director of designee will audit res- ensure orders for x-ra ordered. NP was not 5/3/24. Director of Nursing ar randomly audit five (5 12 weeks to monitor H incidents, falls and wh Results of the audits of the QAPI committee r Nursing and/or their of as needed for three r Corrective action will The facility alleged a The Corrective Action 5/16/24 and conclude an acceptable correct as evidenced by facili interviews. Review of dated 4/29/24 revealer received education th must be assessed by MD/provider must be Interviews with facility in-service education r protocol and were abl when a resident had a	sults daily for 12 weeks to bys are completed as ified of this process on ad/or their designee will b) staff members weekly for chowledge of reporting of that is considered a fall. will be presented monthly to meeting by the Director of lesignee for review/revision nonths. be completed: May 4, 2024 IJ removal date of 5/4/24. IJ removal date of 5/4/24. IJ removal date of 5/4/24. IJ removal date of 5/4/24. I plan was validated on d the facility implemented tive action plan on 5/04/24 ty documentation and staff the in-service sign-in sheets ed all staff/all departments at a resident that had a fall the nurse and the immediately notified. If staff revealed they received egarding the facility's fall e to verbalize what to do a fall and who to notify of the					
	additional education of	urses revealed they received on 4/29/24 regarding the s fall protocol and verbalized					

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE S	URVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPL	
					С	
		345351	B. WING		05/1	6/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
Δυτυμν	CARE OF SALUDA			501 ESSEOLA CIRCLE		
				SALUDA, NC 28773		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 31	F 68	4		
	they were to call the I	MD/provider immediately				
	-	ad a fall with or without injury				
	and regardless if the	resident was on the facility's				
		d 4/26/24 through 5/16/24				
		ompleted as outlined in the				
		with no concerns identified.				
	CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F 68	9		
	§483.25(d) Accidents					
	The facility must ensu					
		sident environment remains				
	as free of accident ha	azards as is possible; and				
	§483.25(d)(2)Each re	sident receives adequate				
	supervision and assis	stance devices to prevent				
	accidents.					
	This REQUIREMENT	is not met as evidenced				
		n, record review, and staff,		Past noncompliance: no plan of		
	Nurse Practitioner, ar			correction required.		
	-	failed to safely transfer a				
	resident from the toile	et to the shower chair when				
		d of the total mechanical lift				
	resulting in the reside	ent falling to the floor for 1 of				
		reviewed for accidents				
	, ,	24/24 Nurse Aide (NA) #1 #1 independently using a sit				
		ift. Resident #1's care plan				
	indicated the resident	t required use of a total				
		-person assistance. During				
		toilet to the sit to stand lent #1's foot slipped, and				
		esident #1 to the floor. NA				
		om NA #2 and they both				
	assisted Resident #1	off the floor without using a				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 06/10/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING			_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				5	01 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA			s	SALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	using the total mecha from two people. On 4 the Nurse Practitioner foot dragged the floor asked for her to asses not inform the NP of F The NP assessed Rea (immediate) x-rays on STAT x-ray results for acute fracture of the le Nursing (DON) notifie Resident #1 to be ser further evaluation and Resident #1 to be ser further evaluation and Resident #1 underwe hip fracture. On 5/1/2 discharged from the h Resident #1 expired of Findings included: Resident #1 was adm 12/11/22 with diagnos disease, mild protein- infarction (a disruption severe vascular deme unsteadiness on feet, mobility, reduced mot coordination. An Activity of Daily Liv revised 03/08/24, reve ADL self-care perform mobility, weakness, p (scarring of the tempo polymyalgia rheumatii disorder that causes r The care plan include	sfers continued without nical lift and assistance 4/25/24 NA #2 reported to (NP) that Resident #1's left when in a wheelchair and as the resident. NA #2 did Resident #1's fall on 4/24/24. sident #1 and ordered STAT a 4/25/2024. On 4/26/24 Resident #1 revealed an eft hip. The Director of d the NP who ordered at out to the hospital for I treatment. On 4/28/24 int surgery to repair the left eA Resident #1 was nospital to hospice care and on 5/2/2024.	F	689				

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			()(0)			10.0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
			A. BOILDIN		с		
		345351	B. WING		0	5/16/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ξ		
	CARE OF SALUDA			501 ESSEOLA CIRCLE			
AUTOMIN	CARE OF SALUDA			SALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE	
F 689	Continued From page	e 33	F 68	89			
		assistance for all transfers.					
0 in th	The quarterly Minimum Data Set (MDS) dated 03/25/24 assessed Resident #1 with severe						
	impairment in cognition and had no impairment of						
		extremities. Resident #1					
	• •	ence on staff assistance					
	with bed mobility (roll transfers, and tub/sho	ower transfers. Resident #1					
	•	hypoglycemic medications.					
	-	5/7/24 at 10:52 AM with NA that she was assigned to					
		wer only on 4/24/24 and had					
		for approximately one					
		ne gathered her items and					
	the sit to stand mecha	anical lift and went to NA #1 stated she transferred					
		bed with the sit to stand lift					
		wer room where she placed					
	Resident #1 on the to	ilet. She then transferred					
		ilet with the sit to stand lift,					
		oped, and she lowered					
		or using the sling from the al lift. Once Resident #1					
	was lowered to the flo						
		nallway and called for help					
		ame to help NA #1. NA # 1					
		ened to NA #2 and NA #2					
	replied that Resident	# I yelled like that Id NA #2 then performed a					
		ft to get Resident #1 up off					
		chair. NA #1 stated she had					
	not called a Nurse to						
		d Resident #1 had not fallen.					
		echanical lift pad, placed it transferred Resident #1 with					
		anical lift to the shower chair					
		er without further incident.					

Facility ID: 922956

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 06/10/2024 APPROVED 0: 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_	(05/	C 16/2024
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP 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 .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 689	Continued From page She stated that she tr to her wheelchair with lift and transported he stated after Resident i dayroom, she told Nu yelling but did not tell slipping from the mec lowered to the ground not received orientation transfers or lift equipm completed a checkoff also stated that she w access resident care i directions for resident Record review of the s revealed that Resident with no identified cond noted and was signed A phone interview on #2 revealed that on 4/ resident's room when hall and asked her to When she entered the Resident #1 sitting on She asked NA #1 wha stated that Resident # mechanical lift. She a was alright, and NA # was okay. She stated side of Resident #1, g placed their arms und her into a wheelchair #1 was supposed to u that Resident #1 "can	 a 34 ansferred Resident #1 back the sit to stand mechanical er to the dayroom. She #1 was transported to the rse #1 about Resident #1 her about Resident #1's foot hanical lift and being NA #1 stated that she had on or education on resident nent from the facility but had list with her agency. NA #1 vas not educated on how to plans and she followed staff care. shower sheet dated 4/24/24 at #1 was given a shower cerns and no skin issues by NA #1. 5/7/24 at 12:22 PM with NA 24/24 she was in another NA #1 came out into the come into the shower room. a shower room, she saw her bottom on the floor. at happened, and NA #1 stated that Resident #1 stated that Resident #1 d she and NA #1 got on each prabbed her by the pants, ler Resident #1's arms, lifted and then NA #2 left the ther revealed that Resident use a total mechanical lift but stand well" which was why 	F 689				
	shower room. She fur #1 was supposed to u that Resident #1 "can she chose to use the	ther revealed that Resident use a total mechanical lift but					

Facility ID: 922956

If continuation sheet Page 35 of 56

	-	D HUMAN SERVICES					FORM	0: 06/10/2024 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		345351	B. WING _			_	(05/	C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
					1 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA				ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	transfer Resident #1 p stated that the Kardez station with all resider as it being on the resi stated that she was R on 04/24/24 and she how to transfer Resid worked from 7:00 AM Resident #1 had not of symptoms of pain or of afternoon observation stated that she had not mechanical lift to get She stated that she p Resident #1 on 4/25/2 sit to stand lift to her v symptom of pain or di was not yelling, moan her leg. She stated th Resident #1 to the da noticed her foot dragg NP. She stated that she because she had not with the shower room A phone interview on Nurse #2 revealed he assigned nurse on 4/2 NA #2 had mentioned Resident #1's fall. He interactions with Resi displayed no signs or stated that his next sh got report from the off waiting for a hip x-ray Resident#1. When th received on 04/26/24	brior to the incident. She is located at the nurse's it's lift requirements as well dent's closet doors. She tesident #1's assigned NA had not instructed NA #1 on ent #1. She stated that she to 3:00. She stated that displayed any signs or discomfort during her as of her on 4/24/24. NA #2 of thought to use the Resident #1 off the floor. rovided incontinence care to 24, transferred her with the wheelchair with no signs or iscomfort and Resident #1 hing, screaming, or guarding hat when she went to take y room on 04/25/24, she ging and went and told the she did not tell the NP about ower the previous day associated the foot drag incident. 5/8/24 at 10:32 AM with was Resident #1's 24/24 and neither NA #1 nor anything to him about a stated that during his dent #1 on 4/24/24 she symptoms of pain. He hift was on 4/26/24 and he f going nurse that they were to be completed for	F	689				

Facility ID: 922956

If continuation sheet Page 36 of 56
		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/10/2024 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
AUTUMN	CARE OF SALUDA			01 ESSEOLA CIRCLE ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	revealed that resident		F 689				
	how to transfer the re was also posted in the contains individualize in a book at the nursin	sidents and the information e Kardex (NA guide that d care information) that was ng station desk.					
	guides revealed they what type of lift and h	Kardex and resident care contained information on ow many people to utilize e of lift were posted in the at the nurses station.					
	to a change in conditi obtained and within n received anticoagular changes in mental or #1 displayed signs/sy order was received for	-					
	revealed on 4/25/24 w the hallway, NA #2 stu something was wrong She stated that NA #2 had provided care to her leg dragged when her in the wheelchair. Resident #1, she yelle upon examination. S	4 at 10:27 AM with the NP when she was coming down opped her and told her g with Resident #1's leg. 2 told her when she (NA #2) Resident #1 she yelled, and a (NA #2) attempted to push When she assessed ed and guarded her left leg he stated that Resident #1 er wheelchair with a very					

Facility ID: 922956

If continuation sheet Page 37 of 56

	MENT OF HEALTH AN					FORM): 06/10/2024 MAPPROVED
STATEMENT (RS FOR MEDICARE & I OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMPI	LETED
		345351	B. WING			05/*	C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, ST	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 ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	calm personality, and day. The DON notifie x-ray results showing then she had the facil the ER. She stated th 4/24/24 when Resider shower. The NP state her about the fall whe Resident #1's pain on revealed that had she fall she would have set the ER. Record review of the F Resident #1 revealed - Tylenol Oral Tablet 3 (Acetaminophen), give times a day for pain s - STAT X-ray for left h motion and pain dated Record review of the F 4/26/24 at 11:28 AM r fracture of the left hip. An interview on 5/7/24 revealed that on 4/24/ Resident #1 into the s staff were given a "rut was necessary for can staff about the resider and told any nursing s questions they may have residents. She stated required 2-person ass Resident #1 was a tot	she was not herself that ed her on 4/26/24 of the a fracture to the left hip and ity to send Resident #1 to hat NA #2 helped NA #1 on nt #1 had the fall in the ed that NA #2 had not told on she was alerted to a 4/25/24. She further a known about Resident #1's ent Resident #1 directly to physician's orders for in part: 325 milligrams (MG) e 650 mg by mouth three tarted on 4/25/2024. ip for decreased range of d 4/25/24 at 12:48 PM. radiology report dated revealed there was an acute 4 at 4:07 PM with the DON /24 NA #1 that had taken shower. She stated agency indown" (information that re delivery) from all nursing ints they would be caring for staff was a resource for ave about giving care to the all total mechanical lifts sistance. She stated that tal lift for transfers and staff correct mechanical lift with	F 689				

If continuation sheet Page 38 of 56

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 06/10/2024 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		E CONSTRUCTION		(X3) DATE COMP	LETED
		345351	B. WING			_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF SALUDA				501 ESSEOLA CIRCLE SALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Medical Director reveaused the correct mech He stated that those in for the safety of the re- stated that if NA #1 ar incorrect mechanical have fallen and acquir that NA #1 and NA #2 facility about the fall, a Resident #1 assessed stated that the fall was #1's death. He stated fallen, she would not have she did not recover from An interview on 5/8/24 Administrator revealed DON will be reviewing ensure they have the safe patient care. His nursing staff use the of were care planned. H fall with major injury w followed the care plan- change of plane (an up position that results in ground or floor) that h considered a fall. On 5/8/24 at 2:24 PM and the Unit Manager with a 2-person assist #2. A green sling was brakes locked, the res- wheelchair; the lift bra- Resident #2 was mov	4 at 10:00 AM with the aled the staff should have nanical lift for Resident #1. Interventions were in place esidents and the staff. He had NA #2 had not used the lifts Resident #1 would not red a fracture. He stated is should have informed the and he would have wanted d before being moved. He is directly related to Resident I that if Resident #1 had not have fractured her hip, and ave needed surgery which om. 4 at 1:49 PM with the d going forward he and the g skills for all agency staff to required skills to provide expectation was that correct mechanical lifts that e stated that Resident #1's vas avoidable if staff had	F	689				

Facility ID: 922956

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345351 B. WING 05/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 501 ESSEOLA CIRCLE SALUDA, NC 28773 501 ESSEOLA CIRCLE SALUDA OF CORRECTION VX3) DATE SURVEY COMPLETED			ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/10/2024 MAPPROVED). 0938-0391
345351 B_WMG 05/16/2024 NUME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE or ESSECULA CIRCLE SALUDA, NC 28773 OPENDER PRETIX STREET ADDRESS, CITY, STATE, 2P CODE or ESSECULA CIRCLE SALUDA, NC 28773 Colspan="2">OPENDER PRETIX IPENDER SULUDA, NC 28773 Colspan="2">Continued From page 39 training upon hire and recently related to the proper use of a total mechanical, st-to-stand always to used 2-person assist. She further stated the nurses helped with 2-person assist total lift transfers if the NAs were busy. F 689 The Administrator was notified of Immediate Jeopardy on 5/8/24 at 4:41 PM. The facility provided the following corrective action plan with a complished for those resident ff in a safe manner which resulted in a left hip fracture. Resident #1 was suppoed to be transferre during a total lift and was transferred by C.N.A.#1 N.A. #1 requested help from C.N.A. #2. Both C.N.A. *1 requested help from C.N.A. #2. Both C.N.A. *1s transferre the resident ff in a safe manner which resulted in a left hip fracture. Resident #1 was subjected by the deficient practice. The facility notified Nurse Practitione of 4/224. The facility failed to transfer resident ff in a safe manner which resulted me and recorder. C.N.A. #1 requested help from C.N.A. #2. Both C.N.A. *transferre the resident ff in the safe manner which resulted in a left hip fracture. Resident #1 was usinibited of A/2/24. Image: Safe fracture of the proper lift. X-ray was obtalined to 4/26/24 with the revaluatin tresident to the	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
AUTUMN CARE OF SALUDA Sol ESSECIA CIRCLE SALUDA, NC 28773 PREEX TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH OPERCENT A CIRCUMPTING INFORMATION) IPREEX PROVIDER'S FLAN OF CORRECTION (EACH OPERCENT A CIRCUMPTING INFORMATION) IPREEX TAG DEVIDER'S FLAN OF CORRECTION (EACH OPERCENT A CIRCUMPTING INFORMATION) IPREEX PROVIDER'S FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF TO THE APPROPRIATE DEFICIENCY OPENCINC (EACH OPERCENT A CIRCUMPTING INFORMATION) IPREEX Taining upon hire and recently related to the proper use of a total mechanical, sit-to-stand lift, and use of gait belt when transferring a resident. She explained a total lift transfer was used for Resident #2 because he cannot bear weight and use a 1-person assist total lift transfers if the NAs were busy. F 689 F 689 The Administrator was notified of Immediate Jopardy on 5/6/24 at 4.41 PM. The facility provided the following corrective action plan with a completion date of 5/4/24. I. Address how corrective action plan with a completion date of 5/4/24. I. Address how corrective action plan with a completion date of 5/4/24. 1. Address how corrective action will be accompleted for those resident found to have been affected by the deficient practice. Image: the thing factor the second of the second of the top the top the top the top the top the transferred using a total lift and was transferred using a total lift and was transferred using a total lift was supposed to be transferred using a total lift and was transferred using a total lift not was transferred using a total lift was supposed to be transferred using a total lift was supposed to be transferred using a total lift was supposed to be transferred using a total lift and was transferented by C.N.A #1 with a sit to stand when the fall occurr			345351	B. WING		_		
SALUDA, NC 28773 SALUDA, NC 28773 (24) [D] PHEFIX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCIENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE FACECORD & PTULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCIES OF UNL RECOLLATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 39 training upon hire and recently related to the proper use of a total mechanical, sit-to-stand lift, She explained a total iff transfer was used for Resident #2 because he cannot bear weight and always to used 2-person assist ance, sit-to-stand was used when for resident that can bear weight and use a 1-person assist total lift transfers if the NAs were busy. F 689 The Administrator was notified of Immediate Jeopardy on 58/24 at 4.41 PM. The facility provided the following corrective action plan with a completion date of 54/24. F 689 1. Address how corrective action plan with a completion date of 54/24. 1. Address resident #1 in a safe maner which resulted in a left hip fracture. Resident #1 was supposed to be transferred using a total iff and was transferred using a total iff and was transferred using a total iff and was transferred using a total iff or the difference by CN A. #1 with a sit to stand when the fail occurred. CN A. # 1 requested hep from CN A. # 2. Both C. N.A: transferred the resident form the flor to her chair without the use of the proper lift. X-ray was obtained to resident to the hospital for further evaluation and treatment. Immediate investigation for injury of Unknown Origin was initiated on 4/26/24.	NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
Will Discrete Submary Statement or DEFICIENCES (Rec) DEFICIENCY WILL THE PERCENDE OF YILL RECULATORY OR LSC IDENTIFYING INFORMATION) Deficition (Rec) DEFICIENCY WILL THE PERCENDE OF YILL RECULATORY OR LSC IDENTIFYING INFORMATION) Deficition (Rec) CONSTRUCT ACTION BIOLOD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Optimity (Rec) CONSTRUCT ACTION (Rec) DEFICIENCY Optimity (Rec) CONSTRUCT ACTION (Rec) DEFICIENCY Optimity (Rec) CONSTRUCT ACTION (Rec) DEFICIENCY Optimity (Rec) CONSTRUCT ACTION (Rec) DEFICIENCY Optimity (Rec) DEFICIENCY F 689 Continued From page 39 training upon hire and recently related to the proper use of a total informal status of gait betwhen transferring a resident. She explained a total lift transfer was used for Resident #2 because he cannot bear weight and use of a person assist total infit transfers if the NAS were busy. F 689 The Administrator was notified of Immediate Jeopardy on 5/8/24 at 4:41 PM. The facility provided the following corrective action plan with a completion date of 5/4/24. I. Address how corrective action plan with a completion date of 5/4/24. I. Address how corrective action will be accomplished for those resident found to have been affected by the deficient practice. The facility failed to transfer resident #1 in a safe manner which resulted in a lift hip facture. Resident #1 was supposed to be transferred using a total lift and was transferred by C.N.A #1 with a sit to sand when the fail occurred, C.N.A #1 requested help from C.N.A #2. Both C.N.A's transferred the resident from the floor to her chair without the use of the proper lift. X-ray was obtained on 4/26/24.				ŧ	501 ESSEOLA CIRCLE			
Preprint TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREPR TAG CEACH OPERCETTIE ACTION BHOLD BE CROSS-REFERENCED To THE APPROPRIATE COMPLETION IDENTIFY F 689 Continued From page 39 F 689	AUTUMN	CARE OF SALUDA		5	SALUDA, NC 28773			
 training upon hire and recently related to the proper use of a total mechanical, sit-to-stand lift, and use of gait belt when transferring a resident. She explained a total lift transfer was used for Resident #2 because he cannot bear weight and always to used 2-person assistance; sit-to-stand was used when for resident that can bear weight and use a 1-person assistance; sit-to-stand was used with 2-person assist total lift transfer was used the nurses helped with 2-person assist total lift transfers if the NAs were busy. The Administrator was notified of Immediate Jeopardy on 5/8/24 at 4:41 PM. The facility provided the following corrective action plan with a completion date of 5/4/24. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to transfer resident #1 in a safe manner which resulted in a left hip fracture. Resident #1 was supposed to be transferred using a total lift and was transferred by C.N.A #1 with a sit to stand when the fallo occurred. C.NA. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help form C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help form C.N.A. # 2. Both C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A. # 1 requested help form C.N.A. # 2. Both C.N.A. # 1 requested help form C.N.A. # 2. Both C.N.A. # 1 requested help form C.N.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		COMPLETION
C.N.A. #2 which confirmed that resident was on the floor in the shower room and she assisted C.N.A #1 in returning resident to chair. CNA #1 is no longer permitted to work at facility, CNA #2	F 689	training upon hire and proper use of a total r and use of gait belt w She explained a total Resident #2 because always to used 2-pers was used when for re and use a 1-person a nurses helped with 2- transfers if the NAs w The Administrator was Jeopardy on 5/8/24 at provided the following a completion date of 8 1. Address how corre accomplished for thos been affected by the of The facility failed to tra- manner which resulte Resident #1 was supp using a total lift and w with a sit to stand whe # 1 requested help for C.N.A.'s transferred th her chair without the to X-ray was obtained of fracture of left hip, fac Practitioner and order resident to the hospita treatment. Immediate Unknown Origin was Director of Nursing co C.N.A. #2 which confit the floor in the showe C.N.A #1 in returning	A recently related to the mechanical, sit-to-stand lift, hen transferring a resident. lift transfer was used for he cannot bear weight and son assistance; sit-to-stand sident that can bear weight ssist. She further stated the person assist total lift ere busy. s notified of Immediate t 4:41 PM. The facility g corrective action plan with 5/4/24. ective action will be se residents found to have deficient practice. ansfer resident #1 in a safe d in a left hip fracture. bosed to be transferred vas transferred by C.N.A #1 en the fall occurred. C.N.A. om C.N.A. # 2. Both he resident from the floor to use of the proper lift. n 4/26/24 which revealed sility notified Nurse rs were obtained to transfer al for further evaluation and e investigation for Injury of initiated on 4/26/24. onducted an interview with irmed that resident was on r room and she assisted resident to chair. CNA #1 is	F 689				

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CENTER	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		FORM	0: 06/10/2024 APPROVED 0: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:				· /	LETED
		345351	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	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 689	residents having the p the same deficient pra Director of Nursing ar	acility will identify other potential to be affected by actice. nd/or designee completed	F 689				
	4/26/24, 5/2/24 and 5 services provided to in unknown origin. No c Unit managers compl residents on 4/26/24 t signs or symptoms of findings were noted. obtained from therapy	to ensure there were no injury noted, no negative Current lift status was / department. Unit enced the lift status to the					
	systemic changes ma deficient practice will The Director of Nursir 4/29/24 educated 100 nurses on safe transfe and accidents, report constitutes a fall, whic Director of Nursing ar educated agency staf facility policies, report accidents, change in constitutes a fall, whic New hires to the facili onboarding procedure and/or their designee Director of Nursing ar educated all C.N.A.s	not recur. Ing and/or their designee on 1% C.N.A.'s and licensed Iers, reporting of incidents Ing protocols, and what th is a change of plane. Ind/or their designee If on 5/3/24 on proper lifts, Ing all incidents and condition and what th is a change of plane. Ity are educated with the les by the Director of Nursing . On 5/2/24 through 5/3/24 Ind/or their designee and licensed staff on lift Insfers. Education also					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/10/2024 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF SALUDA			01 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 CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Staff were educated of and incidents, how to proper transfers, and condition with residen and/or designee educ prior to taking an assi completed return dem understanding and co 4. Indicate how the fa performance to make sustained. The facility made the QAPI committee mee our investigation into decision of the QAPI monitoring of this defi 5/6/24 for a period of To monitor ongoing co Nursing and/or their d observations of five (5 weeks to ensure resic receiving the proper to Unit Mangers will sele the next 12 weeks that compare therapy lift s plan and Kardex to er Results of the audits of the QAPI committee r Nursing and/or their d as needed for three m	licensed staff and C.N.A.'s. on how to report accidents understand the Kardex for how to report change of ts. Director of Nursing sated Agency staff on 5/3/24 gnment on the units and nonstration to ensure impliance with education. Accility plans to monitor it sure that solutions are decision to have an ad hoc ting on 5/3/24 as a result of the incident. It was the committee to begin cient practice beginning on 12 weeks. Oppliance the Director of lesignee will complete 5) residents per week for 12 lents utilizing a lift are ransfer. ect 5 residents weekly over at currently use a lift and tatus to the current care insure accuracy. will be presented monthly to neeting by the Director of lesignee for review/revision	F 689				

Facility ID: 922956

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							FORM	0: 06/10/2024 APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	LETED
		345351	B. WING _			_	(05/	C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF SALUDA				01 ESSEOLA CIRCLE ALUDA, NC 28773			
				3/	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page The facility alleged a l	42 J removal date of 5/4/24.	F 6	89				
F 726 SS=J	The Corrective Action 5/16/24 and conclude implemented an acce on 5/4/24. Interviews agency staff, revealed education and training transfers that included assistance for all trans- identifying a resident's and lift identifying tag training. Staff interview observed performing a after receiving reeduc monitoring tools of me began on 4/26/24 and next 12 weeks were of corrective action plan Competent Nursing S CFR(s): 483.35(a)(3)(§483.35 Nursing Serv The facility must have the appropriate compo- provide nursing and re- resident safety and at practicable physical, r well-being of each res- resident assessments and considering the n diagnoses of the facilit accordance with the fa at §483.35(a)(3) The faci- licensed nurses have	plan was validated on d the facility had ptable corrective action plan with nursing staff, including d the facility had provided g on use of mechanical lift d requiring two-person sfers, using the proper lift, s lift status on the Kardex, on the door, and gait belt wed all verbalized they were a mechanical lift transfer ation. Review of the echanical lift transfers that I continued weekly for the ompleted as outlined in the with no concerns identified. taff 4)(c) rices e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by a and individual plans of care umber, acuity and ty's resident population in acility assessment required	F 7	26				

If continuation sheet Page 43 of 56

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIE	PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	/PLETED
					С	
		345351	B. WING		0	5/16/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
A				501 ESSEOLA CIRCLE		
AUTUWIN	CARE OF SALUDA			SALUDA, NC 28773		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 726	Continued From page	- 12				
F /20	Continued From page		F 72	26		
	needs, as identified the assessments and de	hrough resident escribed in the plan of care.				
		oonood in the plan of oare.				
	§483.35(a)(4) Providi	ing care includes but is not				
	limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.					
1	§483.35(c) Proficienc	cv of nurse aides				
		ure that nurse aides are able				
	to demonstrate comp					
		y to care for residents'				
	needs, as identified the					
	This REQUIREMENT	escribed in the plan of care. Γ is not met as evidenced				
	by: Based on record rev	iew and staff interviews the		Past noncompliance: no plan	of	
		e all nursing staff, including		correction required.	01	
		d orientation to include the				
		are guides or the Kardex				
		t contains individualized				
	care information) and					
		nsfers and total and sit to viding care for the residents				
		4/24 Nurse Aide (NA) #1				
	-	#1 independently using a sit				
		lift. Resident #1's care plan				
		t required use of a total				
		-person assistance. During				
		toilet to the sit to stand				
		lent #1's foot slipped, and Resident #1 to the floor. NA				
		om NA #2 and they both				
		off the floor without using a				
	mechanical lift. Tran	sfers continued without				
	-	anical lift and assistance				
		4/26/24 x-ray results for				
		an acute fracture of the left				
	hip. The Director of I	Nursing (DON) notified the				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	: 06/10/2024 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
	345351	B. WING		_	05/ [,]) 16/2024
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
AUTUMN CARE OF SALUDA			01 ESSEOLA CIRCLE			
AUTUMIN CARE OF SALUDA			SALUDA, NC 28773			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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
 hospital for further ev 4/28/24 Resident #1 the left hip fracture. If discharged from the I Resident #1 expired of of 5 staff members resided Findings included: Record review of the 2/28/24 from the age transfers it stated the and it was marked as experience. There we to indicate knowledge Resident #1 was adm 12/11/22 with diagnost disease, mild protein- infarction (a disruption severe vascular dem falling, unsteadiness and mobility, other re- coordination. An Activity of Daily Li- revised 03/08/24, rev ADL self-care perform mobility, weakness, p (scarring of the tempor polyphagia rheumation that causes muscle polyphagia rheumation that cau	e 44 ident #1 to be sent out to the valuation and treatment. On underwent surgery to repair On 5/1/24 Resident #1 was hospital to hospice care and on 5/2/2024. This was for 1 eviewed for competency. competency checklist dated ncy for NA #1 revealed for e skill as "transfer patient" is previous training and vas no additional information e of using mechanical lifts. nitted to the facility on ses that included Alzheimer's -calorie malnutrition, cerebral in of blood flow to the brain), entia severe, history of on feet, abnormalities of gait educed mobility, and lack of transce deficit related to bain, temporal sclerosis oral lobe of the brain), c (an inflammatory disorder bain and stiffness). The care in intervention that noted a total mechanical lift with a assistance for all transfers.	F 726				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/10/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	CARE OF SALUDA			501 ESSEOLA CIRCLE			
AUTUMIN	CARE OF SALUDA			SALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 726	worked at the facility f month. She stated sh the sit to stand mecha Resident #1's room. N Resident #1 from her proceeded to the show Resident #1 on the to Resident #1 on the to Resident #1 off the to mechanical lift, Resid she lowered Resident sling from the sit to st Resident #1 was lowe stated she stepped out for help from NA #2. NA # 1 explained wha NA #2 replied Resider sometimes. NA #1 an two-person manual lift the floor to her wheeld mechanical lift pad, pl transferred Resident # mechanical lift to the shower without furthe transferred Resident # with the sit to stand m transported her to the she had not received resident transfers or lif facility but had comple agency. NA #1 also s educated on how to a the electronic health r located at the nursing unaware of the Karde guide, and she follow for resident care.	wer only on 4/24/24 and had for approximately one he gathered her items and anical lift and went to VA #1 stated she transferred bed with the sit to stand lift, wer room where she placed ilet. She then transferred ilet with the sit to stand ent #1's foot slipped, and and mechanical lift. Once ared to the floor using the and mechanical lift. Once ared to the floor, NA #1 at into the hallway and called NA #2 came to help NA #1. at happened to NA #2 and ht #1 yelled like that d NA #2 then performed a t to get Resident #1 up off chair. NA #1 got another aced it around Resident #1, #1 with the sit to stand shower chair and gave her a r incident. She stated she #1 back to her wheelchair echanical lift and dayroom. NA #1 stated orientation or education on ft equipment from the eted a check list with her stated that she was not ccess resident care plans in ecord nor that they were station, she was also x information, the care ed nursing staff directions	F 72				
	A phone interview on	5/7/24 at 12:22 PM with NA					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/10/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	CARE OF SALUDA			501 ESSEOLA CIRCLE			
AUTOWIN	CARE OF SALUDA			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-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From page #2 revealed that on 4, #1's assigned NA on 4 instructed NA #1 on h because NA #1 never she was familiar with use the care guides, a were located. A phone interview on Nurse #2 revealed he assigned nurse on 4/2 mentioned anything to asked about a care gu An interview on 5/7/22 revealed residents ha the door or in the resi to transfer the resider also posted in the Kar the nursing station de An interview was com PM with the Director of Scheduler. The Sche a packet from the stat competency check off Scheduler further reve background and wher the staffing agency, s competency check off questions about skill of agencies," to the DON any questions about still of agencies," to the DON any questions about still of agencies," to the DON any questions about skill of agencies," to the DON	 46 (24/24 she was Resident 4/24/24 and she had not ow to transfer Resident #1 asked her. She explained the Kardex system, how to and where each of those 5/8/24 at 10:32 AM with was Resident #1's 24/24 and NA #1 had not o him about Resident #1 or uide. 3 12:06 PM with Nurse #1 d a care guide posted on dent's closet regarding how its and the information was rdex that was in a book at sk. ducted on 5/8/24 at 12:12 of Nursing (DON) and the duler revealed she received fing agency with a skills f sheet for NA #1. The ealed she had no clinical in she received packets from he reviewed the skills f sheet and "just asked checkoff received from N or Unit Manager if she had he skills of agency staff. icheduler were shown NA y check off sheet and asked 	F 726	[
	DON responded the S	ent transfers" meant the Scheduler did what not know he Scheduler nodded her					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 06/10/2024 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
				501 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA			SALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 726	Continued From page	47	F 726				
	revealed that NA #1 (a orientation. She state "rundown" (basic reside including Kardex or ca facility staff about the caring for and told any resource for questions giving care to the resi she had the Schedule competency skills pap from the staffing agen not done a skills comp #1 prior to her providin An interview on 5/8/24 Administrator revealed reviewing skills for all have the required skill care. His expectation the correct mechanica planned. He stated Ra injury was avoidable in plan. The Administrator was Jeopardy on 5/8/24 at provided the following a completion date of 5 1. Address how correct accomplished for those been affected by this of The facility failed to en skills of C.N.A. #1 we care to Resident #1 a	s they may have about dents. She further revealed er review NA #1's berwork that was sent over icy, but she (DON) had had betency check off with NA ing resident care. 4 at 1:49 PM with the d he and the DON would be agency staff to ensure they ls to provide safe patient was that nursing staff use al lifts that were care esident #1's fall with major f staff had followed the care s notified of Immediate t 4:41 PM. The facility corrective action plan with 5/4/24. ective action will be se residents found to have deficient practice. hsure that the competency re verified prior to providing ind failed to ensure that					
	skills of C.N.A. #1 we care to Resident #1 a	re verified prior to providing					

Facility ID: 922956

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/10/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			-	(X3) DATE COMP	SURVEY LETED
		345351	B. WING				C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
AUTUMN	CARE OF SALUDA			501 ESSEOLA CIRCLE			
				SALUDA, NC 28773			0.(7)
(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 726	Continued From page	• 48	F 72	6			
	information for the car	re of Resident #1 prior to					
		nt #1 that resulted in a fall					
		I.A. #2 asked C.N.A. #1 nsfer Resident #1 needed					
		e the sit to stand lift for					
		r. Resident #1 was care					
	•	rred using a total lift, C.N.A. to utilize a sit to stand					
	which resulted in a lef						
		acility will identify other potential to be affected by					
	the same deficient pra	actice.					
		nd/or their designee on					
	facility licensed nurse	npleted education with s and C N A 's on lift					
		rn demonstration. Licensed					
		N.A.'s were educated on					
		y with return demonstration was also provided on where					
		C.N.A.'s can locate current					
	lift status on 5/3/24.						
	3. Address what mea	sures will be put into place					
		made to ensure that the					
	deficient practice will	not recur.					
	Director of Nursing ar	nd/or their designee					
	educated all licensed	-					
	uncluding agency staff guides.	on location of resident care					
	All new facility license	d nurses and C.N.A.'s will					
	receive education from	n the unit managers on the					
		nt care guides during their					
	orientation. Unit Man responsibility on 5/3/2	agers were notified of this 24.					
	All licensed nurses ar	nd C.N.A.'s from an agency					

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		MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
					С	
		345351	B. WING		0	5/16/2024
NAME OF PI	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE		DE	
AUTUMN CARE OF SALUDA				501 ESSEOLA CIRCLE		
				SALUDA, NC 28773		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 726	Continued From page	e 49	F 72	6		
		in prior to their first shift to				
		nd review facility policies.				
	This training is completed by the Director of Nursing and/or their designee. The nursing scheduler is responsible for scheduling agency staff for this orientation. The nursing scheduler notified the agencies on 5/3/24 of this					
		gency staff is now required to				
	read through facility policies and procedures					
		re which are located at each				
		Agency Orientation book. edge understanding of these				
	-	e Policy Acknowledgement				
		are required to complete lift				
		working, this is completed by				
		ng and/or their designee.				
		ng the agency to provide the h agency staff member for				
		ng. The Director of Nursing				
	and/or their designee will review the skills check					
		y have the skills to meet the				
	needs of our resident	ts.				
	The Director of Nursi	ng and/or their designee				
	completed lift compe	•				
	demonstration for all	licensed nurses and				
	C.N.A.'s and agency	staff on 5/3/24.				
	New hires will be edu	cated Director of Nursing				
	and/or designee on fa	8				
	competencies upon h	nire.				
	1 Indicate how the f	anility plana to manitar ita				
		acility plans to monitor its sure that solutions are				
	sustained.					
	The facility made the	decision to have an ad hoc				
	-					
	QAPT QUAIILY ASSULA	ance and Process				

Facility ID: 922956

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/10/2024 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE S COMPL	SURVEY LETED
		345351	B. WING			05/1) 16/2024
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT		00/	0/2024
10 4112 01 11				1 ESSEOLA CIRCLE	_, 0001		
AUTUMN	CARE OF SALUDA			ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 726	result of our investiga the decision of the Q/ monitoring of this defi 5/6/24 for a period of The Director of Nursir audit five (5) agency s C.N.A.'s, to the location residents. The Director of Nursir audit five (5) facility and for 12 weeks observing negative observations immediately. Results of the audits of the QAPI committee of Nursing and or their of revision as needed for Corrective action will The facility alleged a The Corrective Action 5/16/24 and concluded implemented an acce on 5/4/24. Interviews agency staff, revealed education and training transfers that included assistance for all tran- identifying a resident's and lift identifying tag training. Staff interview observed performing after receiving re-edu	tion into the incident. It was API committee to begin cient practice beginning on 12 weeks. Ing and/or their designee will staff, licensed staff and on of the care guides for the ang and/or their designee will nd agency C.N.A.'s weekly ng lift transfers. Any s will be corrected will be presented monthly to meeting by the Director of lesignee for review and/or r three (3) months. be completed: May 4, 2024 IJ removal date of 5/4/24. IJ removal date of 5/4/24. I plan was validated on the facility had ptable corrective action plan with nursing staff, including d the facility had provided g on use of mechanical lift d requiring two-person sfers, using the proper lift, s lift status on the Kardex, on the door, and gait belt wed all verbalized they were a mechanical lift transfer	F 726				

Facility ID: 922956

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				CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	MPLETED	
					С		
		345351	B. WING		05/16/2024		
NAME OF P	ROVIDER OR SUPPLIER			Ξ			
AUTUMN	CARE OF SALUDA			01 ESSEOLA CIRCLE ALUDA, NC 28773			
(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 PREFIX (EACH CORRECTIVE A)		ACTION SHOULD BE COM TO THE APPROPRIATE		
F 726	Continued From page	e 51	F 726				
	began on 4/26/24 an next 12 weeks were	d continued weekly for the completed as outlined in the with no concerns identified.					
F 867 SS=D		nent Activities	F 867			5/31/24	
	monitoring. A facility must establi policies and procedu collections systems, adverse event monito	feedback, data systems and ish and implement written res for feedback, data and monitoring, including oring. The policies and ude, at a minimum, the					
	systems to obtain an from direct care staff resident representation information will be us	r maintenance of effective d use of feedback and input , other staff, residents, and ves, including how such sed to identify problems that lume, or problem-prone, and rovement.					
	systems to identify, c information from all d not limited to the faci §483.70(e) and include	v maintenance of effective collect, and use data and lepartments, including but lity assessment required at ding how such information op and monitor performance					
	and evaluation of per	ology and frequency for such					
		/ adverse event monitoring, s by which the facility will					

Facility ID: 922956

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/10/2024 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345351	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
AUTUMN	CARE OF SALUDA			01 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 867	analyze and use data adverse events in the facility will use the data prevent adverse even §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implement policies ad (i) How they will use a determine underlying impacting larger syste (ii) How they will deven will be designed to effi level to prevent qualit safety problems; and (iii) How the facility wi of its performance imp ensure that improvem §483.75(e)(1) The fac performance improve high-risk, high-volume consider the incidence of problems in those a	 r, report, track, investigate, and information relating to facility, including how the ta to develop activities to ts. eystematic analysis and eility must take actions a improvement and, after ctions, measure its success, e to ensure that alized and sustained. eility will develop and deressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or Il monitor the effectiveness provement activities to tents are sustained. activities. eility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, 	F 867				

Facility ID: 922956

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 06/10/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>				(X3) DATE COMP	SURVEY LETED
		345351	B. WING			_	(05/	C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				5	01 ESSEOLA CIRCLE			
AUTUMN	CARE OF SALUDA			S	ALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	§483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activities distinct performance i number and frequenc conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sect §483.75(g) Quality as §483.75(g)(2) The qui assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under t resulting from drug re available data to make	nance improvement nedical errors and adverse vze their causes, and actions and mechanisms and learning throughout the of their performance s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). must include at least t focuses on high risk or identified through the data s described in paragraphs tion. sessment and assurance. ality assessment and reports to the facility's esignated person(s) ming body regarding its plementation of the QAPI ler paragraphs (a) through e committee must: ement appropriate plans of ified quality deficiencies; and analyze data, including the QAPI program and data gimen reviews, and act on	F	867				

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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 05/16/2024 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 867 Continued From page 54 F 867 Based on record reviews and staff interviews, the The Quality Assurance process was facility's Quality Assessment and Assurance re-evaluated by the Administrator and the (QAA) Committee failed to maintain implemented Director of Nursing on 5/31/2024 procedures and monitor interventions the regarding Abuse/Neglect. The committee put into place following the complaint Administrator and the Director of Nursing investigation survey conducted on 12/12/23. This reviewed the Federal Regulation F-867 failure was for one deficiency originally cited in **Quality Assurance and Performance** the area Free from Abuse and Neglect (F600) Improvement/Quality Assessment and that was subsequently recited on the current Assurance (QAPI/QAA) Improvement complaint investigation survey conducted on Activities and policy and procedure for QAPI on 5/31/2024. 05/16/24. The repeat deficiencies during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality On 5/17/2024 the Administrator and the Assessment and Assurance Program. Director of Nursing reviewed QAPI Committee meeting minutes from The findings included: December 2023 to present, to identify any additional monitoring that needed to occur This tag is cross referred to: regarding F-600. It was determined that monitoring from the 12/12/2023 complaint F600: Based on observation, record review, and was continuing through March 2024 with staff. Nurse Practitioner, and Medical Doctor no additional recommendations from the interviews, the facility failed to protect a resident's committee. As a result of the incident on 4/24/2024, the QAPI Committee right to be free from neglect when staff disregarded Resident #1's plan of care and implemented additional monitoring. This transferred the resident without the use of a total monitoring was put into place on 5/3/2024 mechanical lift and two-person assistance. and will continue for 12 weeks. The During the first transfer Resident #1 was assisted Director of Nursing and/or their designee to the floor. The following day (4/25/24) the educated all facility and agency staff on Nurse Practitioner was asked to assess Resident reporting of abuse/neglect on 5/2/2024 and 5/3/2024. #1 due to her left foot dragging on the floor and x-ray results revealed an acute fracture of the left hip. On 4/28/24 Resident #1 underwent surgery On 5/31/2024 the Administrator and the to repair the left hip fracture. On 5/1/24 Resident Director of Nursing were re-educated by #1 was discharged from the hospital to hospice the Regional Vice President of Operations care and Resident #1 expired on 5/2/2024. (RVPO)related to the requirements of F-867 QAPI/QAA Improvement Activities and policy and procedures for QAPI. During a complaint investigation survey conducted on 12/12/23, the facility failed to The RVPO and/or their designee will

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PRINTED: 06/10/2024

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345351	B. WING		05/16/2024		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
AUTUMN CARE OF SALUDA				01 ESSEOLA CIRCLE SALUDA, NC 28773			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 867	protect the resident's when a family member the resident's hands r left index finger. An interview on 05/16 Administrator and Dir revealed the Quality A Improvement (QAPI) The attendees include Medical Director, and Administrator stated t previous survey invol- was also a facility em and the survey of 05/ when two Nurse Aide incorrect mechanical and both were termin employees were term tolerance for abuse a made aware of this an education. The DON monitoring, and audit including agency and with stern emphasis of during the surveys. T two abuse incidents v	right to be free of abuse er pulled the TV remote from resulting in a fracture of the 6/24 at 3:30 PM with the ector of Nursing (DON) Assurance and Process committee met monthly. ed Department Heads, the I Pharmacist. The the deficiency from the ved a family member who uployee that was terminated 16/24 was related to neglect s (NA) chose to use the lift to transfer the resident, ated. He stated the ninated based on his zero nd neglect and all staff were nd received abuse stated education, s continued of all staff they have been spoken to on the concerns identified The Administrator stated the were not related and he ney of the 05/16/24 survey poor and/or lack of	F 867	complete a QAPI Audit Tool mor minimum of three months begin June 2024 to ensure systems ar processes continue to be monito follow-up is completed as requir Results of the audits will be pres monthly to the QAPI committee Administrator and/or their design review/revision as needed for th months. Completion Date: June 10, 202	ning in nd ored and ed. sented by the nee for ree		

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