| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345514 | A. BUILDING _____ B. WING _____ | C 12/20/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF NASH | 1210 EASTERN AVENUE PO BOX 157 NASHVILLE, NC 27856 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the complaint investigation survey of 12/20/12. Event ID# MOEI11. | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to keep a cold salad made with mayonnaise at or below 41 degrees Fahrenheit during operation of the trayline, failed to dispose of kitchenware with abraded surfaces, and failed to sanitize meal carts which were emptied in the kitchen after returning from dining rooms and resident care areas. Findings include:<br><br>1. At 12:20 PM on 12/18/12 the trayline was in operation, and there were three trays in an open cart upon which bowls of Cole slaw were being stored until being placed on resident trays.<br><br>At 12:22 PM on 12/18/12 a calibrated thermometer was used to check the temperature of three bowls of Cole slaw, one form each of the three trays where it was being stored. The thermometer registered 58 degrees Fahrenheit in one bowl, 59 degrees Fahrenheit in another, and 69 degrees Fahrenheit in another. At this time a dietary employee stated she started preparing the Cole slaw at 8:30 AM on 12/18/12, using | F 371 | This plan of correction will serve as compliance with requirements of 42 CFR, part 483, and Subpart B. Preparation and submission of the plan of correction is in response to HCFA 2567 for the survey and does not constitute an agreement or admission by Autumn Care of Nash of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Autumn Care of Nash contends that it was in substantial compliance with the requirements 42 CFR, Part 483, and Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, Autumn Care of Nash submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of 12/28/2011. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 1/3/12

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| AUTUMN CARE OF NASH | 1210 EASTERN AVENUE PO BOX 157 NASHVILLE, NC 27856 |

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| F 371 | Continued From page 1<br>chilled ingredients from the walk-in refrigerator. She reported the Cole slaw contained shredded cabbage, mayonnaise, salt, pepper, and sugar. According to the employee, she finished preparation of the slaw at 9:00 AM on 12/18/12, and placed the tray pan containing it in the walk-in refrigerator to chill. At 10:30 AM on 12/18/12 she stated the Cole slaw was placed in china bowls, and the bowls were transferred back into the walk-in refrigerator until the trayline began operation just prior to 12:00 noon on 12/18/12.<br><br>At 10:20 AM on 12/20/12 the dietary manager (DM) presented the trayline temperature log for review. It documented the 12/18/12 Cole slaw registered 41 degrees Fahrenheit when a calibrated thermometer was used to check temperature as the trayline began operation. The DM stated the Cole slaw served during the survey was prepared and served on the same day. However, she reported she was going to revise guidance on the preparation of cold salads to instruct dietary employees to prepare these salads containing mayonnaise the day before being served, with storage in the cooler. She commented staff was trained to keep these salads on ice during operation of the trayline.<br><br>At 10:55 AM on 12/18/12 a dietary employee stated the staff had been preparing colds salads the same day they were served, but they were supposed to store them in the walk-in refrigerator on ice. She commented the staff was instructed to only bring a tray of salad bowls out of the walk-in refrigerator at a time so the salads would not lose temperature before being placed on resident trays. | F 371 | For the residents affected and for the residents having the potential to be affected:<br>The coleslaw was removed from the tray line and cooled prior to continued service on 12/18/12.<br>Compromised small wares were disposed of on 12/18/12.<br>Food carts were re-sanitized using quaternary solution unmixed with cleaning solution on 12/18/12.<br><br>Measures put in place:<br>In-service provided to dietary employees by Certified Dietary Manager on 12/21/12 and 12/28/12 regarding preparation and service of cold foods, disposal of compromised small wares and proper use of quaternary solution.<br><br>Monitoring:<br>Certified Dietary Manager or designee will audit preparation and serving of cold foods weekly x 3 weeks and monthly x 3 months.<br>Certified Dietary Manager or designee will audit for damaged/compromised small wares weekly x 3 weeks and monthly x 3 months.<br>Certified Dietary Manager will monitor for appropriate use of quaternary and cleaning solutions weekly x 3 weeks and then monthly x 3 months. | 12/28/12<br><br>12/28/12<br><br>12/28/12 |

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| F 371 | Continued From page 2<br><br>2. During an inspection of kitchenware beginning at 10:25 AM on 12/18/12 11 of 20 plastic soup/cereal bowls were abraded and rough inside, 4 of 12 plastic dessert bowls were abraded and rough inside, and 6 of 20 coffee mugs were abraded and rough inside.<br><br>At 10:20 AM on 12/18/12 the dietary manager (DM) stated the dietary staff was trained to dispose of compromised kitchenware after showing it to her. She reported that compromised kitchenware included items which were cracked or chipped, items where the glaze or finish was damaged, and items which looked unappealing to residents and staff.<br><br>At 10:55 AM on 12/18/12 a dietary employee stated the dietary staff was responsible for pulling kitchenware which was chipped, cracked, scarred, broken, or stained. She reported this kitchenware was presented to the DM who usually instructed staff to throw it out.<br><br>3. At 9:40 AM and 9:55 AM on 12/18/12 a dietary employee wiped down meal carts which had returned from resident halls with a rag which she obtained from a red bucket. At 9:55 AM on 12/18/12 the dietary manager (DM) stated she thought this red bucket contained quaternary sanitizing solution.<br><br>However, at 9:57 AM on 12/18/12 when a strip, compatible with a quaternary sanitizing system, was used to check the solution in the red bucket, the strip did not change color. If quaternary solution was present in the bucket, the DM commented the yellow dot on the strip would | F 371 | Any area of identified concerns will be addressed with retraining and will be brought to the Q. A. Committee for any further needed action. | |

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| F 371 | Continued From page 3<br>change different shades of green based on the strength of the sanitizing agent. At this time the dietary employee who made up the solution told surveyors that the red bucket only contained dishwashing solution.<br><br>At 10:20 AM on 12/18/12 the dietary manager (DM) stated meal carts returning from resident care areas and dining rooms were to be wiped down with quaternary sanitizing solution after they were emptied in the kitchen. She reported a red bucket was filled with quaternary solution from the dispensing system at the three-compartment sink system and kept available for wiping down meal carts. According to the DM, the staff member who filled the bucket with sanitizing solution was supposed to check the strength with a strip before actually using it.<br><br>At 10:55 AM on 12/18/12 the dietary employee, who made up the red bucket of solution used on 12/18/12 for wiping down meal carts, stated she usually mixed soapy water with quaternary sanitizing solution when filling the bucket. She explained with this mixture the carts were both cleaned and sanitized. The employee reported it was important to kill the germs on the meal carts. She commented a strip, which changed different shades of green, was to be used to check the strength of the cart-cleaning solution. | F 371 | | |

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| | 345514 | A. BUILDING 01 - MAIN BUILDING<br>B. WING _____ | 02/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN CARE OF NASH | 1210 EASTERN AVENUE PO BOX 157<br>NASHVILLE, NC 27856 |

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| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type (V 111) construction, one story, with a complete automatic sprinkler system.<br><br>The deficiencies determined during the survey are as follows: | K 000 | This plan of correction will serve as the facility's allegation of compliance with requirements of 42CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of the plan of correction is in response to HCFA 2567 for the survey conducted 02/12/2013 and does not constitute an agreement or admission by Autumn Care of Nash of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. | |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 02/12/2013 the doors to the Equip. Room on the 400 hall, the soiled linen and the clean linen side of the laundry failed to close and latch.<br>42 CFR 483.70 (a) | K 029 | For the residents found to be affected and for those having the potential to be affected: Doors to Equipment Room and both doors to Laundry Room were repaired on 2/26/12. All doors checked and repaired as needed for proper closing and latching.<br><br>Measures put in place: Staff in-serviced to alert maintenance or administration of any doors which do not close/latch properly for immediate repair.<br><br>Monitoring: Environmental Services Director or his designee will perform audits to check for proper door latching/closings weekly for 4 weeks and then monthly thereafter to ensure they continue to operate appropriately. Any problems will be addressed immediately with repair. Results of these audits will be brought to Quality Assurance team quarterly for review and any necessary further action. | 2/26/13<br><br>3/3/13<br><br>3/4/13 |
| K 038<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section | K 038 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

3/1/13

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| K 038 | Continued From page 1<br>7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 02/12/2013 the staff interviewed did not know about the master release switch at the nurses station.<br>42 CFR 483.70 (a) | K 038 | For the residents found to be affected and those having the potential to be affected: Staff who were interviewed on 2/12/13 by Life Safety Surveyor were in-serviced regarding the master switches at nurses stations.<br>Measures put in place: All staff in-serviced to insure knowledge of master switches at nurses stations and individual release switches at each door.<br>Monitoring: Administrator or designee will audit by asking 4 persons each week about master switches for four weeks and then four persons monthly for 5 months to insure knowledge and compliance. Results will be brought to the Quality Assurance team for review and any necessary further action. | 2/12/13<br>3/3/13<br>3/4/13 |
| K 062<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 02/12/2013 the facility did not have documentation of the five (5) year obstruction test being done on the dry sprinkler system.<br>42 CFr 483.70 (a) | K 062 | For the residents found to be affected and for those having the potential to be affected: Five year obstruction tests were completed on 2/25/13 on both dry sprinkler systems.<br>Facility's Env. Services Director will keep records of needed inspections and follow up with contractor to ensure inspections are completed via a calendar/notebook.<br><br>Measures put in place: Calendar/notebook will be kept and monitored for required inspections by Environmental Services Director monthly. Book will be taken to QA. Committee to confirm testing complete and that future needed testing is scheduled timely. | 2/25/13<br>3/4/13<br>3/4/13 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2013
FORM APPROVED
OMB NO. 0938-0391

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| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type (V 111) construction, one story, with a complete automatic sprinkler system.<br><br>The deficiencies determined during the survey are as follows: | K 000 | This plan of correction will serve as the facility's allegation of compliance with requirements of 42CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of the plan of correction is in response to HCFA 2567 for the survey conducted 02/12/2013 and does not constitute an agreement or admission by Autumn Care of Nash of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. | |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 02/12/2013 the doors to the Equip. Room on the 400 hall, the soiled linen and the clean linen side of the laundry failed to close and latch.<br>42 CFR 483.70 (a) | K 029 | For the residents found to be affected and for those having the potential to be affected: Doors to Equipment Room and both doors to Laundry Room were repaired on 2/26/13. All doors checked and repaired as needed for proper closing and latching.<br><br>Measures put in place: Staff in-serviced to alert maintenance or administration of any doors which do not close/latch properly for immediate repair.<br><br>Monitoring: Environmental Services Director or his designee will perform audits to check for proper door latching/closings weekly for 4 weeks and then monthly thereafter to ensure they continue to operate appropriately. Any problems will be addressed immediately with repair. Results of these audits will be brought to Quality Assurance team quarterly for review and any necessary further action. | 2/26/13<br><br>3/3/13<br><br>3/4/13 |
| K 038<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section | K 038 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 3/1/13

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| K 038 | Continued From page 1<br>7.1, 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 02/12/2013 the staff interviewed did not know about the master release switch at the nurses station.<br>42 CFR 483.70 (a) | K 038 | For the residents found to be affected and those having the potential to be affected: Staff who were interviewed on 2/12/13 by Life Safety Surveyor were in-serviced regarding the master switches at nurses stations.<br>Measures put in place: All staff in-serviced to insure knowledge of master switches at nurses stations and individual release switches at each door.<br>Monitoring: Administrator or designee will audit by asking 4 persons each week about master switches for four weeks and then four persons monthly for 5 months to insure knowledge and compliance. Results will be brought to the Quality Assurance team for review and any necessary further action. | 2/12/13<br>3/3/13<br>3/4/13 |
| K 062<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 02/12/2013 the facility did not have documentation of the five (5) year obstruction test being done on the dry sprinkler system.<br>42 CFr 483.70 (a) | K 062 | For the residents found to be affected and for those having the potential to be affected: Five year obstruction tests were completed on 2/25/13 on both dry sprinkler systems.<br>Facility's Env. Services Director will keep records of needed inspections and follow up with contractor to ensure inspections are completed via a calendar/notebook.<br><br>Measures put in place: Calendar/notebook will be kept and monitored for required inspections by Environmental Services Director monthly. Book will be taken to QA, Committee to confirm testing complete and that future needed testing is scheduled timely. | 2/25/13<br>3/4/13<br><br>3/4/13 |