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

NOV 1 8 2013

-PRINTED; 11/01/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	**	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED	
		345514		B. WING		C 10/24/2013
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
4117171111	aine ar man		Ä	1	210 EASTERN AVENUE PO BOX 157	
AUTUMN	CARE OF NASH		1	N	IASHVILLE, NC 27856	
(X4) ID		ATEMENT OF DEFICIENCIES		ID .	PROVIDER'S PLAN OF CORRECTION	
Prefix Tag		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	
			200		DEFICIENCY)	
			- 1			
F 000	INITIAL COMMENTS		\$ 1 1 1	F 000	The state of the s	
		The second secon	1		Preparation and submission	
	No deficiencies were	clted as a result of the			of the plan of correction is in	
	complaint investigation	on survey. Event ID#	* 4		response to HCFA 2567 for	
	IVO511.		•		the 10/21/13-10/24/13	
F 248	483.15(f)(1) ACTIVIT	IES MEET		F 248	survey and does not	
SS=D	INTERESTS/NEEDS	OF EACH RES			constitute an agreement or	
	- ,,				admission by Autumn Care	
		ide for an ongoing program			of Nash of the truth of the	
		to meet, in accordance with ssessment, the Interests and			facts alleged or the	
		and psychosocial well-being			correctness of the	
		end payonosocial non-somig			conclusions stated on the	
			***		statement of deficiencies.	İ
					This plan of correction is	
	This REQUIREMENT	Is not met as evidenced	:	,	prepared and submitted	
	by:			,		
		n, resident and staff		,	because of the requirements	
		d review, the facility falled to			under state and federal laws.	
		lies for 2 of 3 residents.			Autumn Care of Nash	
	(Resident #30 and #1	47)			contends that it was in	
	Findings include:				substantial compliance with	
	Thungo mondo.		•		the requirements 42 CFR,	
	#1. Resident #30 was	s admitted to the facility on	7.		Part 483, Subpart B	
	4/3/13 with diagnoses	s of: hip fracture, dementia,		* ·	throughout the time period	
,		ase, congestive heart failure,	•		stated in the statement of	1
	urinary tract infection,				deficiencies. In accordance	
		deficiency, glaucoma,			with state and federal law,	[
	Osteoporosis; esopha	ageal reflux, and			Autumn Care of Nash	******
ŀ	hyperlipidemia.		•		submits this plan of	70
	Psychiatrist note date	d 10/4/13 stated resident			correction to address the	ĺ
		mosis of anxiety, dementia,			statement of deficiencies and	
	depression, insomnia					
		, (and the same of th	to serve	
-	Minimum Data Set (M	IDS) Admission/5 day dated			as its allegation of	
	4/10/13 section F, list	ed the following activity	.		compliance with the	
	preferences as very in	mportant: have books,			pertinent requirements as of	
	- A-C	dent of Albana				IVALDEYE
**************************************	HOLO OKS OR PROVIDERYS	UPPLIER REPRESENTATIVE'S SIGNAT	UKE	 تســـت	TITLE ()	(X8) DATE
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1-1 1 X			· - 1	10nunistration	<u> 川州ろ</u>

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 regulate to continued program participation.

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID:1VO511

Facily ID: 970979 - ...

If continuation sheet Page 1 of 8

	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES			FO FO	FED;11/01/2013 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE BUILDING		TE SURVEY MPLETED
		345514	В	. WING		C 0/24/2013
NAME OF P	ROVIDER OR SUPPLIER		14	\$	TREET ADDRESS, CITY, STATE, ZIP CODE	
ARITHMAN	OADE OF MACH	£	3.5	1	210 EASTERN AVENUE PO BOX 157	
AUTOMN	CARE OF NASH		11:	N	IASHVILLE, NC 27856	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		· ·		
F 248	Continued From page	:1	11	F 248		ļ
	newspapers, and mad	pazines to read, listen to			the dates stated in the plan of	
		und animals such as pels,			correction and as fully	
		s, do things with groups of			completed in all areas as of	
		te activities, go outside to			November 11, 2013.	
		weather is good, and			FOR THOSE RESIDENTS	
;	participate in religious	services or practices.			AFFECTED: Resident	
			- 1			1 . July
	ł .	on was made of resident on			#30's activity care plan was	11/11/13
		noted resident sitting in a	- 1		updated by the activity	
	wheelchair in the Activ				director on 10/29/13 to	
	listening to gospel mu	sic.			reflect the individual needs	
					of the resident with	
		Activity Director (AD) on	313		information gained via	
		the AD stated she has			Interview of resident,	Ì
		sic with resident for the last				
į		r week. One progress note	,i		Activity care plan goal was	:
		outer note section dated	. :.		updated on 11/08/13 and	
		stating "resident sit with			11/11/13 for Resident #30 by	
		ten to gospel music and	- 1		the activity director and the	
	me spending time with	She said she appreciated	· .	. [Q. A. nurse. For resident	
		the progress notes for			#147, the activity care plan	
		nt #147. The AD stated she			was updated on 10/29/13 by	
		n-house church weekly,			the activity director to reflect	
		oul of her room as much as	l			1
		ne is in her room too much			individual needs of the	
		go to bed ". The AD	.		resident with information	
		ust started " the music and		. [gathered by interview of	[
		/2013, she purchased 4		l	resident and family. Activity	[i
		, and is ready to download		İ	care plan goal was updated	
		uy a lap-top computer for		İ	on 11/11/13 by the Q.A.	
		The AD was asked if they			nurse. Activity Director is	
	have set up an in-roon			1		
-	residents ' who are ro	om bound or find it difficult	:	- "	responsible for	
	to get out of their room	s, she said no.		. 1	implementation of the care	
				}	plans. Residents #30 and	
		bservation on 10/23/13 at	::		#147 both have interventions	
		nt resting with bed in low	1	-	of in-room activities at least	
- [position, fall mat on rig	ht side of bed,1/2 side rails		.	twice weekly by activity	

	MCNT OF BEALTH AN			•		FOR	M APPROVED
CENTER	S FOR MEDICARE &			· · · · · · · · · · · · · · · · · · ·		OMB NO	O. 0938-0391
	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	(X2) MÜLTIPLI A. BUILDING	E CONSTRUCTION'	(X3) DATE	E SURVEY PLETED
İ			~ 4				C
		346514		B. WING		10.	/24/2013
NAME OF P	ROVIDER OR SUPPLIER	No. 2011		1 8	STREET ADDRESS, CITY, STATE, ZIP CODE	1 1.32	<u> </u>
			4-4-		1210 EASTERN AVENUE PO BOX 167		
<u> </u>	CARE OF NASH			1	NASHVILLE, NC 27856		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL		ID.	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG		SCIDENTIFYING INFORMATION;	1	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFIC(ENCY)		1
					12,000		
F 248	Continued From page	2	1	F 248			l
				1 240	personnel or volunteers.		1
	up, and a call light will	mi reach.			FOR THOSE RESIDENTS	ı	
:	An interview with the f	adillia AD ADIDAMO -1	11				
	10:11 am the AD state	acility AD on 10/24/13 at and the resident's family has		1 1 1	WITH THE POTENTIAL		
	foton the resident te a	su the resident's family has	- :		TO BE AFFECTED: AI	l	
		ctivities in the past, but he le AD stated she did not			other residents were	;	
					reviewed who were assessed		
	document every reside	, it would take her all day to			for the need for in-room		11/11/13
	document avera residi	ints refusal,		k.	activities by the activity		1141413
	Eiva minuta abassuatie	on was made of resident on					
		Resident was resting in			director completed 11/8/13		
	had lights were out of	de ralis up, call light within			Updating of care plan focus		
		y doll at bedside, head of	[* * .	and goals was completed on		
		w position, and fall mat	. [11/11/13 by the activity		
	was on the floor on the	w position, and fall that			director and the Q.A. nurse,		
	Mas on the hoof on the	right side of the bed.	ŀ		Activity director is		
	Stoff Intonious with the	facility AD on 10/24/13 at					
	2.30 nm who elalad	we will be starting an in			responsible for		
		for all residents ' 5 days			implementation of care		
1		/2013. Her activity-assistant			plans. Those residents		
		and do activities in T	.;		needing in-room		
		that today she set up an		1000	interventions have been		
		he residents rooms. Also,			interviewed by the activities		
	the AD said she is wor	king on starting the Music	_ 1		director to determine		
	in Memories Program.			**			[
1					interests for activities. Each		1
ŀ	NA Care guide dated 1	0/14/13, noted "	- 1		resident will receive in room		
la de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de	ambulation with assista		- 1		activities at least twice		
-	walker, ensure proper			* ***	weekly and documented.		
	ambulation. Bed mobil				MEASURES PUT IN		
	Restorative, physical th		.		PLACE TO PREVENT		ļ ļ
		erapy by certified nursing			RECURRENCE Activity		, 1
	assistants * " .						11/11/13
					personnel in-serviced		
					11/8/13 by Regional		ļ
	2. Resident #147 was	admitted 8/28/13 with a	- [MDS/Care Plan Nurse in	. [
	diagnosis of: bladder n				reference to the formalizing		
	gastrointestinal hemore				of resident care plans to		
		, dysphasia, acule kldney			include individualized focus		

include individualized focus

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D;_11/01/2013_ WAPPROVED D, 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		345514		B. WNG		l	C 24/2013
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF NASH		2		210 EASTERN AVENUE PO BOX 157 IASHVILLE, NC 27856		
WALID	TO VOLUMBE	NEMENT OF DEFICIENCIES	-	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
5040			į			-, -, -,	
F 248	Continued From page		-	F 248	as it pertains to resident		
		e retention, personal history			choice and measurable goals.		
		muscle weakness, and the periension, with a status of	•		In addition, an individualized		
	do not resuscitate.	penension, with a status of			activity roster will be		
	do not roodoonato,		•	:	maintained on each		
	Review of resident's	medical record, medical	÷				
	data set dated 9/27/13	3 under section C revealed			resident to document activity		
		S) summary score of 3.			attendance, designating		
		DS) Admission/5 day dated			group or in-room activities.		
		er activity preferences listed	. :		Q.A./MONITORING:		
		as very important: have indicate magazines to read,			Administrator or designee	,	
		e, be around animals such			will audit four residents who	}	while
		the news, do things with	: . Ĭ	(X - X	have been assessed to need		11/11/13
		our favorile activities, go	-		in-room visits weekly for 4		
		r when the weather is good,			weeks and then monthly for		
	and participate in relig	ious services or practices:			4 months to insure that care		
[plan focus is individualized		
		facility Activity Director on			to meet resident choices of	ļ	
j	#147 's wife takes hin	The AD stated resident			activities and to insure that		
	weekly. She also state				the goal is measurable.		i
		, but gets agitated, and that	2.5		Documentation will be		
1		y usually takes him to the			reviewed by administrator or		
1	activities.				designee to check for activity		·
				.:	occurrences and]
		on 10/23/13 at 3:28 pm,	- 1		resident/family will be		1
		m, bed in low position, 1/2			interviewed to determine		l
	and the TV was on. T	present on left side of floor,			satisfaction with		
	watching the TV; he ju				provision/appropriateness of		
	ceiling.	Trucks Aming Minio			activities. Any area of		
	·		;. 		identified concern will be		
		tivity Director on 10/24/13 at		14	addressed at the time.	1	
•		resident's family have taken			Results of all audits will be		
		the past, but he never	- 1				
	stayed long. The AD s		.	: ;	discussed quarterly at the		
	document this; stating, document every reside	, it would take her all day to ents' refusal.		n 11	facility's Q.A. meetings to		

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED:11/01/2013- FORM APPROVED DMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NOD PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		:. :.	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345614	::	B. WING		10/24/2013
NAME OF P	ROVIDER OR SUPPLIER		1.	., . 3	TREET ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	CARE OF NASH				210 EASTÉRN AVENUE PO BOX 167 ASHVILLE, NC, 27868	
(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 BE CROSS REFERENCED TO THE APPROPRIAL DEFICIENCY)	
F 248	Continued From page	·4	: 1	F 248	determine if any further	
	Resident interview on	10/24/13 at 11:08 am,			action is needed.	
	resident stated he like	s to go to the activities	:	*:		
	when taken, and does was taken to an activi	not know the last time he ty.		٠		
	Facility Administrator of facilities role to help a	ssist the resident to meet		·		
	his/hers activity needs	as a group or individually,"				
	•			٠,		
	call light within reach, of bed elevated, bed in	10/24/13 at 2:28 pm, I, lights out, side ralls up, baby doll at bedside, head n low position, fall mat on				
	right side of bed.	A Table				
	2:39 pm, who stated the					
	week, with the activity implement activities in	residents 1 room. She		100-100 miles		
İ	for the activity assistar	she set up an activity cart it to take to the residents; she is working to start the		Thronger		
ŀ	Music in Memories Pro	ogram,	1			
	NA Care Guide dated inform resident of daily	10/14/13 listed "'Activitles,				
İ	non-ambulatory. Spea	ik to resident calmly and				
	monitor for pain and re	nitor agitation/restlessness,				
	Monitor for risk for falli	lus and report to nurse, ng. Communication - rect questions/answers,				
		eded, allow adequate time		1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CEMIE	S FUR MEDICARE &	MEDICAID SERVICES	ــــــــــــــــــــــــــــــــــــــ	· · · · · · · · · · · · · · · · · · ·	OMB NO. 0938-	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345514	B. WNG		C	
NAME OF F	PROVIDER OR SUPPLIER	030014		STREET ADDRESS, CITY, STATE, ZIP CODE	10/24/2013	
				1210 FASTERN AVENUE PO BOX 167		
AUTUMN	CARE OF NASH	الله النظيم في المعتبر الله الله الله الله الله الله المناطقة الله المناطقة الله المناطقة الله المناطقة الله ا المناطقة الله الله الله الله الله الله الله الل		NASHVILLE, NC 27856		
	Out the first or					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TO BE COMPTE	
				1,1		
F 248	Continued From page	E.				
, 2.10	a annument a sent bende		F2	48		
	Activity Progress note					
		interested in attending some	,			
	activities.	Gamelant man matter than the transfer				
		Itended any activities, but is			Í	
	care.	lly is very supportive in his				
	1	attended any activities but is				
		lly is very supportive in his				
	care.	ny is vory supportive in this				
	9/24/13 - He has not a	altended any group			ŀ	
	activities. His family i	s very supportive			•	
	10/23/13 - Went to off	fer to play music for				
		vant to hear music at this	1.1 (2.50)	and the second		
	time. He said he wan		400000			
	10/24/13 - He has not		1 10 00			
	activities. We will con	nlinue to check and see if he				
		some music. His brother			-	
		ile for him sometimes. His				
	family is supportive.		ŀ			
F 281	483.20(k)(3)(i) SERVI	CES PROVIDED MEET	F 28	81 POD THE DEGREEN	err.	
\$S≒D				FOR THE RESIDEN	1	
				AFFECTED:		
		f or arranged by the facility		On: 10/23/13, the R.7		
	must meet profession	al standards of quality. 📜 🖐		Nursing Supervise	or ,	
			:	scheduled the sliding sca	le 11/11/1	
	TIL OF AUTOR LOUIS			insulin for Resident #19	in	
		is not met as evidenced	1	the electronic health reco		
	by:	and the second second		to insure nurses docume		
		ew and staff interviews, the		each time sliding scale do		
		s elevated blood sugars for				
	include:	ent # 19). The findings		is administered according	1	
	HICIUGO:			blood sugar paramete		
	A review of the Dream	ss Notes for resident # 19		given by the attendir	ıg	
		23/2013 and 10/24/2013.	- 1	physician.		
		e nursing staff falled to		FOR THOSE RESIDENT	'S	
	document the assessm			WITH THE POTENTIA		
	coverage of elevated t			TO BE AFFECTED: Four		
Į	vo. viego oi oioraiga i	NAAA AASIRIA IAI IA		TO THE ULTRATEDITIES TO BE	ı	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			
· .			V. BOILDING		C		
		345514	B. WING		10/24/2013		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/24/2010		
1				1210 EASTERN AVENUE PO BOX 167			
AUTUMN	Care of Nash	一 郭 二二乙基氯酚醇 莉	- 1	NASHVILLE, NC 27856			
(X4) ID	SUMMARY SY	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION		
F 281	Continued From page		F.281	attian matdanta man			
		ree month period. The		other residents were			
	dates and time include	ed:		identified as having orders			
	10/20/13 at 6:30AM,			for sliding scale insulin			
	10/17/13 at 4:30PM,	一位 建流纹套		based upon blood sugars.	į		
	10/15/13 at 4:30PM,	State of the state	·	On 10/23/13 and 10/24/13,			
	10/14/13 at 4:10PM,			the R.N. supervisor reviewed	1		
	9/23/13 at 4:30PM, 9/22,13 at 6:19AM,			all residents to determine	1.1		
	9/22/13 at 4:30PM,			existence of orders for	14/4/13		
	9/21/13 at 6:30AM,			sliding scale insulin. During	, , , ,		
	9/18/13 at 4:30PM,			the audit, 4 residents were			
	9/15/13at 4:30PM,			identified to have been			
	9/11/13 at 3:42PM,						
	9/10/13 at 4:30PM,			affected, and orders were	1		
	9/9/13 at 4:30PM,	1 !		correctly scheduled in the			
	8/16/13 at 4:00PM,			electronic health record by]		
	8/10/13 at 4:30PM.		1	the R.N. Supervisor to	1		
				insure nurses document each	1		
		ian 's orders for resident;		time sliding scale dose is			
		n 10/23/2013. The review let stating "Blood Glucose		administered according to			
	monitoring BID continu			blood sugar parameters			
{		Sliding Scale Humulin R as	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	given by the attending			
		=None, 200-300= 5 Units,		physician.			
	301-400=10 Units, 40			MEASURES PUT IN	-		
			1	PLACE TO PREVENT			
	On 10/24/2013 telephi	one interviews were		RECURRENCE: Licensed	, ,		
	conducted with Nurse	#2, Nurse #3, Nurse #5			11/11/13		
		rses all stated they were		staff in-serviced by the Staff			
		lent # 19 had an elevated		Development			
		ove mentioned dates. The		Coordinator(R,N.)beginning			
		y were unable to recall		10/23/13 in regards to proper			
		ssment of elevated blood		entry of blood sugar readings			
	sugars or the administ	dent # 19 on the above	1	and subsequent use of sliding			
	mentioned dates.			scale insulin into the			
1	monation ages,		, ,	electronic health record,			
Ì	On 10/23/2013 at 3:45	PM a telephone interview		17 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
		urse #4. The nurse stated					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DAT		
				c	
NAME OF O	PROVIDER OR SUPPLIER	345514.33.33.33	B. WING		10/24/2013
				STREET ADDRESS, GITY, STATE, ZIP CODE 1210 EASTERN AVENUE PO BOX 167	
AUTUMN	CARE OF NASH		1	NASHVILLE, NC 27866	
(X4) 1D		ATEMENT OF DEFICIENCIES	, ID	PROVIDERS PLAN OF CORRECTION	E CONNETION (X2)
PREFIX TAG		Y MUST BE PRECEDED BY FULL. SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS REFERENCED TO THE APPROPRI	
				DEFICIENCY)	
F 281	Continued From page	17 The Park 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	F 281		
		elevated blood sugar on	1 201	Q.A./MONITORING: Director	
	10/20/2013 at 6:30AN	1. She was unable to recall	1 1 1 1 1	of Nursing or designee will	1
	documenting the asse	essment of the elevated 💛 🐰		monitor all residents receiving	
	blood sugar or the ad	ministration of insulin in the		sliding scale insulin for two	İ
	nurses incles for the	resident on 10/20/2013.		weeks, then will monitor 4 residents on sliding scale	
	On 10/23/2013 at 11%	15AM an Interview was		insulin weekly for two weeks	
	conducted with the DI	rector of Nursing (DON).		and then monthly for 4 months	
	The DON stated the o	order for Humulin R Sliding	Ì	to insure sliding scale insulin is	
		ent # 19 was "Incorrectly		entered into the electronic	Whiles
		edication administration		health record accurately, Audit	11/11/13
		he order was recorded on		includes checking to insure	
		ment which did not provide		residents with sliding scale	
		to record the amount of She further stated some of		insulin orders have the orders	
	the nurses record the	one further stated some of		correctly entered into the	
	administered in the nu		1	electronic health record	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			insuring proper documentation	
				of sliding scale insulin as	
				related to documented blood	
				sugars. During daily clinical	
ĺ				conferences, all new orders will	
				be reviewed to insure residents	1
				with sliding scale insulin are	ĺ
		: 1		entered correctly in the electronic health record by the	
				D.O.N./designee. Any area of	
				identified concern will be	
				corrected at that time. Results	ļ
				will be reviewed monthly by	
				the Q.A. team to determine	
				sustained compliance and any	
	•			continued area of concern will	***************************************
				be reviewed for further action	
į		# 2. #1. #1. #1. #1. #1. #1. #1. #1. #1. #1		plan."	
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ļ			1	医二氯磺胺 医多睫囊炎	

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

NOV 2 6 2013

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	STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION				riple constr <u>uction</u> ng 01 - mainchluiding TION SECTIO	(X3) DATE SURVEY COMPLETED
AUTUMN CARE OF NASH AUTUMN CARE OF NASH 120 EASTERN AVENUE NASHVILLE, NC 27865	345514			B. WING_		11/15/2013
K 000 INITIAL COMMENTS 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 list referenced publications. This building is TypeVI (111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exils, or hazardous areas are substantial doors, such as those constructed of 11/1 Inch sollid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means sutlable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Roller latches are prohibited by CMS regulations in all health care facilities. This plan of correction will serve as the facility's allagation of complance with requirements of description of the plan of correction in the representation of the plan of correction in the representation of the plan of correction in prepared and ashmission of the plan of correction in the representative because of the requirements of description and prepared and ashmission of the plan of correction in the representation of the current of the correction is the representation of the current of the correction in the close of the requirements of description and represents of the current of the correction of the current of the curr	AUTUMN CARE OF NASH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				1210 EASTERN AVENUE NASHVILLE, NC 27856 PROVIDER'S PLAN OF CORE	RECTION (X6)
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 TypeVI (111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: K 018 NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dulch doors meeting 19.3.6.3.6 are permitted. Roller latches are prohibited by CMS regulations in all health care facilities. This plan of correction with certain at legation of compliance with requirements of 42CRP, part 483, Subpat B for long term care facilities. Preparation and submission of the plan of correction is prepared and submitted because of the conclusions stated on the statement of deficience. This plan of correction is prepared and submitted because of the requirements winder state and federal laws. For the resident found to be affected: Door to Room 105 was repaired in Initial state on the statement of well and deficient laws of the conclusions stated on the statement of deficience. This plan of the correction is prepared and submitted because of the requirements and defined laws and technical state of the correction is prepared and submitted because of the requirements under state and federal laws. For the resident having the potential to be affected: All doors checked and repaired as needed for proper closing and latching as of 1117/13. Measures part in place: Staff in serviced to alert maintenance or administration of any doors which do not closed	TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE DATE
NFPA 101 LIFE SAFETY CODE STANDARD NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means sulfable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. K 018 K 018 For the residents having the potential to be affected: All doors checked and repaired as needed for proper closing and latching as of 11/17/13. Measures put in place: Staff in-serviced to alert maintenance or administration of any doors which do not close/fatch properly for immediate repair. Monitoring: Environmental Services Director or his designed will perform audits to check 10 doors for proper door latching/closings weekly for 4 weeks and then mountally for 5 months to ensure they continue to operate appropriately. Any problems will be addressed immediately. Results of these audits will be brought to Quality Assurance team quarterly for review and any necessary further action. This STANDARD is not met as evidenced by: A. Based on observation on 11/15/2013 the door	K 000	This Life Safety Co conducted as per T at 42CFR 483,70(a Health Care section publications. This b construction, one si automatic sprinkler	ode(LSC) survey was he Code of Federal Register); using the 2000 Existing n of the LSC and its referenced uilding is TypeVi (111) tory, with a complete system.	K 00	This plan of correction will serve as the allegation of compliance with requirem 42CFR, Part 483, Subpart B for long to facilities. Preparation and submission correction is in response to HCFA 2567 survey conducted 11/15/2013 and does an agreement or admission by Autumn of the truth of the facts alleged or the cothe conclusions stated on the statement deficiencies. This plan of correction is submitted because of the requirements of the requirements of the requirements.	ents of rm care of the plan of 7 for the not constitute Care of Nash orrectness of of prepared and under state
A. Based on observation on 11/15/2013 the door ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6)/QATE		Doors protecting corequired enclosures hazardous areas ar those constructed of wood, or capable of minutes. Doors in srequired to resist the no impediment to the are provided with a the door closed. Do are permitted. 19 Roller latches are pin all health care face.	orridor openings in other than so of vertical openings, exits, or e substantial doors, such as if 1% inch solid-bonded core fresisting fire for at least 20 sprinklered buildings are only e passage of smoke. There is ne closing of the doors. Doors means suitable for keeping atch doors meeting 19.3.6.3.6.3.6.3.6.3.6.3.6.3.6.3.6.3.6.3.	K 01	105 was repaired 11/16/13. For the residents having the potential to Ali doors checked and repaired as needeclosing and latching as of 11/17/13. Measures put in place: Staff in-serviced maintenance or administration of any denot close/latch properly for immediate reproper door latching/closings weekly for and then monthly for 5 months to ensure continue to operate appropriately. Any be addressed immediately, Results of the will be brought to Quality Assurance terms.	be affected: ed for proper I to alert oors which do repair. Prirector or his 0 doors for or 4 weeks e they problems will lesse audits am quarterly
	ABORATOR			IATURE	Amuns Val	(X6),QATE

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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STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED	
		345514	B. WING		11/15/2013	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1210 EASTERN AVENUE NASHVILLE, NC 27856		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETION	N
K 018	Continued From pa to bed room 105 fai 42 483.70 (a)	ge 1 led to latch when closed.	K 018			
77.70						