STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0456	A. BUILDING: _____ B. WING _____	C 09/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

(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) COMPLETE DATE
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure staff transferred a resident with 2 staff members as directed on the Resident Report Sheet for 1 of 2 sampled residents reviewed for transfers (Resident #1).The findings included: Resident #1 was admitted to the facility on 4/26/10 and had diagnoses that included Cerebrovascular Accident with Right Hemiparesis and Right Foot Contracture. The resident was discharged from the facility on 8/19/14. The most recent Resident Mobility/Transfer Profile form for the resident dated 5/29/13 revealed a hand written note under the comments section that the resident was to be transferred with 2 person assist per family request. A quarterly assessment review dated 5/16/14 revealed the resident was able to make her needs known and follow directions but was forgetful and needed reminders. The assessment revealed the resident was non-ambulatory, used a wheelchair for mobility and had no limitations of her upper extremities. The assessment revealed the resident was up in her wheelchair daily and was independent with mobility in the wheelchair after set-up. The assessment revealed there had	D 270	This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to HCFA 2567 for the 9-16-14 survey and does not constitute an agreement or admission of Autumn Care of Shallotte 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 of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it□s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 9/24/14 Resident Affected Resident #1 - Transferred immediatley to hospital on 8/19/14 for further evaluation. Resident With The Potential To Be	9/24/14

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D 270	Continued From page 1 been no significant changes since the last assessment. The Director of Nursing (DON) stated in an interview on 9/15/15 at 2:00 PM that the Resident Report sheet included preferences from the resident, family and instructions from the care plan. The DON stated the Resident Report Sheet for Resident #1 stated the resident was a 2 person assist for transfers. NA (Nursing Assistant) #1 stated in an interview on 9/15/14 at 5:10 PM that she assisted the resident to the bathroom on 8/19/14. The NA stated the Resident Report Sheet she received at the beginning of her shift included information that Resident #1 was to be transferred with 2 staff members. The NA stated she frequently transferred the resident by herself and the resident could hold onto the bar in the bathroom and assist with the transfer. The NA stated on 8/19/14 she knew the resident was supposed to be transferred with 2 staff members but she was the only NA on the 300 hall and the NA on the 400 hall was orienting a new NA and she did not want to bother them so she transferred the resident by herself. The Physical Therapist (PT) that did the mobility assessment on 5/29/13 stated in an interview on 9/16/14 at 2:55 PM the family had requested that 2 staff members assist the resident with transfers, therefore the resident had not been re-assessed by physical therapy for transfers since that time. The DON stated in an interview on 9/16/14 at 12:40 PM that she had started a plan of correction and the staff had already been in-serviced on transferring residents and they	D 270	Affected Nursing staff was in-serviced by DON on 8/19/14, 8/20/14, 8/26/14, 8/27/14 and 8/28/14 on wheelchair positioning, transfers and mobility status, and adhearing to resident transfer assessment. Systemic Changes DON or designee will observe at least 4 C.N.A. weekly, times 4 weeks and then monthly for 3 months during transfer of residents to ensure C.N.A.'s adhere to transfer/mobility status as indicated on transfer assessment. DON and Administrator or designee will review 5 times a week for 3 months, all incidents involving transferring of residents to ensure adhearance to resident transfer assessment. Monitoring Changes/Systems to Ensure No Deficient Practices Findings of the above stated audits will be reviewed by the Quality Assurance/Performance Improvement Committee, monthly for 3 months for recommentations and furthr follow-up,as indicated. If substantial compliance has been met and no further areas of concerns are identified, review of the audits for resident mobility status will be discontinued for the purpose of this audit and PoC.	

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D 270	Continued From page 2 were in the process of re-evaluating all residents to determine their current transfer needs.	D 270		